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The Magazine for
Healthcare Leaders
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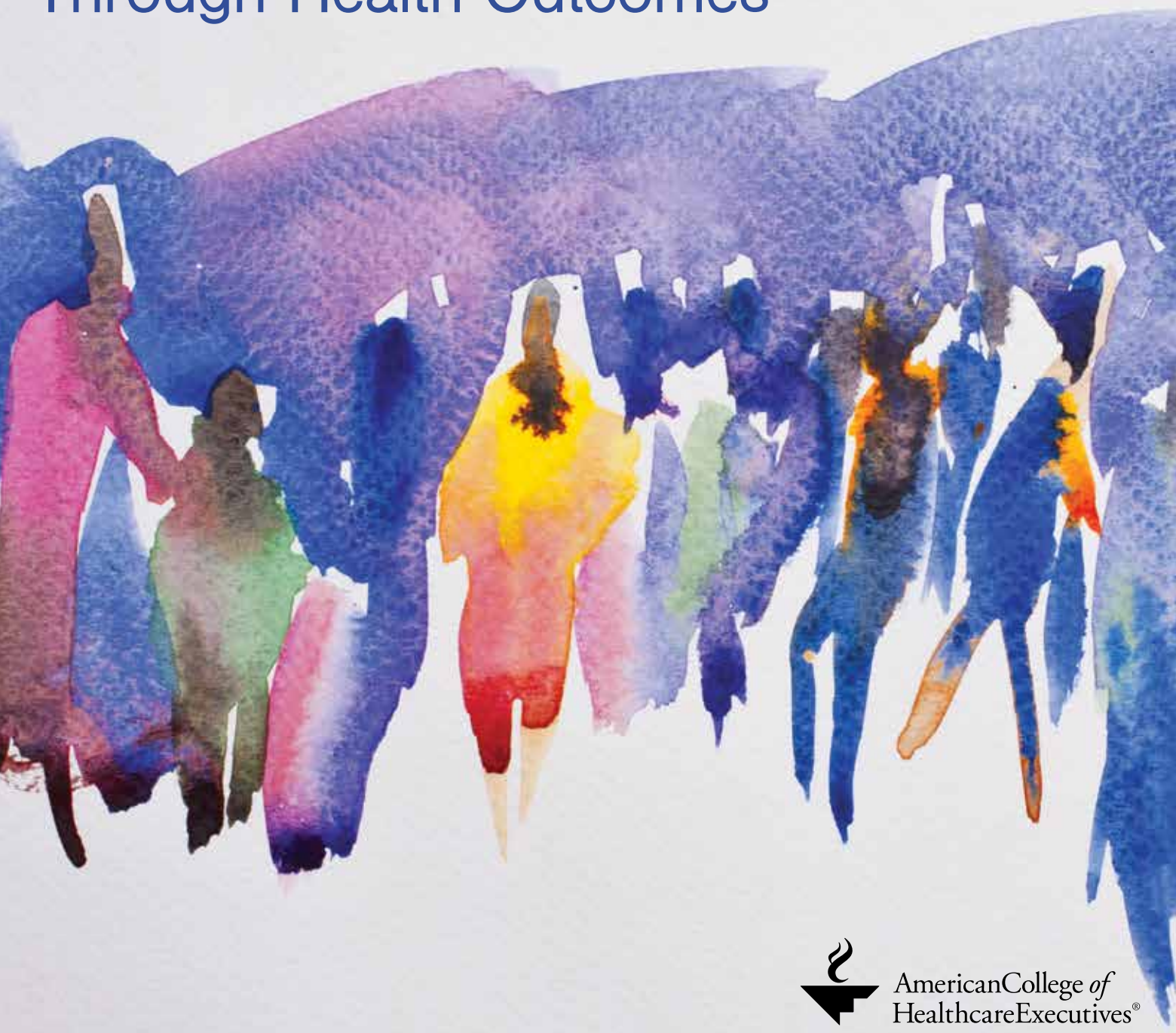
Strengthening Communities Through Health Outcomes



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Collaboration among stakeholders can facilitate innovative and sustainable solutions.

At the Forefront

Four goals demonstrate how to focus a strategic plan: maximize physician impact, improve access to care, embrace the journey to value, and enhance governance effectiveness.

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Inside ACHE

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In this article, Paul B. Hofmann, DrPH, LFACHE, president of the Hofmann Healthcare Group, Moraga, Calif., says others have expectations of how we will perform and behave. Our goal should be to consistently exceed these expectations.

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The Challenges of Safety Net Hospitals [1,2]

While there is no formal definition of a safety net hospital, you will know it when you see one. They can be public or private, non-profit or for-profit. They can be urban or rural. The US medical safety net includes over 20,000 clinical sites providing health services to over 25 million people regardless of their ability to pay.

Who

They take care of low income communities, with high proportions of **Medicaid** and **uninsured** individuals.

What

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1. Dr. Michael Shen et al. "Safety Net Hospitals, A Disproportionate Share." Accessed July 11, 2024. https://www.coreimpodcast.com/2023/03/02/safety-net-hospitals/.
2. "What is the "Safety Net" in the US Public Health System." Accessed July 11, 2024. https://brothersbrother.org/what-is-the-safety-net-in-the-us-public-health-system/.

Randy F. Liss

Taking Collaboration to the Community

Each of us understands the importance of teamwork and collaboration in healthcare, which can result in improved patient care, better health outcomes, higher patient satisfaction and operational efficiencies.

Of course, the benefits of teamwork don't end there. They also extend to the broader health of communities when healthcare organizations partner with local institutions and residents to solve their surrounding area's specific heath needs.

Our cover story, "Strengthening Communities Through Health Outcomes" (Page 8), offers two examples of that, with Advocate Trinity Hospital on Chicago's South Side and Good Samaritan Hospital in San Jose, Calif., both making significant investments in their respective communities. Results take time to emerge, but such collaboration and engagement can go a long way toward addressing risk factors, improving outcomes and enhancing people's lives. As Dia Nichols, FACHE, president, Advocate Health Care, told us, "Engaging [community partners] is the best way to shift the paradigm when it comes to improving the health of a community."

I'm also excited to introduce At the Forefront, our new thought leadership offering that delves into a specific topic by ACHE Learn authors. In this issue, that's "Getting Ahead: Strategic Planning for a Competitive Edge" (Page 18) by Meredith Inniger, FACHE, and John Harris, who share how focus, engagement and agility can achieve maximum results when developing a strategic plan.

The plan is for At the Forefront to appear in every other issue, and I'd love to hear what you think about it. If you have any feedback about that or any other aspect of the magazine, just send me a note at rliss@ache.org. Thanks so much for reading. ▲

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Leading Ethically in Challenging Times

It's an essential part of serving our communities.

Today's uncertainty combined with healthcare's already complex nature is challenging us at a pace not before seen. Geopolitical shifts, cybersecurity risks and rapid breakthroughs in artificial intelligence and other innovative tools, among other things, mix with our ongoing focus on patient care, workforce support, business needs and balancing stakeholder interests to test us in new and unexpected ways.

With all that is on our plates, standing on solid ethical ground is more critical than ever to ensure we account for the myriad interests and people impacted by our decisions. For example, the multitude of choices we face regarding AI requires more vigilance in ethical frameworks that account for equitable access, data privacy and responsible innovation while gaining the full promise of its power for the benefit of others. In many ways and on numerous fronts, we are charting new territory for the organizations we lead and the profession as a whole.

While we cannot control all the conditions that surround us, ACHE's *Code of Ethics* has served a helpful role for many. Since 1933, ACHE's commitment to a relevant *Code* has been the hallmark of our profession. It offers guidance, grounds us in our values and reminds us of the important responsibility we carry, regardless of the circumstances, to the patients, workforce and communities we serve.

While not a literal display of the *Code*, here are some highlights from it that continue to stand the test of time:

Leadership begins with governing ourselves. The *Code* calls on us to live our purpose and values with courage and heart. It requires us to demonstrate respect, integrity, fairness and good faith in working with others. And it asks us to continue to learn and adapt as our environment and tools change.

Patient care is our primary duty and responsibility. Through an ethical lens, we fulfill that duty by ensuring equal opportunities for patients and others to live to their highest potential for health in an environment free from harm. We can build trust with patients, caregivers and the community by serving as beacons of hope. And we can provide the safest, most equitable, evidence-based clinical practices—learning and improving along the way.

Equally important is our duty and responsibility to our workforce. The *Code* calls for us to provide an environment in which ethical and equitable conduct thrive. By promoting and investing in healthy work practices, we can ensure safe, inclusive, collaborative environments free from violence. Finally, we can support clinicians and other members of the workforce, so together we can provide the best care possible to patients.

Of course, the *Code* also reminds us that we are leaders in our community and society, and as such we have other roles to play that foster trust, provide service and can serve as visible reminders of our commitments.

Along with the *Code*, ACHE also offers other ethics resources to help you navigate the sometimes thorny issues that today's challenges raise. Our Ethical Policy Statements address specific ethical issues in healthcare. Our Ethics Self-Assessment can help you think through your own ethics-related leadership and actions. Our Ethics Toolkit offers guidance to better integrate ethics into your organization. And our ethics resources can help with organizational ethical decision-making. All are available at **ache.org/Ethics**.

One thing will remain constant as the world around us changes and evolves: courageous ethical leadership is needed to serve our communities. As we find new paths and innovate for the future, we hope the *Code* can serve as your North Star. ▲

Deborah J. Bowen, FACHE, CAE, is president/CEO of the American College of Healthcare Executives (dbowen@ache.org).

GRIEF OR GRATITUDE?

EARLY DETECTION DECIDES

"**I truly believe screening for CRC saved my life. Having a noninvasive stool-based test available in my health system** gave me the push I needed. Without it, I would have continued putting off a colonoscopy and my cancer would have grown. I got the treatment I needed **so I could be here to see my daughters get married**."

LEIGH ANNE | cancer survivor

Leigh Anne received travel reimbursement for this campaign.

Colonoscopy alone is not enough to close the CRC screening gap[1-4]

~60M people in the United States are eligible for CRC screening and **~40%** are not up to date.

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CRC=colorectal cancer.

