Healthcare Administration Professional Advisory Group Newsletter
Summer 2021

Dear Colleagues,

Welcome to the 2021 Health Administration Professional Advisory Group (HAPAG) Summer Newsletter! I hope you enjoy this edition's content. It reflects the thoughts and activities of your HAPAG colleagues. A special thanks to the members of the communications team for coordinating the content and to those officers who took the time to submit an article.

My name is CDR Brandon Johnson and I am your 2021 Chair. I joined the U.S. Public Health Service in 2007 in Rockville, MD and served for greater than a decade at my first duty station, the Substance Abuse and Mental Health Services Administration. I have been an active participant in HAPAG, BCOAG, and COA subgroups and many committees throughout my career. I currently serve as a Health Services Administrator for Immigration and Customs Enforcement in the New York City Metropolitan Area. I oversee three health service units in New York and New Jersey.

To recount our goals for the year, we have three focal areas: data informed decision making, recruitment, and collaboration. We have continued efforts to use our 2019 and 2020 needs assessment data to offer programming to you, our constituents. We have also begun to evaluate each event via post attendance surveys for real-time data on our initiatives. Our recruitment, stakeholder and community engagement, and training education and mentorship sub-groups are actively developing initiatives and in collaboration with officers. The HAPAG has engaged in inter-PAG collaborative programming and discussions with HSPAC and PAG leaders on how to better serve our membership. Our recent successful event was "A Conversation on Leadership with General David Petraeus" which reflected the high quality events and targeted events we plan to bring you in the future. An article highlighting the event is part of this newsletter. I hope you are able to review it or witness the webinar recording first hand.

These initiatives reflect our efforts to address the needs indicated in recent surveys. We are encouraged by your increased engagement and responsiveness to post-event evaluation surveys. If something we implement does not provide value, please reach out and let us know or indicate this in the surveys! We want to know.

We have a packed calendar planned! Join us on our bi-monthly call, get engaged with a committee, and let us know how we're doing! Remember, many hands make light work and no contribution is too small.

Sincerely,

Brandon T. Johnson, Ph.D. MBA
CDR, U.S. Public Health Service
Chair, Health Administration Professional Advisory Group

Visit the HAPAG Webpage for updates and additional information, including the HAPAG Roster.

HAPAG Stakeholders and Community Engagement News

By LCDR Brandy Rose, MSHI, RHIA and LCDR Gene Crisp, MHA, MBA

The HAPAG Stakeholders and Community Engagement Subcommittee has been working to establish networks among our fellow officers for promoting advanced credentials and/or certifications. As a HAPAG officer, we have obligations to fulfill benchmark criteria, with one being to obtain credentials or certifications to display an officer's extensive knowledge and expertise. This is one of the reasons why we have reached out to fellow HAPAG officers for information regarding their advanced credentials and how anyone can acquire them.

Some officers face the requirement for an advanced credential placed upon them by their assigned duty stations, and we as professionals seek opportunities to promote our knowledge and skillsets by holding credentials and certifications.

To support our project, we have contacted all HAPAG officers to inquire who holds an advanced credential beyond their requirement for commissioning and asked for them to respond with the information listed below regarding the type of credential, primary use, requirements for obtaining it, and estimated overall cost.

Our next step will be to collaborate with the Education Training and Mentorship Subcommittee to provide more information and support to those who are seeking an advanced credential.

Type of Advanced Credential	Primary Use	Requirements to Earn Credential	Estimated Cost
Certified Health Data Analyst (**CHDA**)	Health Informatics Position	Candidates must meet one of the following eligibility requirements to sit for the CHDA examination: • Hold an RHIT® or RHIA® credential; or • Bachelor's degree or higher degree from an accredited college or university While not required, the following are recommended: • Minimum of 3 years of healthcare data experience • Experience in data acquisition, data analysis, data management, data interpretation and reporting, and data governance	The exam cost is $329 for Non-AHIMA member; $259 for AHIMA member

