Interview With Sherril B. Gelmon, DrPH, FACHE, Professor of Health Systems Management and Policy, Oregon Health & Science University and Portland State University School of Public Health

Sherril B. Gelmon, DrPH, FACHE, is a nationally recognized scholar on the accreditation of health professions education and a leader in service-learning and community engagement research.

As professor of health systems management and policy at the Oregon Health & Science University and Portland State University School of Public Health in Portland, Oregon, she directs the PhD program in health systems and policy and teaches courses in the theory and practice of health management and policy, with a focus on improvement science, program evaluation, organizational behavior, values and ethics, and health systems. She has conducted research for projects sponsored by the Institute for Healthcare Improvement (IHI), Robert Wood Johnson Foundation, Community–Campus Partnerships for Health, and other organizations.

Dr. Gelmon received her doctorate in health policy from the School of Public Health at the University of Michigan, her master's degree in health administration from the University of Toronto, and undergraduate degrees in physiotherapy from the University of Toronto and the University of Saskatchewan. She was the founding chair of the International Association for Research on Service-Learning and Community Engagement, and is a past board member of the Oregon Foundation for Reproductive Health and of the Physiotherapy Foundation of Canada.

In 2011, she received the national Thomas Ehrlich Civically Engaged Faculty Award—bestowed annually on a tenured faculty member for exemplary leadership in advancing students' civic learning, community engagement, and contributions to the public good—from Campus Compact, a coalition of college and university presidents representing 6 million students.

Dr. Kash: *As a researcher and teacher, you have worked with community agencies, providers, and graduate students to gather evidence of impact for education and health improvement interventions. Tell us about your experience.*

Dr. Gelmon: First, we need to agree on what *evidence* means. We all use the word, but we don't always mean the same thing by it. To me, strong evidence is more than just strong quantitative data, because some of the richest evidence in the areas of

education and community health improvement is observable and tells stories. Bar charts and statistics are nice, but they don't really tell the story. What can we conclude from pictures, voice recordings, digital communications, and the like? Then there is the question of what *impact* means. Impact on whom? When and where? Also, how much is needed? When we are interested in measuring the impact of an intervention, how do we determine when we will see that impact, and what evidence is required? In working toward improvement, we set benchmarks—for example, we may say that as a result of this work, 90% of the target population will be affected by the intervention. But does the intervention have an impact only if we reach 90%? Or can significant improvement in health happen if we see 75%?

So when we consider evidence, we need to know who defines impact, who measures it, and who sets the benchmark. Given those qualifiers, I would say that for students—particularly graduate students in health management and policy—one of the most important things to learn is that we don't live in a world with absolute rules. In so many situations, we must determine results without benchmarks and qualify our conclusions with, "It depends." When studying the impact of an intervention, we are interacting with people in a rapidly developing health system. We all have circumstances that affect what we can do or achieve—whether we are the consumer, the provider, the administrator, or the teacher.

To me, the most promising approach is to draw on multiple sources of evidence and look at the impact on different stakeholders. For example, I lead a research team at Portland State University that has been working for five years with the Oregon Health Authority to evaluate the implementation of the patient-centered primary care home, which is Oregon's approach to the medical home. Our current iteration builds on hard quantitative data that come from the state's All Payer All Claims Database. While a colleague of mine has been busy analyzing this huge database of claims, I have been working on the qualitative side by conducting focus groups and interviews with administrators and clinicians. Our team is integrating our findings so we can report to the Health Authority and say, "Here is the cost evidence for every dollar spent, and here is the experience. This is what the clinicians, administrators, and patients say." The evidence of impact must have that broad perspective drawn from multiple sources. We need to bring it all together for the various stakeholders—the state (which is funding the implementation of the primary care homes program), the insurers, the clinicians, the administrators, and the patients.

Dr. Kash: *What is the best way to prepare health management students and young professionals with a broad perspective on communities and population health?*

Dr. Gelmon: Rigorous academic learning is important, specifically through graduate programs in health management and policy that have a strong curriculum accredited by the Commission on Accreditation of Healthcare Management Education (CAHME). As a former executive director of the predecessor agency to CAHME, the Accrediting Commission on Education for Health Services

Administration (ACEHSA), I firmly believe in the role of accreditation to protect the public's interest and ensure a quality education. Students should seek out CAHME-accredited programs in which academic learning is combined with field experiences for true community-based learning. By *community-based learning*, I don't mean traditional internships where students are casual observers or do things that affect people or communities but are not really part of those communities. Truly rich, community-based learning involves mutuality and reciprocity of power in relationships. This approach can be hard for health management students if they work with administrators who are focused on leading organizations rather than grassroots health. Students must be able to learn in and with the community.

True interprofessional learning, too, is critical for health management students. It's more than simply putting medical, nursing, and health management students in the same class—the learning experience must be blended. Students need to learn from and about each other and draw on the different models that the different professions use. An example is an initiative I helped lead in the early 1990s for the IHI. At one point, the nursing education leaders explained the fundamental organizing principles and models that nurses use, and the physician and health management educators said, "Oh, *now* we understand why nurses do what they do." That kind of interprofessional learning needs to expand so that it's not just the managers learning with the nurses, doctors, or dentists but also understanding what behavioral health providers do and understanding what goes on in other sectors, such as social services, community development, job training, and housing.

Students need to be prepared to think at all levels of the delivery system. I am a great believer in the IHI's Triple Aim—improving the individual experience of care, improving population health, and reducing per capita costs. The Triple Aim is a good organizing framework for health management students for thinking about the experience of the patient and family, the microsystem that is involved in services delivery, the healthcare organization, and finally the larger environment and social system. Some health management programs focus on the organization level. Although that is where many graduates want to work, to work effectively they need to understand the entire system. We need to figure out how to put all those things together for our graduates so that they can provide terrific leadership for our health system in the future.