References: 1. Ebner DW, Kisiel JB, Fendrick AM, et al. Estimated average-risk colorectal cancer screening-eligible population in the US. *JAMA Netw Open*. 2024;7(3):e245537. **2.** Active physicians with a U.S. doctor of medicine (U.S. MD) degree by specialty, 2015. AAMC. Updated December 2015. Accessed April 14, 2025. https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-us-doctor-medicine-us-md-degree-specialty-2015 **3.** Eberth JM, Josey MJ, Mobley LR, et al. Who performs colonoscopy? Workforce trends over space and time. *J Rural Health*. 2018;34(2):138-147. **4.** Fendrick AM, Ebner DW, Kisiel JB, et al. Eliminating the colonoscopy backlog with stool-based colorectal cancer screening options. Abstract presented at: Digestive Disease Week (DDW) 2024 Annual Meeting; May 18-21, 2024; Washington, DC. **5.** Doubeni CA, Fedewa SA, Levin TR, et al. Modifiable failures in the colorectal cancer screening process and their association with risk of death. *Gastroenterology*. 2019;156(1):63-74.

EXACT SCIENCES®

Strengthening Communities Through Health Outcomes

Collaboration among stakeholders can facilitate innovative and sustainable solutions.

By Ellen Lanser May

Residents on the South Side of Chicago have a life expectancy that is 30 years shorter than that of North Side residents, according to a study by NYU Langone Health. Factors such as socioeconomic status, access to healthcare and racial segregation have created and further exacerbated health disparities there. It's a stunning health equity gap, but Chicago is far from the only place grappling with this sort of crisis. Large metropolitan areas, small industrial cities, rural America, commuter suburbs and college towns are all facing similar imbalances.

Given that every factor is interconnected with another, finding ways to improve health by meeting the unique needs of individual communities can feel like an overwhelming endeavor, especially when institutions attempt to do so on their own. When nonprofits, government agencies and other groups work separately, efforts are uncoordinated and often ineffective. But two healthcare organizations are finding that when they collaborate with community entities, they can create innovative, widespread and long-lasting solutions to pervasive population and community health problems.

Advocate Trinity Hospital
Chicago

Part of Illinois' Advocate Health Care system, Advocate Trinity Hospital has been providing care to residents in southeast Chicago for over 120 years. Advocate Trinity treats more than 90,000 patients annually, offering access

Strengthening Communities Through Health Outcomes

to 300 physicians across 50 specialties, including advanced heart attack care, primary stroke care and oncology. Many of the hospital's Medicare patients are from areas with high deprivation levels. In fact, in Advocate Trinity's primary service area, the percentage of families living below the federal poverty level is 22.85%, which is higher than both Illinois (10.79%) and Cook County (13.83%) percentages. The percentage of families living below the FPL in Advocate Trinity's secondary service area is 31.84%, nearly three times the state percentage.

Although Advocate Trinity has been recognized as one of the best regional hospitals, the glaring life expectancy imbalance in Chicago—rooted in the hospital's own service area—has fueled leaders to take a much broader, yet targeted, approach to closing that gap. "We have the data to show that the status quo isn't working, and that data alone would be enough to drive many hospitals to leave a market like ours," says Michelle Y. Blakely, PhD, FACHE, president, Advocate Trinity Hospital, who was born and raised on Chicago's South Side. "But we said 'no'. We are doubling down and disrupting the idea that closing the gap is too difficult."

"We have the data to show that the status quo isn't working, and that data alone would be enough to drive many hospitals to leave a market like ours. But we said 'no'. We are doubling down and disrupting the idea that closing the gap is too difficult."

—Michelle Y. Blakely, PhD, FACHE
Advocate Trinity Hospital

Using $300 million of a total $1 billion commitment, Advocate plans to replace the aging Trinity hospital with a new 23-acre, state-of-the-art facility. Advocate Health Care leaders say they hope to break ground on the new 52-bed hospital by the end of 2025 and open by 2029. Equally as important, however, is that the remaining $725 million of this unprecedented investment will fund Advocate's ultimate goal: improving wellness for South Side Chicago residents.

"The new hospital is a significant part of this project," says Dia Nichols, FACHE, president, Advocate Health Care. "But it's about so much more. We are committed to expanding health and wellness on the South Side of Chicago with the help and input of community partners. Engaging them is the best way to shift the paradigm when it comes to improving the health of a community."

Advocate aims to help change the trajectory of healthcare delivery in its community by focusing on the following tactics.

Getting community input. To ensure that the new wellness project would effectively meet the community's needs, the hospital first held dozens of listening sessions at local churches, civic centers and libraries. Hundreds of residents—including clergy, political allies and community leaders—participated in these meetings.

"We asked people about how they access care and how we could improve that access," says Blakely. "We wanted the community to help us design a model that fits their lives and could serve them well." These conversations and the themes that emerged from them became the basis for Advocate's new, ambulatory-forward outpatient care model.

Growing the outpatient footprint. On Chicago's South Side, 84% of residents who are hospitalized have two or more chronic conditions, according to Advocate Health Care. Furthermore, the rate of diabetes-related deaths is four times higher for South Side residents than it is on Chicago's North Side. Thus, preventive care and wellness are serious targets.

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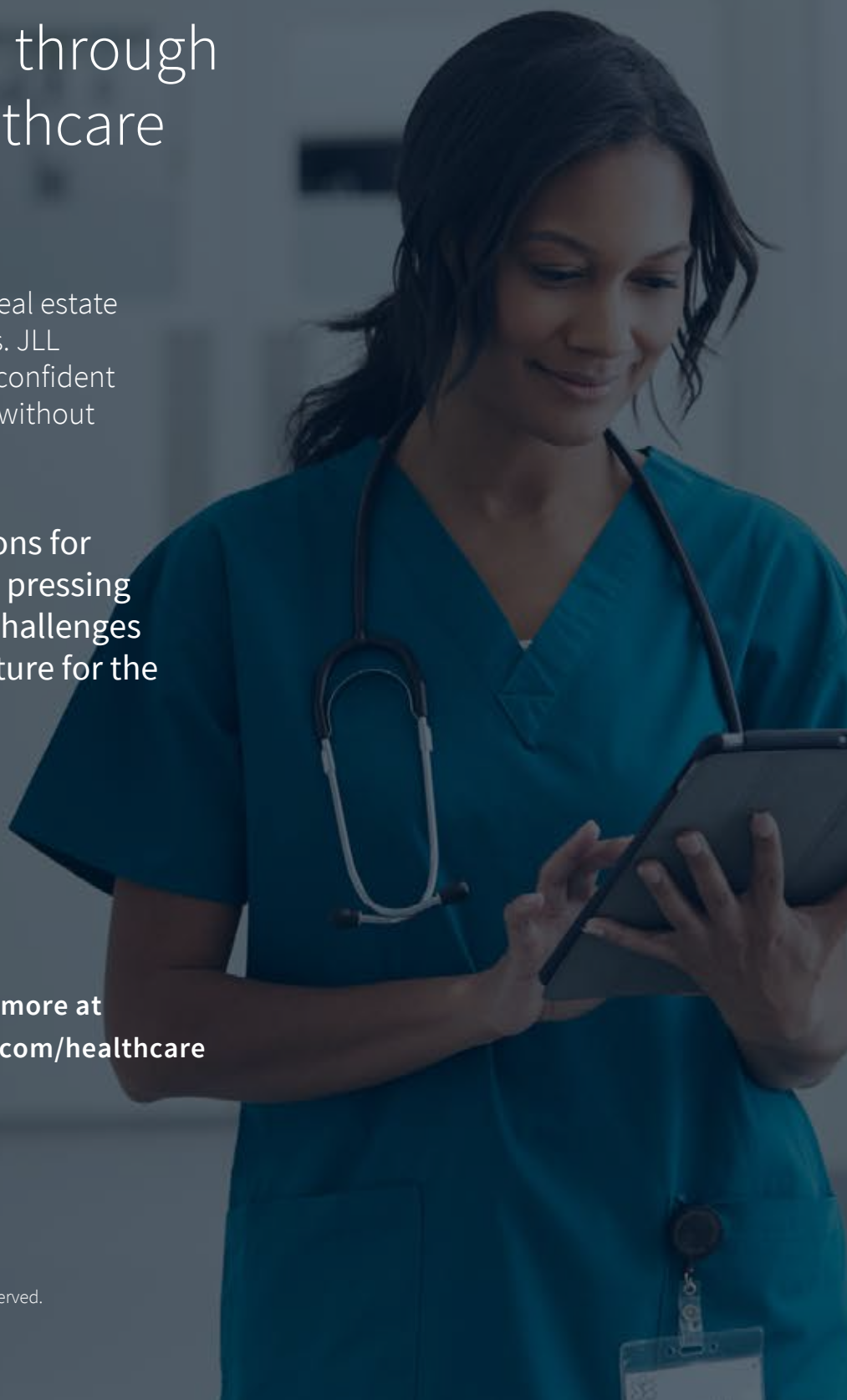

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Strengthening Communities Through Health Outcomes

To address the enormous task of improving health, Advocate is creating 10 neighborhood care sites over the next three years to expand access to primary and specialty care, diagnostics and chronic disease management support.

The input gathered at the community listening sessions spurred leadership to place these clinical access points where people naturally gravitate, such as churches and community centers. The clinics are being staffed by certified Advocate medical assistants who use leading-edge telemedicine to evaluate adult patients and children aged 2 years and older. Patients then receive on-site care for minor illnesses like flu and strep throat or, when appropriate, referral to an urgent care facility or hospital for more emergent or higher-level care needs. Ultimately, these local clinics will offer convenient hours daily and also act as bridges to social services.

"The success of these clinics depends on collaboration with community organizations," says Blakely. "By sharing the data about health in our community and hosting the listening sessions, we were able to fully engage local organizations that are eager to help facilitate touchpoints and introduce our services to residents."

> "Part of a healthcare leader's job is to recognize that we can improve the lives of the communities we serve outside of the four walls of our hospitals."
>
> —Patrick Rohan, FACHE
> Good Samaritan

Expanding food pharmacies. Limited access to affordable and healthy food options impacts food security and can lead to an increase in diabetes, high blood pressure and other chronic conditions. Unfortunately, many South Side neighborhoods are known as "food deserts," which means that at least 33% of the population lives more than half a mile from a supermarket or large grocery store. Addressing the challenges of nutrition is one way Advocate "gets upstream and catches people before they become patients," says Nichols. To that end, Advocate providers can write prescriptions for food that residents take to a local food pharmacy that is operated by Advocate, with support from organizations like the Greater Food Depository. Twice per month, the food pharmacy dispenses nutritious foods and pantry staples and provides recipes for healthy preparation.