American Academy of Medical Administrators (**AAMA**) / American College of Healthcare Executives	Fellow Credential	Written examination and complete over 40 hours of continuing education credits	Look up cost using webpage - https://www.ache.org/fache/earn-my-fache
COR Level III	Federal Contract Management	80 Hours of Coursework via Defense Acquisition University	Free
Graduate Certificate in Applied Behavioral Analysis (**ABA**)	Organizational Behavior Management (OBM), Consulting, Performance Improvement	6 graduate level courses in ABA	$9,000
MPH-Master's in Public Health, PhD in Epidemiology	Work and future consulting	Attending several universities, internships, and money	$172,294
Certified Project Management Practitioner (**PMP**)	The objective of the CPMP course is to add value to management professionals by developing managerial, leadership and technical skills required to make any project, small or complex, a success	PMP Exam Application Process - • Register to become a member of the Project Management Institute. • Take our PMP certification training course to satisfy the required 35 hours of education requirement. • Submit your PMP application online. • Schedule your exam with Prometric. Take and Pass the PMP Exam.	• $139 to become a member, but it saves you money on exam fees. • The standard non-member price to take the exam is $555 • The PMI member price for the exam is $405
Certified Health Education Specialist **(CHES)**	General	Exam	• Exam fee $270-$320 • Annual dues $60

Modern Healthcare, Evidence-Based Leadership, and the Unique Role of USPHS Healthcare Administrators

By CDR Brandon T. Johnson, PhD, MBA

Health administrators have a unique role in the U.S. Healthcare system. We serve as experts in business, economics, data analysis, and management and bring these expertise to bear to direct, advise, and consult healthcare organizations (Novick, Morrow, & Mays, 2008). The field of public health often focuses on maximizing the impact of interventions (Frieden, 2015). Health administrators focus on the role of organizations and systems in addressing health problems, which complements the emphasis in public health. Over the past two decades, two pivotal events have also changed our relationship with the field of healthcare and public health.

First, following the events of September 11, 2001, the U.S. placed greater emphasis on public health preparedness and infrastructure. The U.S. government created the Department of Homeland Security (DHS), reorganized Federal Emergency Management Agency (FEMA) under the DHS hierarchy, and subsequently impacted the National Disaster Medical System (NDMS) through additional investments and collaboration with public health partners (Khan, 2011; Koenig, 2012). While the NDMS had been in place since the 1980s, its role had evolved to support local and national medical and public health emergencies as part of the national response plan under emergency support function (ESF)-8, the public health and medical support mechanism (FEMA, 2008). This role further expanded after September 11 to include response activities for terrorist attacks and national health security functions for pre-planned events (Franco, Toner, Waldhorn, Inglesby, & O'Toole, 2007). Novick and colleagues (2008) notes that the expanded role of public health infrastructure includes addressing threats from bioterrorism and infectious disease. Given the global health crisis surrounding COVID-19, public health responses to infectious disease and other crisis events remain a particularly salient issue. The changing landscape of public health practice requires leadership with the ability to function in crisis (Rowitz, 2014). Given training on the NDMS and deploy capabilities of health administrators serving with Commissioned Corps of the U.S. Public Health Service, we are uniquely positioned to meet that challenge.

Second, the prevention and management of chronic diseases became a major emphasis in public health and healthcare during the past half-century (Remington & Brownson, 2001). While less stirring and perhaps slower paced than national public health emergencies, bioterrorism, and pandemic response, chronic disease poses no lesser threat to the health of the American public. Many chronic disease states, driven primarily driven by environmental contingencies and behavioral excesses or deficits (Halpin, Morales-Suárez-Varela, & Martin-Moreno, 2010; Remington & Brownson, 2001), can be succinctly highlighted through two problems which represent both past success and present challenge. Tobacco cessation and obesity represent both old and new challenges for the field of public health (Remington & Brownson, 2001). We have witnessed a significant reduction in tobacco use due to regulatory and health related intervention and this is a significant achievement for the field of public health (Halpin, Morales-Suárez-Varela, & Martin-Moreno, 2010; Remington & Brownson, 2001). It further represents real-world outcomes on incidence of cancer and other preventable disease. In contrast, increases in the rate of obesity have resulted in increased hypertension and diabetes in the American public and globally (Halpin, Morales-Suárez-Varela, & Martin-Moreno, 2010; Remington & Brownson, 2001).