Dr. Kash: *One of your areas of research is healthcare workforce development. In your view, what are the top workforce challenges the U.S. healthcare system is facing?*

Dr. Gelmon: As I mentioned, addressing the need for interprofessional education certainly is a challenge we must meet. I don't see a lot of schools doing it really well, although it seems to work best when clinicians and administrators learn together.

Many schools are preparing students for what the academics who designed the program thought was relevant 5 or 10 years ago. We need to redesign the programs so

that they both reflect the current system and anticipate as much as possible where our graduates are going to go. For example, when nursing students graduate, they often go to work in a health system where they need 6 to 18 months of additional training to be excellent nurses at the top of their skill set. Is the same true of our health management graduates, but perhaps not as openly reported? What's wrong with the educational program if it's not preparing students for the workplace? Somehow we need to align our programs with the workplaces where our graduates are going. That is a huge challenge because graduates of the master's program I teach in enter various kinds of organizations in various roles in multiple jurisdictions all over the country. It's hard to prepare them for everywhere. Our students need to learn how to be nimble, agile, and adaptable and to recognize that once they get their master's degree, they are not done learning.

We also need to help our students realize how many organizations are involved in delivering services that affect the health of populations. It starts with understanding the social determinants of health. How does housing contribute to a community's health? How does social stability contribute? How does my job contribute? How do we understand complex personal realities such as working parents with children who may occasionally need to leave work to care for their kids, possibly affecting their jobs? Everything is connected to everything. I worry, sometimes, when my colleagues at other health management programs seem to be focused exclusively on preparing their students to be a hospital CEO. Of course we need CEOs, but one of those graduates may someday move to a community that doesn't need a hospital CEO but rather a CEO for a community-based social service organization. A broad systems perspective is critical because healthcare administrators are so mobile. People often move to places where the perfect job might not exist, so we need to prepare our students to adapt to other kinds of positions.

Another challenge is ensuring that professional organizations are positioned to support graduates early in their careers. When I graduated, almost all of my classmates wanted to go into hospital jobs. I had no interest in working in a hospital because I had already worked in a hospital as a physical therapist, but that's the setting that my education prepared me for. Today, only half of our program graduates go to work in a hospital or health system. The American College of Healthcare Executives (ACHE) and other relevant professional organizations can help prepare students for a range of careers.

Dr. Kash: *Do you have any advice for both our seasoned and our young professional leaders and health administration students?*

Dr. Gelmon: A commitment to continuous learning is essential. Even after you receive your master's, doctorate, or whatever degree, you don't stop learning. Leaders need continuing professional development—conferences and exposure to new ideas and new ways of seeing and thinking about things. You may not adopt a particular idea, but you at least can put it through your own filters and ask yourself, "Is this

something I can do? Will this work for me? How can I learn from it?" Continuous learning doesn't necessarily mean getting more degrees; it means always staying current. Think of how many changes have happened with the Affordable Care Act and all we need to know to understand the transformation that's taking place, let alone what will happen with the new administration in Washington, DC.

Continuing education programs must have a high level of quality and rigor and not just be a commercial activity. Who's teaching the program? What's their experience, and how can I learn from it? You don't want to spend a lot of time and money on something that disappoints you in the end because it wasn't well done or well organized or you didn't get out of it what you thought you would.

For students, practical experience is huge. As I explained earlier, students can't simply be exposed to classroom learning and then enter an organization—they need to take what they learn in theory (e.g., a model or strategy), apply it in a practice setting, and return to the classroom to test it against other theoretical frameworks; then they need to go back to the practice setting and apply it again. This process should happen as students engage with community organizations over the course of their educational experience, rather than taking their classes and then getting immersed in the field for a culminating experience.

Student involvement in organizational work, such as with a local chapter of the IHI Open School, a student group supported by ACHE, or a local community-based nonprofit, is great for leadership development. I have seen students achieve amazing professional growth in student leadership roles, which position them at graduation to bring strong leadership skills to their employing organizations, the boards of community-based nonprofits, neighborhood associations, and even their kids' school organizations. Because of what they learn about leadership, management, organization, policy, finance, and strategy, health management graduates are well prepared to help strengthen the infrastructure of their communities. Their contributions to both the health services sector as well as the philanthropic sector can be profound.

I have learned so much over the past 25 years by being involved in health services improvement. Much of my education is anchored in the IHI and its multiple programs, which provide a vital resource that crosses our professional boundaries and sectors and our ways of delivering health services. The IHI encourages us to think about how we can use improvement science every day, and how we can use that knowledge base across the traditional disciplines that we teach in health management and policy programs. It covers organizational behavior, finance, leadership, governance, policy, and everything else we do.

Dr. Kash: *What are your thoughts on the role of mentoring?*

Dr. Gelmon: Mentoring is a huge part of professional development. Many mentors have helped me and challenged me as I moved through my career. Peggy Leatt was my professor at the University of Toronto and is still my friend and mentor even though she's now retired and I'm at an advanced stage in my career. Gary

Filerman recruited me to work at the Association of University Programs in Health Administration and ACEHSA and profoundly influenced the way I think about my professional career and how I do my work. Through IHI, I was privileged to be mentored by both Paul Batalden and Don Berwick.

Mentors are so valuable, and mentoring can be immensely gratifying. It's something I take very seriously, and in my current role I have the opportunity to mentor numerous master's and doctoral students. I take great pride in seeing their subsequent successes!