What makes this program unique is that Advocate sources some of its pharmacy food from a 60-acre farm in northern Illinois that is aligned with Advocate Health Care. "The hospital's medical staff collaborates with farmers to decide what to plant so that the output reflects evidence-based nutritional guidelines," says Nichols. "Through this program, we come full circle within our system where the food we grow is the medicine we provide."

Developing the workforce. Along with the new hospital site and community wellness programs, Advocate will spend $25 million on workforce development as Advocate Health Care seeks to hire more than 1,000 new employees to support the new South Side care model in the coming years. By creating jobs and stimulating economic growth, Advocate hopes that this community investment will serve as a catalyst for further investment and revitalization in the area.

Knowing that it will take time to feel the impact of the program, Blakely and Nichols believe that frequent communication with residents at every step and incorporating that feedback into operational plans can go a long way toward engaging the community in its own health while also earning trust.

"We are confronting the enormous challenge of improving the health and wellness of the South Side in an area that has been hurting for generations," says Nichols. "It's humbling as a leader to be in a position

where we can move the needle and create community health in partnership with the very people we serve."

Good Samaritan Hospital
San Jose, Calif.

Like the rest of the Bay Area, San Jose suffers from a severe shortage of affordable housing, escalating rents and a high cost of living. This makes it challenging for low-income people and families to find stable, secure housing.

To help address this, Good Samaritan Hospital—a 474-bed facility in San Jose serving Silicon Valley since 1965—has pledged $1 million to the city's emergency interim housing project for people living unsheltered along the Guadalupe River. The project broke ground early this year. The donation is part of a larger $3 million contribution from HCA Healthcare, Good Samaritan's parent company, to address San Jose's affordable housing needs.

Housing as a Social Determinant of Health

Joining efforts to address the area's increasing homeless population was a natural fit for Good Samaritan Hospital. A 2025 study by Johns Hopkins Bloomberg School of Public Health confirms the belief that poorer housing

Strategies for Engaging and Integrating Community Perspectives

A 2021 brief from the Center for Health Care Strategies Inc. emphasizes the importance of integrating the perspectives of community members when it comes to designing and implementing new programs. The authors recommend that healthcare organizations use the following strategies to elicit and incorporate input from community members:

Collective Impact: This structured form of collaboration aims to help organizers gain commitment from individuals in different sectors by coalescing around a common agenda to solve a specific social problem.

Community-Based Participatory Research: By involving multiple partners in the research process, leaders can use this collaborative research approach with an end goal of integrating community expertise into policy or social change benefiting the community members.

Consumer Advisory Boards: Healthcare systems can formally convene groups of community members who regularly provide input to help organizations better understand health issues and improve care delivery.

Human-Centered Design: This problem-solving approach can be used to engage the human/patient perspective in all steps of the problem identification and solving process.

Participatory Budgeting: By giving community members a role in community spending decisions, healthcare leaders can use this process to determine how to allocate part of a public budget.

Patient-Centered Outcomes Measures: For enhanced understanding of the patient population, look at measures that are driven by patients' expressed preferences, needs and values that inform progress toward better health, better care and lower costs.

Results-Based Accountability: This strategy can be used to help communities and organizations move to action. It uses an outcome-based approach to assess how much was accomplished, how well it was accomplished and whether people are better off.

Strengthening Communities Through Health Outcomes

conditions are associated with negative physical and mental health outcomes, highlighting the impact of housing quality on population health. Given the connection between housing and health, Good Samaritan CEO Patrick Rohan, FACHE, believes the hospital has an important role to play in addressing San Jose's affordable housing crisis.

"Part of a healthcare leader's job is to recognize that we can improve the lives of the communities we serve outside of the four walls of our hospitals," he says. "To change the landscape, we must take a holistic view of what it means to care for our patients and recognize that treatment extends beyond surgical procedures or medications."

Long-Term Solutions Through Interim Housing

Good Samaritan's $1 million contribution is helping fund a new supportive housing community known as The Cherry Avenue Project. Able to house up to 136 people, the project aims to help San Jose achieve its goal to nearly triple its shelter capacity over the next 18 months. Serving the immediate vicinity of the hospital, the project is set up to provide safe, temporary housing for those transitioning out of homelessness. This means that Cherry Avenue is about much more than housing. "It's a connectivity point for resources that can break unhealthy cycles," says Rohan. "Although the project addresses the community's immediate needs, it also sets people up with long-term solutions."

Underlying Cherry Avenue is the belief that its residents deserve a safe and dignified space. While other partners involved in the project will tackle issues like job training and support services, Good Samaritan is connecting its behavioral health team with intake specialists at Cherry Avenue. The hope is that forging these connections will bring preventive mental healthcare to those who need it and, thus, prevent an escalation of care to inpatient or more acute service settings. Ultimately, the goal is to ensure that no one falls through the cracks, and then to bridge the gap between homelessness and the mental health issues that might lead to it.

Coordinating Multiple Stakeholders

The Cherry Avenue project differs from other interim housing initiatives because of its collaborative approach with local and state government, nonprofit providers and philanthropists. For example, the San Jose City Council acknowledged the urgency of the city's housing crisis by unanimously authorizing broad powers—which is consistent with the ordinances the city has been operating under for the past several years—to facilitate rapid development, such as suspending land use and zoning requirements and maximizing legal and administrative flexibility.

Between private philanthropic contributions and fee discounts, the city will be able to save $2.4 million in costs for the project. The area's water resource management agency, Valley Water, hopes to create a protection zone to safeguard the Guadalupe River waterway, where many homeless residents have created encampments. The agency also aims to help people living in those encampments find other shelter during construction at Cherry Avenue and will give them first priority for living at the new site.

"It's critically important to collaborate and coordinate strategically among the multiple stakeholders working on Cherry Avenue," says Rohan. "For the project to be built and implemented effectively, priorities and logistics have to be aligned."

As with Advocate Trinity's wellness project, Rohan knows that there are no short-term fixes to the complex social issues that impact health and health equity. Sustainability in this space is critical.

"We aren't just handing over a check and walking away," he says. "Continued engagement will help us understand if our approach is working. If it is, we replicate it. If it isn't, we pivot and keep searching for a better solution."

Ellen Lanser May is a freelance writer based in Naperville, Illinois.

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GLP-1 Medications: Threat or Opportunity for Today's Surgical Programs?

For one health system, they've been both.

GLP-1 agonist weight loss drugs have taken the healthcare industry by storm. Since the U.S. Food and Drug Administration's approval of semaglutide (brand name Wegovy) in 2021, patient interest in these drugs has grown, with net sales of all anti-obesity drugs increasing to an estimated $1.1 billion in 2023, according to The Congressional Budget Office. At the same time, bariatric surgery rates fell by 25.6% between 2022 and 2023, according to a 2024 study by researchers at Harvard Medical School and Brigham and Women's Hospital. To meet patient demand for these medications and adjust to changes like reduced interest in surgical weight loss, healthcare providers have had to shift course.

For Allentown, Pa.-based Lehigh Valley Health Network, the rise of GLP-1 medications has been a disruptor—but not necessarily a negative one.

Like many organizations, the health system has seen declines in bariatric weight loss surgery in the past couple of years, but it has found success staying nimble amid market changes like those brought about by GLP-1s, according to Hope L. Johnson, DNP, RN, NEA-BC, vice president, Perioperative Services. That success includes a revamp of its approach to educating its providers and the community.

Preparing Clinicians to Meet Changing Patient Needs

A holistic, integrated approach to offering patients weight loss solutions has allowed Lehigh Valley Health Network to adapt to changing patient needs. Part of that has included widening its surgeons' skill sets.

"Some of the pivoting we have done with our bariatric surgeons is to have them become trained in medical weight management. When a patient goes to them for a GLP-1, but then hits a plateau or they're ready for something else, they already have built a rapport with that physician, who can help them manage their weight through robotic surgery," Johnson says.

Having additional clinicians certified in medical weight management has allowed more patients to be seen by these specialists while taking the burden off primary care physicians, according to Johnson. Because they are often those referring patients to specialists, however, she says the health system has made a point to emphasize education of primary care physicians and other referring providers on how to best direct patients to the best care pathway, rather than just prescribing a GLP-1 medication right off the bat.

Lehigh Valley Health Network's clinicians have also flexed their agility in other ways. When the health system experienced an increased hernia surgical volume following its popular free community screenings, it turned to its bariatric surgeons, who are also trained in hernia surgeries. They were able to address the increased hernia surgery volume while filling gaps in their bariatric surgery schedules, which had experienced declines due to the popularity of weight loss medications.

The health system has also seen an overall gastrointestinal surgical procedural volume increase—up 15% in 2023-2024. As its bariatric surgeons have become more specialized in comprehensive medical weight loss, they are seeing higher volumes of patients. Consequently, the surgeons have seen an increase in endoscopy procedures and are identifying other conditions in which a patient might need surgery, such as foregut procedures, which have increased by 30% in 2023-2024.

Getting the Word Out

Just like the organization was adaptable on the clinical side, its marketing team was nimble when it came to letting the community know about the health system's comprehensive weight loss program, says Jennifer Adamski, director,

Brand Marketing. One tactic was positioning Lehigh Valley Health Network as an expert in the region.

"We want to be seen as an authority on the topic so that people trust and believe in us when they're ready to begin their weight loss journey," Adamski says.

Messaging emphasizes the health system's expertise in bariatric surgery and robotic surgery in general. Lehigh Valley's robotic surgery program currently boasts 18 da Vinci robotic surgical systems, with 75 da Vinci surgeons performing surgeries across 13 specialties at eight locations. Marketing campaigns also emphasize the benefits of robotic surgery, such as fewer incisions, less scarring, less blood loss and a faster recovery time, according to Adamski. Campaigns also include information about the successful results seen from bariatric weight loss surgery.

"We know from science and have data to back up the sustainability of robotic bariatric surgery," Adamski says. "We don't yet have all the data for the GLP-1s, so we try to educate people with what we know now."

Patients undergoing bariatric da Vinci surgery lost up to 77% of excess weight, according to a November 2023 article in the *Annals of Medicine & Surgery* journal, compared to those patients who used medication for weight loss, who lost up to 20% of weight, according to 2024 research by the American Society for Metabolic and Bariatric Surgery.