Additional challenges also present additional opportunities. The use of telehealth, remote monitoring, and other technological innovations offers new strategies for engaging with patients (Coye, Haselkorn, & DeMello, 2009). Implementing these new technologies requires something USPHS officers are positioned to offer, evidence-based leadership. Moreover, Halpin, Morales-Suárez-Varela, and Martin-Moreno (2010) assert that addressing the population health challenges posed by chronic condition requires leadership from within government. Finally, two primary drivers of technological innovation fall squarely within the role of

healthcare administrations, improvement in outcomes and reductions in cost (Coye, Haselkorn, & DeMello, 2009). These are squarely within the business skillsets of healthcare administrators.

In a 2012 article, Brownson and colleagues discuss the use of evidence-based decision making in public health organizations (Brownson, Allen, Duggan, Stamatakis, & Erwin, 2012). The article examined the status of current literature on the topic and found plenty of evidence on what to implement, but limited data on “how” to implement the interventions. Janati and colleagues (2018) assert that leading in current healthcare environments requires the use of evidence-based decision making and management. They further point out that the decision of healthcare manager have significant impact on organizational success and quality of care (Janati, Hasanpoor, Hajebrahimi, & Sadeghi-Bazargani, 2018). Along these lines, Davidson et al., (2012) identified several key competencies for healthcare leaders, among these competencies were scientific competence. Thus, while we may not be on the front line of providing healthcare, we should be utilizing evidenced-based approaches to ensure the effective management of healthcare.

Thus, healthcare administrators are scientist-practitioners. They lead and manage organizations, they implement organizational and system-level improvements, and they engage in the dissemination of evidence-based practice through the scientific enterprise. Healthcare administrators have a significant role in the current healthcare environment. High quality management is in demand (Janati, Hasanpoor, Hajebrahimi, & Sadeghi-Bazargani, 2018) and the healthcare administrators of the U.S. Public Health Service are the vangaurd.

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Advanced Readiness Program Overview

By LCDR Ramses Dias-Vargas and LCDR Sunshine Jones-Chaney

For Health Services Officers (HSOs), the Advanced Readiness Program (ARP) focuses on deployment and technical readiness preparation far above and beyond the USPHS Basic Readiness requirements. The focal point of the extensive two-year ARP program is deployment, technical, and field readiness covering topics such as management, leadership, and communication. Clinical areas of study, including practical application, topics of field readiness like the Field Medical Readiness (FMR), and awareness of the Readiness Deployment Branch requirements are also elements of the ARP.

Advanced Readiness is made up of three (3) components: Deployment, Technical and Field.

> Deployment Readiness component consists of training that applies to all HSOs, regardless of discipline (i.e., PAG designation); these courses typically cover management, leadership, and communications;
>
> Technical Readiness component courses are discipline specific, and for clinical PAGs include clinical courses and/or increased practiced clinical hours; and
>
> Field Readiness component to ensure officers have some field experience such as FMRB in PIR, FMRB courses completed, or 7 days of agency and/or RDB deployments.

Applications for enrollment in the Advanced Readiness Program (ARP) are initiated by engaging your Professional Advisory Group (PAG) Technical Readiness Subgroup and submitting the completed application to ADVANCEDREADINESS_HSPAC@LIST.NIH.GOV . The enrollment period begins April 1 (program starts July 1), and October 1 (program start January 1) of each year. Successful completion of the ARP requires 50 hours of pre-approved advanced readiness training courses and for officers in a clinical discipline, an additional 120 hours of chronicled practice per each year of the program.

Highlights from a Leadership Conversation with Retired General Petraeus

By CDR Helen Hunter Cox, MHS

On March 18, 2021 HAPAG officers were given a golden opportunity to hear leadership perspectives from General David H. Petraeus (US Army, Ret). HAPAG and the Social Work Professional Advisory Group (SWPAG) co-hosted this well-attended virtual event. After an introduction by CDR Stephanie Felder and opening remarks by RADM Matthew Kleiman, the leadership discussion with General Petraeus was moderated by LT Janelle Phillip. With more than 37 years of distinguished military service and recognition as one of "America's 25 Best Leaders" by *US News and World Report,* General Petraeus provided key insights from his career experiences and gave officers in attendance challenging reflective questions to consider in our own career paths. Below are just a few highlights from the discussion.