Adamski and the marketing team at Lehigh Valley Health Network also highlight patient stories. One particularly successful 2024 marketing campaign involved a series of patient testimonial videos, which appeared across five markets in print, billboard, digital, radio and video platforms. A group of patients spanning various ages, genders and ethnicities shared their personal stories about how the weight loss program has improved their quality of life. The campaign led to 7,109 patient encounters, 1,300 unique patient visits and 531 da Vinci surgeries for a variable contribution margin of $3.12 million.

Adamski emphasizes that organizations can lean on "zero-budget" tactics, including using their own websites, blogs, social media, video content and internal communications. For larger paid campaigns, Adamski says her organization earns additional ROI by repurposing the content on its website and social media.

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Both Adamski and Johnson say alignment across Lehigh Valley Health Network's operations, clinical and marketing teams has contributed to the organization's success in navigating market changers like GLP-1 medications. The teams meet regularly, with marketing and their Intuitive partners included in discussions "to hear about the business goals firsthand," Adamski says.

"We really think about bidirectionally sharing information and creating plans together that will work best to get the word out about surgical procedures and other health initiatives, which has helped us get ahead of the curve with the GLP-1s," Johnson adds.

Lehigh Valley Health Network has taken what could have been a disaster—a temporary dip in weight loss surgery and reduced revenue—and turned it into several opportunities to better connect with its community and serve its patients.

"You never prepare for the exact day when there's a change like this," Johnson says. "But this opportunity has shown us we do have plenty of tools in our toolbox to handle adversity."

For more information, please contact Executive Education, Intuitive, at executive.education@intusurg.com.

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Getting Ahead

Strategic Planning for a Competitive Edge

By Meredith Inniger, FACHE, and John Harris

Shockwaves have rattled hospitals and health systems in the past five years. Amid the chaos, some executives have abandoned strategic planning in favor of addressing immediate needs. But successful leaders are using it to gain a competitive edge.

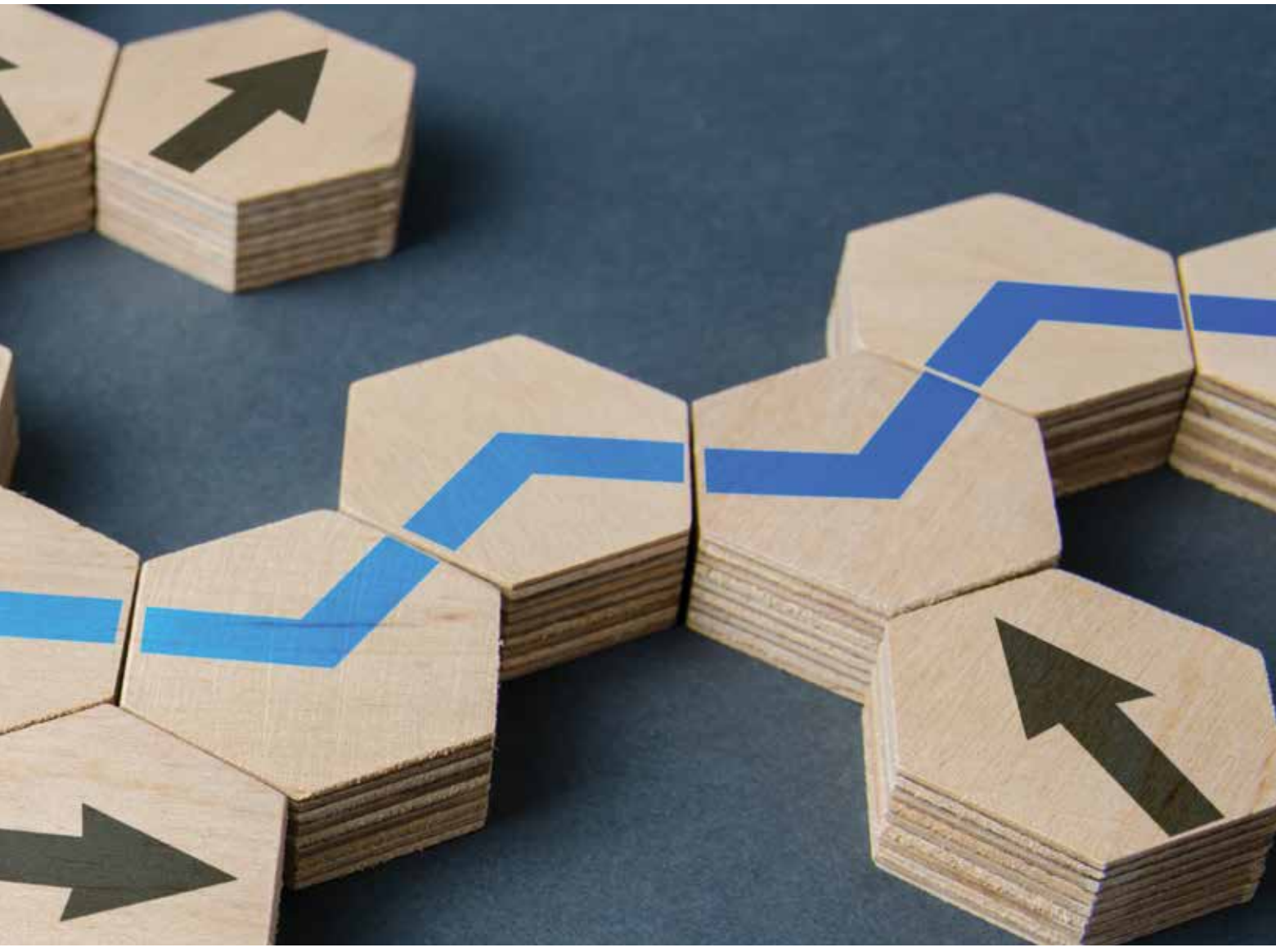
Gone are the tedious 5x5 strategic plans: five years of Five Pillars, tracked on a balanced scorecard. While this approach helped guide organizations in stabler times, top hospitals and health systems now gain a competitive edge through focus, engagement and agility in their strategic plans.

To focus a strategic plan, an organization identifies three to five critical issues that need addressing. Leaders select the issues based on an external and internal strategic assessment, then develop goals to address them.

The four goals described below demonstrate how to focus a strategic plan. These examples reflect the challenges and opportunities many hospitals and health systems face, although they of course will differ for each organization.

1. Maximize Physician Impact

Enhancing alignment and engagement with physicians is a competitive differentiator, which is especially crucial to



regain or grow market share. As clinician burnout increases and physicians become more active in unions, adopt a dedicated strategy to strengthen the organization's physician enterprise.

A multifaceted, strategic approach includes initiatives spanning the comprehensive portfolio of alignment approaches, addressing current and anticipated issues for the enterprise. Programs include enhancing employed network financial performance, achieving clinical excellence, offering innovative relationship options for independents, and developing (or partnering to provide) comprehensive practice management and population health capabilities. This will likely require redesigning physician compensation models and changes to the organization's physician governance structure and function.

An organization's commitment and ability to tackle these complex challenges requires strong physician leadership and attention to organizational culture. When done correctly, they will form a strong foundation for organizational success.

2. Improve Access to Care

As clinician shortages extend wait times, access to care is becoming a competitive advantage. To truly enhance

Getting Ahead

Strategic Planning for a Competitive Edge

access, examine wait times and bottlenecks across primary, specialty, ancillary and surgical care.

A welcoming digital front door, AI-driven scheduling and virtual provider options can optimize patient access. Expanding and integrating advanced practice providers can extend clinician capacity, creating an environment where patients are more likely to schedule appointments when they feel they need to be seen and spend less time in the office overall. To improve recruitment and retention, partnerships with a physician practice manager or aggregator can grow the physician base.

At the same time, right-size the ambulatory footprint, offering primary and specialty services aligned with community needs. Also, adjust surgical capacity so patients can receive care in the right setting, efficiently maximizing capacity to further enhance access.

These changes require organizations to think and act very differently than they do today, which may spark resistance. To mitigate opposition, proactively engage stakeholders in cultivating a shared vision for the optimal care delivery model of the future and embrace a plan to achieve it over time. Additional measures include ongoing and transparent communication across the organization.

3. Embrace the Journey to Value

The journey to value is often filled with twists and turns, and 2025 is no different. Committing (or recommitting) to value-based care in a strategic plan may look different for health systems than in years past. Some components remain, including goals to eliminate avoidable and high-cost care, which will free up clinical capacity for better-reimbursed services.

Additional focus may include establishing a strong plan for government payers, particularly as the segment grows. Systems that aim to achieve a margin on government payers through value-based contracts, coupled with a focus on commercial value-based contracting opportunities, may expand market share and enhance access.

> Some executives have abandoned strategic planning in favor of addressing immediate needs. But successful leaders are using it to gain a competitive edge.

The expertise that drives success on the journey to value has led some organizations to consider partnering with value-based care enablers that offer new expertise, speed transformation and may provide capital that helps realize higher rewards in risk contracts.

4. Enhance Governance Effectiveness

Today's dynamic healthcare environment has increased public scrutiny on hospital and health system boards. At a time when public perception of hospitals is at an all-time low, it is imperative for boards to be in top form, making timely, informed and community-centric decisions to foster a positive public image.

A high-performing board requires a range of experience and perspectives to appropriately understand and address the challenges the organization may face. Boards that proactively recruit this expertise and continuously invest in education are positioned to ensure members are well-versed in vital industry topics.

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Strategic Planning for a Competitive Edge

Education is particularly critical for new board members, allowing them to get up to speed quickly and contribute effectively from the start.

The board, working closely with senior management, drives the strategic planning process. The planning effort must be efficient, inclusive and engaging, and it should contain the right strategies for organizational success over the short and long term.

> A healthy strategic plan typically undergoes material revisions to roughly 25% of its strategies each year.

At the same time, the board should empower management to flexibly address issues within the strategic plan's framework. This flexibility may be needed to address local strategies in a health system strategic plan. Flexibility is also needed to adjust and refine strategies as internal and external circumstances change.

Other Potential Focus Areas

The goals above are just a few examples of what a particular hospital or health system may prioritize. Others can include partnerships, mergers and affiliations, achieving benefits post-merger, innovation, community engagement, technology and AI, and more. Each serves as the foundation of the plan while also allowing flexibility to be responsive as the strategic environment changes.

Other issues that may be important to address in the planning process include:

Engagement

While incorporating the right critical issues in your plan is important, what else can healthcare leaders do to ensure their strategies result in a competitive advantage for the organization? The answer lies in having effective processes, meaningful data, engaged people and flexibility.