Gen. Petraeus began with recommending that officers consider seeking vantage point positions – those positions that involve working for a very senior leader with visibility. These positions provide opportunities to learn best practices that those leaders exhibit, as well as insight on the types of characteristics that you do **not** want to model.

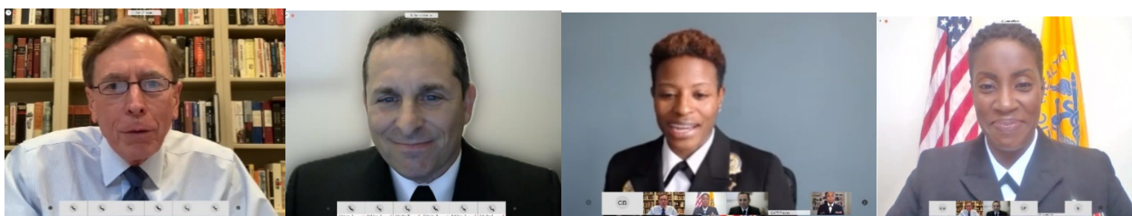
He encouraged officers to consider how we deal with challenges, missteps, or adversity. These are things that we will always encounter – there will be mistakes made, setbacks, and the unexpected. In each case, understand and recognize what happened, learn from it, and keep moving forward. His words of advice – "Never allow your shoulders to slump," because others are taking their lead from you. Later in the conversation he revisited this and stated that "leadership under pressure is what leadership is all about."

In defining leadership, he challenged participants to consider "are you influencing others?" If so, this is leadership – no matter the position title! In discussing our work alongside those in sister services, he encouraged USPHS officers to exhibit true excellence – be the best that you can possibly be and do it better than the rest.

Team cohesion was a key point – he emphasized that every member of a team should be considered mission critical, and how important it is to remind them that you recognize that they are critical to the mission. Never underestimate anyone's importance in the success of a mission; you never know when one single person – whether it be from their role, their perspective, their observations, their actions – will be the most important person for that particular mission at a given time.

Finally, in reflecting on leadership in the context of COVID-19, he drew upon experiences in Iraq while explaining the critical importance of these concepts when facing missions of this magnitude: 1) getting the big ideas right, 2) communicating the big ideas to the team, 3) overseeing implementation of the big ideas, and 4) determining how to refine along the way.

Closing remarks were provided by CAPT Diedre Presley, Chief Professional Officer of the Health Services Category. While this article cannot cover every single pearl of wisdom shared, it is anticipated that a recording of this presentation will be posted on the MAX.gov HSPAC site.



L to R: GEN Petraeus, RADM Kleiman, CAPT Presley, LT Phillip.

Leadership Pitfalls

A poem by CAPT Charelene Majersky, PhD, MPH

Examples with grave outcomes to an organization:

Technical incompetence at its best

Poor, untimely communication

Passive aggressive, ill-will behaviors

Not addressing issues, with denial prevailing

Excluding, no input whatsoever

Unilateral decisions

Micromanaging

Control freak due to insecurity and jealousy

Toxic work environment with low morale

Lack of trust

Leading by example and walking the talk speaks volumes.

Responsibility and accountability rests with you, as a leader.

For meaningful transformative change to occur, the first key step is looking at yourself, from the inside out.

Stop blaming others for your absent leadership.

Insight, openness and receptivity to change is paramount.

Commitment and perseverance pave the way.

Leading with a compassionate heart coupled with integrity at work and in life is important.

A deep, soulful connection with people demonstrates caring and support.

We all answer to a higher power, who watches over us and takes note of our actions and how we treat others.

Words and actions matter immensely, especially if they are not in sync.

Servant leadership promulgates dedication to serving others in positively impactful ways.

Nobody is guaranteed tomorrow.

Today is what we have, so make it a memorable one.

Positivity, grace, and faith are our anchors reminding us that hope is possible.

What legacy will you leave as a leader in the public health arena?