The Human Factor

One of the toughest challenges in healthcare right now is motivating staff who are already feeling burned out. Asking staff to take on strategic plan implementation in this environment may feel counter to the overarching goal of decreasing burnout. However, sharing a future vision for the organization may bring out the best in staff, both individually and collectively as a team.

Clear communication and involvement in the strategic planning process can increase the buy-in needed to achieve results. Making the process engaging (and not burdensome) can spark joy and commitment to achieving the organization's shared goals. The key is for your organization to identify issues that need your team's strategic focus, while providing the resources, authority and flexibility to address other issues as they evolve.

An organization's people and culture drive its ongoing success. Leaders who understand, appreciate and harness their teams to work together toward a common goal will position their organization to thrive.

Implementing for Success

Former GE CEO Jack Welch aptly said, "In reality, strategy is actually very straightforward. You pick a general direction and implement like hell."

When leaders have done the analysis, selected the right issues, and cultivated a culture to motivate and

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– Aaron Miri, MBA, FCHIME, FHIMSS, CHCIO, SVP and Chief Digital and Information Officer, Baptist Health

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engage staff, the last piece of the puzzle is execution. Implementation is (of course) easier said than done. Organizations that are prepared and vigilant during implementation can secure a strong start, maintain momentum and allow for course corrections along the way.

Ensuring a strong start to implementation includes formalizing a communication plan and tracking mechanism so that leaders and staff are clear on deliverables, responsibilities and timelines. Executive leadership and the board should also allocate appropriate resources to the plan's initiatives. Schedule regular meetings with initiative owners to gauge progress and troubleshoot where necessary. Additionally, provide the board with regular updates to keep them informed and engaged.

Agility

A stale strategic plan is worse than no strategic plan. Failure to update a strategic plan makes it ineffective in responding to new challenges or opportunities. Once leaders see that a strategic plan no longer addresses key issues, they will abandon it completely or let it limp along, losing the thoughtful insights that led to each strategy.

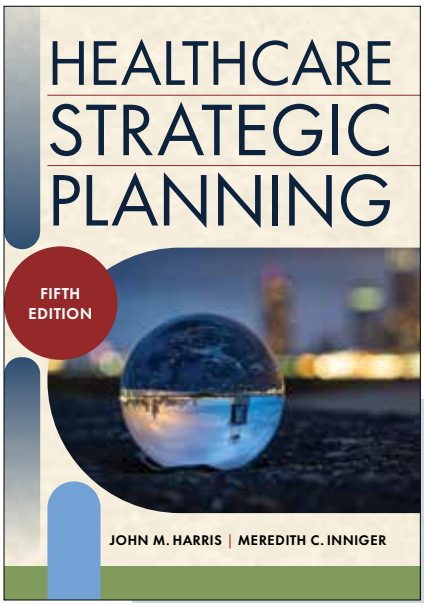
Use annual reviews to ensure your plan is an up-to-date vehicle that can revise market insights, goals and key strategies to accommodate evolving challenges and opportunities.

Real-time data allows leaders to refine strategies quickly and effectively, allowing for the monitoring of key indicators that may signal a need to change course on specific strategies. Taking advantage of business intelligence and other project management tools can also help with scenario planning, ensuring leaders are prepared for unforeseen challenges so they can flex the strategic plan accordingly.

A healthy strategic plan typically undergoes material revisions to roughly 25% of its strategies each year. Exceptional leaders show a willingness to adapt and can cultivate a culture of resilience among their teams that will allow the organization to succeed in the face of market changes.

Strategic planning is no longer just about survival and predictability; it's about positioning for excellence in a rapidly changing healthcare landscape. Strategic planning empowers leading organizations to establish a lasting competitive edge. By capitalizing on new data resources, engaging stakeholders, and continually updating strategies, organizations can increase the likelihood of fully executing the plan and achieving their potential.

Leaders who embrace this new approach to strategic planning with focus, engagement and agility will create a sustainable competitive advantage, ensuring their organization stays resilient and continues building on its success for years to come.



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Unlocking Acute Care

Innovative Solutions to Overcome Access Barriers

One of television's most urgent new dramas, HBO Max's *The Pitt*, rips the curtain back on the relentless fight for access to acute care, depicting an overcrowded, understaffed and under-resourced emergency department at a fictional Pittsburgh hospital. But for today's healthcare leaders, the crisis onscreen is all too real: Across the country, emergency departments are buckling under the weight of patient surges, staffing shortages and clinician burnout, resulting in dangerously prolonged wait times, boarding and, most critically, barriers to timely acute care.

"Rising costs, shrinking reimbursements and workforce shortages all converge into a single, critical issue: limited access to acute care for patients," says Rachel Thompson, MD, CMO at Core Clinical Partners.

Revolutionizing Patient Flow and Transfers

To open the bottleneck and get patients the acute care they need, organizations are rethinking transfer coordination and patient flow. Innovative command center-style transfer hubs, like the Judy Reitz Capacity Command Center at Johns Hopkins, use predictive analytics and real-time tracking to optimize patient flow and anticipate surges, enabling hospitals to flex staffing and resources. Even mid-size hospitals are leveraging EHR tools to pinpoint bottlenecks and streamline transfers, ensuring that acute care beds are available.

"This is care coordination in a superpowered way," says Thompson. "It doesn't erase the fact that some days there are no physical beds available, but it does give us line of sight to figure out why."

Telemedicine: Care Without Walls

Widespread healthcare workforce shortages have made telemedicine a vital tool for maintaining care access despite limited on-site staff.

"At Core, we have leveraged telemedicine to extend our clinician workforce, allowing more clinical care without driving up costs," Thompson says. "When deployed properly, telemedicine can also redistribute time-consuming tasks such as nursing intake, hospitalist admissions or even ED triage." Additionally, telemedicine can bring specialists to the bedside where they may not have been available in the past, broadening the reach and access.

Thompson suggests that "the potential for telemedicine to shatter barriers to access is limited only by our imagination—and our willingness to turn bold ideas into reality."

Policy, Infrastructure and Workforce: Building Capacity for Acute Needs

Improving access to care depends on having enough caregivers; innovative ways to grow this workforce are needed. Thompson asks, "How do we incentivize individuals to the field? Are there ways to offer loan forgiveness? How else can we pull people into medicine, whether it's nursing or lab tech or clinician—wherever our shortages are?"

Offering more training and education can help grow the workforce, especially in areas like mental health that face ongoing shortages. Building up the workforce is essential for meeting patient needs. Thompson also suggests infrastructure changes, such as hospital-at-home programs, which let hospitals care for more patients without needing to build new facilities.

"There are some creative ways we can increase the number of places where we care for people without necessarily building new hospitals," she says. She adds that creating dedicated behavioral health centers would help keep mental health patients out of the ED and ease the strain on acute care. Many patients end up in the ED because there aren't better options for their needs.

By focusing on workforce growth, new care models and better mental health resources, hospitals can make meaningful progress in expanding access to acute care.

Whole-Person Care and Social Determinants

Access to acute care isn't just about beds and staff—it's also about addressing the root causes that lead patients to seek it in the first place. Factoring in social determinants like housing and access to medication can prevent unnecessary acute care utilization and ensure that resources are reserved for true emergencies. Integrating social determinants of health into patient care workflows can make a meaningful impact.

"When patients are dealing with financial strain, housing instability or other challenges, it significantly affects what we're able to do for them," Thompson says. She explains that many patients return to the hospital simply because they lack access to essential medications or a safe place to recover.

The Pitt may be fiction, but the struggle for acute care access is a reality demanding bold solutions, relentless innovation and unwavering focus on getting every patient the right care, right now.

Culture and Collaboration: From Silos to Synergy

Ultimately, improving acute care access demands investment in people and culture. Multidisciplinary teams, equipped with the right tools and empowered to communicate, can unlock capacity and accelerate patient flow.

"You need to have multidisciplinary teams with skilled people equipped with the right education and resources to do their job well. When they're coming together and communicating on a regular basis, that can open beds," Thompson says. "In the hospital, one of the best models is to hold a brief morning multidisciplinary huddle to identify what can be done today to get appropriate patients discharged, coupled with an afternoon multidisciplinary meeting to address more complex matters regarding flow."

She cites her organization's partnership with one large urban hospital that, prior to its work with Core Clinical Partners, was turning away 500 patients every month due to a lack of beds. "Thanks to collaborative efforts across multidisciplinary teams, 93% of those patients are able to access the care they need."

The Pitt may be fiction, but the struggle for acute care access is a reality demanding bold solutions, relentless innovation and unwavering focus on getting every patient the right care, right now.

"When even one patient can't access acute care, the impact is profound," says Thompson. "Across the country, patients are waiting right now—waiting for the level of care they desperately need."

If you'd like to discuss strategies for improving acute care access or integrating clinician leadership into system-level solutions, feel free to reach out to Dr. Rachel Thompson, Chief Medical Officer at Core Clinical Partners, at rthompson@coreclinicalpartners.com.

CORE CLINICAL PARTNERS

Susan A. Reeves, EdD, RN, CENP

Tough Decisions in Tough Times

How ethicists and ethical decision-making resources can help.

A recent review of healthcare professional workforce statistics and trends points to a disturbing reality: Significant shortages will continue to impact organizations for the foreseeable future. Physicians, nurses, allied health workers and a wide variety of support staff roles are all forecasted to be in short supply through mid-century.

Leaders are regularly confronted with access-to-care issues resulting from these shortages and often must decide whether to hire expensive contract labor, overtax their staff, or limit or even close services. Such choices can introduce a variety of ethical conflicts, raising questions such as:

- How would patients be affected by necessary service closures?
- How are staff impacted by constantly having to "stretch" to do more to keep vital services available?
- Are the transient staff available through staffing agencies capable of providing the level of care necessary, and how do we know?
- What effects does the organization experience from constantly having to operate in this pressure cooker environment?

Healthcare leaders face these dilemmas practically every day, and their impact on the well-being of the organization, its people and leadership is often underappreciated. The timely and judicious introduction of an ethicist or individual trained in ethical reasoning, as well as the application of ethics resources, such as ethical decision-making frameworks, can help mitigate the impact of these challenges until the results of macro approaches to projected workforce shortages can be felt. Below are several ideas to get started.

Everyday Decisions Have Ethical Dimensions

Because the staffing choices leaders face are so commonplace, it can be easy to lose sight of the ethical dimensions inherent in them. The way decisions are made concerning issues like organ allocation, or, as was the case during the COVID-19 pandemic, which patients receive ventilators, are obviously moral choices about the allocation of scarce resources, which are readily appreciated. These decisions bring the ethical principle of justice into focus, requiring leaders to carefully weigh their costs and benefits. It is often typical for ethics professionals to become involved in helping with the decision-making process and follow-up evaluation for these types of issues.

However, how often has it happened that an ethicist is invited to discussions regarding responses to inadequate resources for safe staffing of our programs and services? Is it recognized that the same ethical threads run through these challenges as in the organ and ventilator examples? Would it even occur to leaders to have an ethicist or someone with ethics training participate in management meetings as they work through the daunting questions of how to continue to provide safe care in the face of dwindling and inadequate human resources?

Introducing ethicists and ethical decision-making resources is a powerful tool to reduce stress on leaders while ensuring a systematic approach to making tough decisions with an ethical basis.

An important first step to enhanced, ethically grounded decision-making is recognizing that a leader's decision to limit services, stretch existing staff to fill gaps or contract with temporary (and often expensive) labor is a classic "allocation of scarce resources" (justice/fairness) dilemma.

Deploying Ethical Resources

With the understanding that persistent shortages of key human resources do

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present challenging ethical decisions comes the recognition that engaging ethics resources to assist in decision-making processes can be beneficial. It is an understatement to say that many decisions weigh heavily on the minds of the leaders who are charged with making them. The introduction of an ethicist, therefore, is a gift that leaders give themselves. And, the application of ethical decision-making frameworks provides a road map to assist the leader in what are often emotion-heavy discussions and decisions.

Although the weight of the ultimate decision continues to rest upon the leader, a comprehensive ethical decision-making process helps gain support for making the decision and evaluating its impact—and having a confidante along the way is far more desirable than carrying the burden alone. Further, the use of an ethicist in these leadership discussions and decisions may, in fact, decrease stress and bolster leader resilience in the long term.

Communicating Openly and Honestly

In this time of healthcare human resource shortages, those who are employed want to know that their leaders understand the impact of the shortages on their work and that they are committed to improving their work experience. In addition, it has been clear that people working within the healthcare system want to know that their leaders are making ethical decisions.

At every opportunity, leaders must communicate openly and honestly with stakeholders about the challenging workforce shortage environment and its impacts on the organization. Have at the ready solid answers to why a program might be closing or how long a department will have to work shorthanded without respite. And have answers to questions about why a decision was made to invest in expensive contract workers in lieu of pursuing other needed resources.

When a leader can describe a shortage-related decision as having been arrived at using an ethical decision-making process—and can clearly articulate the cost-benefit analysis that was done before the decision was made—stakeholders will then have assurances that decisions have a strong ethical basis.

This type of communication helps build and maintain trust in leaders. It is far more effective than often-used (and trite) responses such as, "It's not in the budget," "Everyone just needs to work smarter, not harder," and "Everyone needs to get used to it because this is our new normal."

Allocating scarce resources is a necessity that every healthcare system has likely been performing since its inception. The difference today might be that resources are not allocated using traditional cost-benefit methods but, rather, in a "which is the lesser harm" or "lesser of two evils" mode. This is extra taxing on leaders. Introducing ethicists and ethical decision-making resources is a powerful tool to reduce stress on leaders while ensuring a systematic approach to making tough decisions with an ethical basis. ▲

Susan A. Reeves, EdD, RN, CENP, is system chief nurse executive for Dartmouth Health, Lebanon, N.H. (susan.a.reeves@hitchcock.org).

Mitch Graves

Sylvia Richey, MD

Beam Me to the Clinic

Holograms prove beneficial to patients in rural communities.

When the only physician at West Cancer Center & Research Institute's Paris, Tenn., clinic was going on a six-week leave, leaders knew that finding someone to fill in for such an extended period of time would be challenging, if not impossible.

Paris is located north of Memphis, near the Kentucky border. To care for patients in rural communities like it, the institute typically relies on telehealth visits, using videoconferencing, or physicians spending long hours traveling to these clinics in these locations. In this situation, though, something innovative was going to be needed.

The organization has 12 clinics, which saw 63,000 unique patient visits in 2024. Headquartered in Germantown, Tenn., just outside Memphis, a great deal of farmland and a number of small communities make up the institute's service area. Two clinics, in Paris and Corinth, Miss., have populations of fewer than 15,000 people.

To address the immediate concern of the Paris physician's absence, assigned physicians commuted to the clinic or patients drove to the main clinic two hours away. Several clinical and administrative leaders then met to figure out a long-term solution so cancer patients in those communities could continue to visit with an oncologist near where they live.

The CEO jokingly suggested using a hologram to "send" its best physicians to patients at the institute's rural locations. Everyone laughed—a nice big chuckle—but the idea stuck. After researching options, the one company that stood out to the organization's leaders was a hologram manufacturer with an office that just happened to be in Nashville.

Testing and Approving the Hologram

West Cancer Center & Research Institute's senior leaders traveled across the state to the manufacturer for a demonstration. At first they were skeptical of the technology. Would the physician look real? Would there be a delay in communication, as there is sometimes with videoconferencing calls? Holograms, after all, aren't intended for use in healthcare.

Despite the demonstration's $6,000 price tag, leaders gave the thumbs up to proceed. The hologram technology passed the test with flying colors, and senior leaders immediately thought it could make a huge difference for the cancer institute's patients.

Back in Germantown, the idea to purchase the technology was discussed with additional executive leaders, physicians and the governing board. Everyone agreed using the hologram was worth the investment.

Implementing and Using the Hologram

One year later, West Cancer Center & Research Institute implemented the technology at its Paris and Corinth clinics. The process was relatively simple. At one end, the physician is in a production studio at the Germantown clinic. The physician's image is beamed over the internet to an exam room at the remote location.

In the exam room, the physician appears as a hologram in what is called a lightbox that's about 7 feet tall by 4 feet wide. The front of the box has an LCD screen; inside the box, special lighting projects the image in three dimensions versus the flat image of a video call. In many ways, it actually appears as though the physician is really in the room with the patient.

The image is of the entire person, which allows the patient to see the physician's body language, an important detail in specialties such as oncology. A lot of insight comes from hand gestures

or other movements that can get lost in a telehealth visit, which is essentially just talking heads. Patients also sometimes aren't comfortable using videoconferencing platforms in their homes.

The physician sees and communicates with the patient through a camera. The physician is in the hologram technology studio, where a large monitor shows the patient and family in the exam room. It made more sense for the physician to be projected from the studio to the box rather than having the patient standing in the studio and being projected to the physician. In the studio, the physician can see the patient in the exam room; the camera is on the lightbox that is projecting the physician, and if the physician needs to see something close-up, the patient can move closer to the lightbox.

So far, the hologram technology has fully met the organization's expectations. Without it, cancer patients in rural communities would have to travel hundreds of miles to visit the nearest oncologist.

This technology, like videoconferencing, does have a downside: The physician is unable to touch the patient. However, a clinician, such as a nurse practitioner, is in the room with the patient during each visit to take a blood pressure reading or more closely examine a rash, for example.

Patients have expressed only appreciation for this new way of seeing their physician. One would think some people might be intimidated by the technology, but that has not been the case. Patients say using a hologram is much better than a regular telehealth visit.

"It was exactly like an in-person visit," according to one patient. She previously used her cellphone for a virtual visit, but that doesn't compare to the hologram visit. Another patient said he was able to see everything clearly. "The body language (of the physician) was there, which made it very personal."

Realizing a Good Investment

The technology's cost is not prohibitive. Each lightbox costs $35,000 and has been worth the investment. So far, 10 patients use the hologram each week, and many are in palliative care.

Hologram technology is commonly used for marketing and education purposes in healthcare, but this is the first example of it being used for patient visits. It's an exciting innovation that offers great potential in healthcare. For insurance purposes, the hologram visit is coded the same way as a remote visit; there is no difference.

A hologram visit could be a solution for many rural communities, as in most cases the population numbers are not enough to support a full-time specialized physician. It may be nearly impossible to get a cardiologist, for example, to live in a rural community, but a nurse practitioner is more likely to practice and live there. The cardiologist would be able to see the patient via this technology.

Even after one year, the hologram technology has advanced to where a new lightbox is thinner and more lightweight, and it's eventually going to be more mobile and less expensive. Another feature that will be coming out soon is language translation. For example, a patient could speak to the physician in Chinese, and the physician would hear the translation in English. The physician would answer in English, and that would be translated into Chinese for the patient.

Senior leaders advised the hologram manufacturer's engineers as they were developing this language technology to make sure that everything is HIPAA compliant and to load the software with universal medical language. The possibilities with holograms in healthcare are endless, and the institute's leaders look forward to making them a reality for our patients. ▲

A hologram visit could be a solution for many rural communities, as in most cases the population numbers are not enough to support a full-time specialized physician.

Mitch Graves is CEO and an ACHE Member. Sylvia Richey, MD, is CMO and a medical oncologist. Both are with West Cancer Center & Research Institute, Germantown, Tenn.

Paul H. Keckley, PhD

Focus on the Workforce of the Future

Emergent trends and strategic considerations for leaders.

Healthcare workforce modernization is needed to align the industry's future with clinical innovations, economic realities and the population's health needs. Efforts to this end are a focus in the field's trade associations; educational institutions; federal, state and local licensing agencies; and organizations operating within the $4.9 trillion U.S. healthcare economy.

Recent federal and state legislation has advanced awareness of the need to assess the availability and preparedness of the expansive healthcare workforce. These efforts are promising, but they may fall short unless the scope of modernization strategy is expanded in a public-private partnership.

The U.S. healthcare industry employed 21.4 million people and accounted for 12.8% of total U.S. employment in 2023 (most recent data available), according to the U.S. Bureau of Labor Statistics. The need for labor is expected to increase to 24 million by 2030, as public health professionals, alternative health providers and technology-enabled self-care management are added. In 2023, 29% of physicians and 15% of nurses were foreign born, almost three-fourths of the workforce were women, two-thirds were non-Hispanic whites, and the majority were older than 50.

Most of the healthcare workforce (70%) are employed in caregiving settings (doctors, nurses, techs, therapists and support staff), and one-third (7.4 million) work in hospitals, per BLS. Wages and benefits account for 60% of operating costs in hospitals, clinics and long-term care settings—increasing faster than inflation and other direct costs since the COVID-19 pandemic.

The industry's growth and complexity are attributed to three major factors: the aging of the population, the growing prevalence of chronic diseases and an increased demand for clinical innovations that clinicians accept, payers cover and consumers expect.

The population of seniors is expected to triple in the next three decades, according to the U.S. Census Bureau. The "silver tsunami" of baby boomers—those born between 1946–1964—are now all over age 60, further driving the demand for healthcare services. In addition, the prevalence of disease in the U.S. population is expected to increase to 180.4 million (63.5%) by 2030, from 137.3 million (52.1% of the population) in 2020, according to the U.S. Centers for Disease Control and Prevention.

Social services involving food insecurity, loneliness, clean air and safe housing are critical factors in the prevalence and intensity of chronic care demand, necessitating collaboration between state and local public health agencies, licensed provider professions, family caregivers and faith communities. The workforce necessary to address chronic care needs extends well beyond traditional roles in healthcare.

Modernization focused on physicians and nurses alone is not enough.

Clinical innovations, such as noninvasive or minimally invasive surgical procedures, and precision diagnostics and therapeutics have changed how, where and by whom care is provided. Coverage determination by health insurers has introduced payment uncertainty into the workforce, and direct-to-consumer social media/advertising for new drugs and devices has increased patient expectations about workforce/patient interactions. Collectively, these outside factors contribute to the workforce's growing stress and organizational costs for equipping them to adapt.

This column is made possible in part by Quest Diagnostics.

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Current modernization efforts focus primarily on physicians and nurses, including the areas of clinical training, job satisfaction, recruitment and retention, compensation and error avoidance. Using state and federal government funding, education and training programs for licensed professional nurses and physicians have been upgraded to accelerate competency-based performance using technologies and team-based models. Medical schools and residency sponsors have integrated problem-based methodologies and a whole-person well-being (social determinants of health) orientation to patient care to improve preparedness.

Modernization is also addressing workforce compensation—since labor constitutes 60% of operating costs in provider settings. Among hourly workers, the focus is on achieving a livable minimum wage. Among physicians, the focus is on reducing reimbursement cuts by Medicare that have fallen short of medical inflation for the last five years and increasing net compensation in primary care and behavioral health. And there's growing sensitivity across the industry about executive compensation. In hospitals, for example, from 2023 to 2024, clinicians' salaries fluctuated between -2.4% to +2.4%, while executives saw an increase of +3.6% to +8.3%, per Sullivan Cotter—the Chicago-based healthcare consulting firm.

And modernization has necessarily addressed stress and burnout among physicians and nurses. Over half of pharmacists, nurses, advanced practice nurses, physicians and administrative personnel have admitted to experiencing burnout symptoms, per the 2023 Well-Being Index. A correlation between burnout, staff effectiveness and patient safety and outcomes in acute and long-term care settings has been shown in academic studies, prompting individual organizations and professional societies to adopt interventions geared toward patient safety, but the issue remains largely unsolved.

Shortages of health professionals in behavioral health, infectious disease, optical services, respiratory therapy and home health in rural and underserved populations are more pronounced than in physician and nursing services. Modernization efforts have focused on funding for scholarships and signing bonuses, flexible work conditions, attractive wages and benefits, debt forgiveness, enhanced administrative support and more. But acute shortages remain in at least one-third of all U.S. counties, and modernization efforts addressing maldistribution have not been as effective as desired.

Here's what leaders should consider in developing healthcare workforce modernization strategies. Healthcare workforce modernization is needed in every healthcare organization. Significant progress has been made in the areas previously mentioned, but next-generation strategies should consider three more:

Outsourcing partnerships: For many in the healthcare workforce, including the majority of workers in administrative functions, outsourcing to solution providers and/or centralization of administrative functions in multi-facility corporate hubs plays an increasingly important role. Often, applications of artificial intelligence and automation are the rationale for outsourcing partnerships. Consistency of strategy in modernization must necessarily include the policies, procedures, performance evaluation criteria and cultural underpinnings of outsource partners.

Expansion of workforce modernization to new workforce cohorts: A larger group of clinical, administrative and operational personnel should be included in modernization efforts, along with unpaid direct caregivers, practitioners in alternative and complementary health, school clinic operators and public health providers. Modernization focused on physicians and nurses alone is not enough.

Understanding the voice of the customer: Understanding consumer attitudes, complaints, misinformation and expectations is a critical element in workforce modernization. A culture in which patients, members and customers are respected, recognized and heard is vital to workforce stability and sense of purpose.

The healthcare industry is labor intense. Its workforce is being asked to do more with less. Modernization is not arbitrary. It should be the highest priority for every organization in healthcare. ▲

Paul H. Keckley, PhD, is managing editor of The Keckley Report *(pkeckley@paulkeckley.com).*

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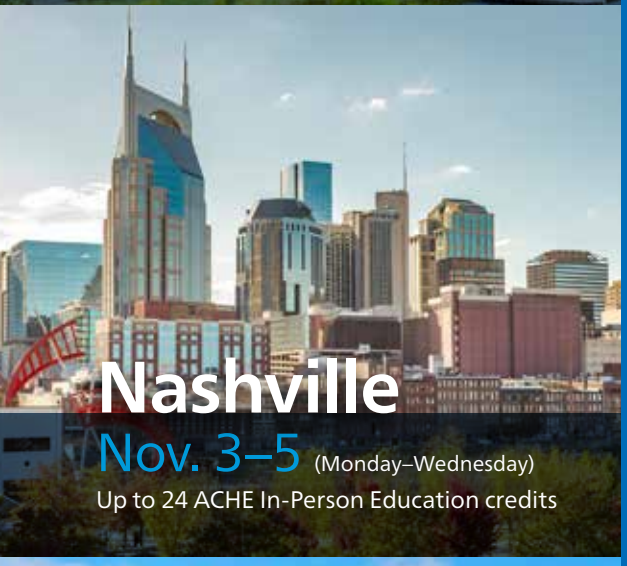

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Ryan Donohue

Patients Are 'Patient' No Longer

Harness the board's powerful perspective to improve the healthcare experience.

In healthcare, patients lie at the center of decisions made and actions taken. Board meetings or leadership retreats often begin with patients top of mind—perhaps by sharing a reflection on a patient experience or reading a letter written by someone recently treated. But, as leaders get into the myriad challenges they face—issues with access, reimbursement, workforce, physician shortages, employee burnout or other operational and cultural challenges—they can begin to lose that all-important focus on the patient.

As healthcare leaders find themselves navigating an ever-changing landscape, now is the moment to enhance the focus on consumers and patients, and it requires unified leadership from both boards and senior executives. Patients want improved healthcare experiences, and they are tired of waiting.

Though departments aimed at improving the patient experience are important in driving the consumer- and patient-led revolution for better experiences, these efforts should stretch throughout the organization. An unlikely but suitable partner is the board of directors. With one foot inside the organization, many board members bring customer-oriented skills from the outside world. They also often hold personal knowledge of how long and sometimes lonely the patient journey can seem.

Engaging with patients usually requires overcoming one of six barriers: care deferment, the blurring of traditional brands in consumers' minds, new entrants that offer additional care choices, higher patient expectations, paying for care, and the lack of lasting relationships between providers and patients. It's a sometimes vicious cycle of consumers grappling with being a patient and possibly feeling like a number in the healthcare system.

To truly address these challenges, leadership can:

- ***Use the board's fresh perspective*:** It's true that those working inside the hospital are closest to the patients and provide valuable perspectives, but solutions may require a wider lens with more objectivity. Senior leaders harnessing the generative wisdom of the board and asking for their input on patient engagement challenges can be powerful, offering bigger-picture ideas and solutions.

- ***Build a strong commitment at both the board and CEO level*:** Board members should be willing to commit to a future-facing strategy in which money invested in an integrated consumer-facing platform becomes preeminent, and CEOs are held accountable for progress in addressing patient and community needs.

- ***Collaborate to ensure the patient is always the focus*:** The two-way benefits of conversations between the board and management around patient experience can reverberate throughout an organization. Board members often seek engagement with those on the inside, and management seeks board approval and a general feeling that they are doing a good job. While the board typically maintains a strategic distance, management can easily become consumed by their work and tangled up in processes, which can sap attention—even at the top. By maintaining focus and prioritizing the patient experience, the board and senior leaders can work together to ensure that they don't lose focus on patients while solving the problems of the system.

- ***View care through the patient's eyes*:** Consumers and patients may feel they aren't directly involved enough in their own care and that they spend too much of their own money on that care. Leaders should consider that consumers and patients envision

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healthcare much like any other service—something that is personally tailored to their needs and done accurately and quickly. Otherwise, they are willing to go elsewhere.

Healthcare leaders can use patient-centeredness, advocated by the CEO and backed by the board, as an antidote to healthcare's systems distractions. Centering on patients can also provide good boundaries. CEOs work hard to strike a balance between engaging board members and keeping them out of the operational weeds. Centering on patients requires the board to keep patients in a wide but strategic focus, asking patient-focused questions and giving resources based on how they help patients.

Patient-centeredness also gives management the power to execute their work through a tighter lens and enables them to use their dedicated talents all the way to the bedside. Top to bottom, patients can serve as the strategic connector among the many levels of the organization.

CEOs own the overall consumer journey, but they cannot do it alone. A CEO's job starts with their trustees. Every leader needs a strong, courageous board. It takes a bold group of trustees to look at the future, culture change, innovation and commitment to the community. They need to ask themselves who represents the community and how can they be supported. It seems the board may be the secret weapon in the consumer- and patient-led revolution.

Understanding how patients and consumers feel and gauging the current state of the revolution in a particular area requires community engagement. Patients and consumers will be more than willing to share their needs and expectations. With the patient in focus and engaged leadership in tow, the future of healthcare will be brighter for all. ▲

Ryan Donohue is strategic advisor at NRC Health and an advisor with The Governance Institute (rdonohue@gmail.com). He and Stephen Klasko, MD, are authors of Patient No Longer: How YOU Can Lead the Consumer Revolution in Healthcare*, Second Edition (ACHE Learn, 2025).*

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Responsible Use of AI

A quantum leap opportunity for healthcare.

Jonathan B. Perlin, MD, PhD, FACMI

When you have the privilege of leading a global enterprise like The Joint Commission, certain universal truths are revealed. One especially stands out.

Healthcare today is brutally complex. Our field is facing unprecedented clinical, operational, financial and even political challenges. Patients still have trouble accessing the safest, highest-quality care available. In fact, a 2024 study suggests 23% of people who die or deteriorate in U.S. hospitals do so because of a missed or misdiagnosis, according to research led by the University of California San Francisco's Andrew Auerbach, MD, published in *JAMA Internal Medicine* last year. U.S. hospitals and health systems are under immense strain, with 37% operating at a loss, Kaufman Hall reported in February. Workforce shortages and burnout persist. Violence toward healthcare workers is intensifying. And the headwinds seem to keep coming.

Still there is optimism, as we are on the brink of significant transformation. Artificial intelligence offers tremendous opportunity for a much-needed step-change in healthcare. From meeting patients' needs in a timelier fashion, reducing administrative overhead, easing clinician burden and improving diagnosis to dramatically accelerating drug discovery, AI has the potential to unlock advances we have yet to envision.

Artificial intelligence offers tremendous opportunity for a much-needed step-change in healthcare.

Consider for a moment the enormous amount of data that contemporary clinicians are expected to manage. In the ICU, evidence indicates the average patient generates more than 1,300 data points per day. The "magical number seven" theory in cognitive psychology suggests the brain's working memory is calibrated to remember only about seven variables simultaneously—the length of a typical local U.S. phone number, excluding area codes.

Just how many unique combinations can seven digits make? 5,040. Now, let's do the same factorial exercise for 1,300 variables, calculating all the possible permutations of 1,300 that could surface in the ICU for a given patient.

Is it 1 million? 1 billion? No; it's the head-spinning number of 3.16 times 10 to the 3,485th power. That's more than the number of sand grains estimated to be on Earth. Likely more, even, than the number of particles thought to exist in the universe. We have reached a point where "the complexity of modern medicine has surpassed the capacity of the human mind," as my colleagues and I wrote in the *New England Journal of Medicine AI* last year.

The bottom line is healthcare needs help. That's why the potential for AI to augment our work is so intriguing, across all aspects of quality, patient safety and operations. Early uses of AI and their results have been encouraging.

Six years ago, for instance, following traditional attempts to improve care for sepsis and reduce mortality rates, a large, national health system turned to AI and developed an algorithm that alerted care teams the instant an inpatient began exhibiting signs, using data being tracked in the patient's EHR. The algorithm, called SPOT, or Sepsis Prediction and Optimization of Therapy, dramatically improved sepsis diagnosis and saved 8,000

additional lives over a five-year period. This occurred well before ChatGPT and the rapidly evolving AI capabilities we are witnessing today.

At the same time, two fears persist: The fear that as a society we won't have sufficient guardrails in place to protect us from the unintended consequences of AI in healthcare, which could cause real harm. These range from user error, hallucinations and algorithmic biases that amplify care disparities to novel data security threats and inappropriate use. On the other hand, there is the fear that overregulation and too many controls will stifle progress, hampering the ingenuity of entrepreneurial innovators, thereby obstructing healthcare's ability to harness the transformative power of AI.

We must land somewhere in the middle. Last September, The Joint Commission convened experts on operationalizing the responsible use of health AI in healthcare. U.S. policymakers, patient advocates, healthcare workers, tech industry leaders and healthcare executives gathered for spirited discussions around the opportunities and challenges that AI in healthcare presents. What emerged was excitement for the value of AI tools, a desire for guidance to drive innovation and a strong interest in common-sense guardrails with a focus on governance to ensure that healthcare organizations are meeting their obligations to patients.

When we think about developing a framework governing the responsible use of AI in healthcare, it's important to recognize AI is not one thing, adding complexity to an already complex picture. As Michael Howell, MD, chief clinical officer, and Karen DeSalvo, MD, chief health officer, both at Google, wrote last year in the *Journal of the American Medical Association*, we can divide AI into three epochs, each with "fundamentally different capabilities and risks."

- AI 1.0, which dates back to the 1950s and is characterized by symbolic and probabilistic models; picture if/then statements.
- AI 2.0, which entails deep learning models that "do one thing at a time" and "primarily focus on classification and prediction."

- AI 3.0, which are foundation models and generative AI that "can do many different kinds of tasks without being retrained on a new dataset."

Therefore, the governance and regulation of AI in healthcare will necessitate agility, with consideration for the specific AI category and its use cases versus a one-size-fits-all approach. Probabilistic models that we've been creating for more than half a century, for example, may require a different framework than, say, agentic AI, which can operate with some autonomy and make decisions. James Zou, PhD, and Eric Topol, MD, both of Stanford University, recently wrote in a column published in *The Lancet* that such AI agents hold great promise in medicine and "have the potential to become valuable teammates to human clinicians," provided they are carefully investigated and regulated.

In 2024, The Joint Commission launched a Responsible Use of Health Data certification program, which provides healthcare organizations with a blueprint for safely and appropriately managing secondary patient data—health data used for purposes beyond clinical care such as for research, registry creation or the training of AI tools.

Informed by Health Evolution Forum's "The Trust Framework for Accelerating Responsible Use of De-identified Data in Algorithm and Product Development," the certification affirms that organizations have the necessary protocols and governance processes in place to keep patients informed, safeguard their privacy, prevent data misuse and validate algorithms.

The Joint Commission sees this as the precursor to a future certification program that will guide healthcare organizations on the responsible use of health AI. The organization's vision is to empower hospitals and health systems to improve patient outcomes by harnessing AI's potential, while at the same time addressing and mitigating safety concerns. More details are on the horizon, but it begins with a strong belief that the speed of innovation necessary for transformative solutions to pressing problems should be nurtured with responsible and informed

self-governance, not stifled with overregulation.

Let's use AI to harvest variation. Let's use AI to discover the best practices we didn't intuit. Let's recognize the potential for a new level of thinking augmented by technology.

It's fashionable in safety and quality circles to say we want to stop variation, but a higher aspiration is required. Let's use AI to harvest variation. Let's use AI to discover the best practices we didn't intuit. Let's recognize the potential for a new level of thinking augmented by technology that can help us wrestle those 3.16-times-10-to-the-3,485th-power challenges of complexity. All of us—as healthcare leaders—bear the responsibility of making healthcare safer, more effective, more efficient, more accessible, more affordable and more compassionate.

Paradoxically, as AI grows more facile at reducing clinician burden and improving diagnosis—from generating visit notes to analyzing radiology imaging—we have the chance to return joy to work by preserving more time for interaction with the patient, not the computer.

I have seen examples of how AI can relieve a patient's anxiety by speeding up the process of alerting them to reassuring biopsy results and channeling patients diagnosed with cancer to appropriate care. Not only does this result in better outcomes for patients with time-sensitive cancers, but it also completely changes the role of nurse navigators who have shifted 70% of their time dedicated to direct patient engagement from spending 70% of their time on administrative tasks.

As we look ahead to the many possibilities, let's embrace the potential for AI to make healthcare more human. And there is nothing artificial about that. ▲

Jonathan B. Perlin, MD, PhD, FACMI, is president and CEO, The Joint Commission Enterprise, Oak Brook Terrace, Ill.

Kofi A. Cash, DSc, FACHE

How to Succeed as a COO

Pathways and tactics for operational leadership.

As the senior leader responsible for day-to-day operations, the COO advances strategic priorities by delivering high-quality care and driving efficiencies and operational excellence. This appointment can define one's career or be a final step toward a hospital CEO or president role.

Becoming a COO requires significant practical experience and power skills, including attributes such as a growth mindset, a transformational leadership style and practical multimodal communication skills.

However, vertical career advancement has expanded due to mergers and acquisitions of hospitals and healthcare systems. For example, market or regional COO roles are now commonplace. These roles oversee a geographical market (often involving several hospitals and sites of care) and therefore require greater responsibility than a single entity. In these instances, the hospital CEO or president usually reports to the market COO or healthcare system COO.

Becoming a COO requires significant practical experience and power skills, including attributes such as a growth mindset, a transformational leadership style, practical multimodal communication skills, an ability to cultivate followership and demonstrated intellectual curiosity, which can sharply differentiate a COO from the rest of the field.

Relevant Professional Experience

Most aspiring and newly appointed hospital COOs have extensive experience leading numerous ancillary (non-nursing) departments. For example, an aspiring COO can gain relevant experience by volunteering to lead or assist with hospital-wide initiatives such as improving patient safety, reducing readmission rates or optimizing staffing schedules.

As another example, gaining hands-on experience in managing specific operational functions—supply chain management, patient flow optimization, facilities, environmental services, laboratory services, security or transportation—can help further develop an appreciation for hospital efficiency.

Executive Operational Competencies

The heart of the COO's responsibilities is overseeing the hospital's daily operations, ensuring services are delivered efficiently and effectively. Senior operational leadership requires balancing competing priorities, including growing service lines, maintaining operational costs, and managing licensed and non-licensed staff members.

The most effective COOs demonstrate expertise in many wide-ranging competencies. However, the following competencies, or "hard skills," are necessary for success.

Stakeholder engagement. The COO works closely and collaboratively with other C-suite leaders, the hospital board, the medical staff and external partners to develop and execute strategic plans. Reporting to the hospital CEO requires an unflappable presence, effective multimodal (public speaking, email, telephone, text) communication and professional dependability.

In practice, the COO hosts regular discussions with senior leaders, department heads, physicians and front-line staff to gather feedback on operational challenges and collaboratively develop solutions, ensuring all voices are heard and valued in decision-making. Despite managing complexity and dealing with ongoing pressure, the COO provides reliable and data-driven recommendations to the CEO.

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Capital and expense management. COOs are clear-eyed about where spending can be reduced without compromising quality. This might involve negotiating better contracts with external vendors, optimizing staffing schedules, reducing contract labor, growing procedure and surgical volume, increasing operational capacity, and reducing unwarranted lengths of stay.

Here, the COO evaluates and prioritizes major equipment purchases, such as imaging equipment, a fleet of hospital beds or surgical robots—based on ROI, patient demand and long-term strategic goals—ensuring hospital capital is invested wisely.

Quality improvement programs. COOs may lead or support quality improvement initiatives such as reducing hospital-acquired infections, minimizing medical errors, preparing for Joint Commission surveys, elevating patient experience scores and improving patient safety. Therefore, the COO needs to master the application of performance improvement science and use that knowledge to improve outcomes.

In this competency, the COO leads a multidisciplinary team to analyze patient discharge delays, identify bottlenecks and implement a new streamlined discharge protocol that reduces length of stay and improves patient satisfaction.

Technology adoption and innovation. COOs are fervent sponsors of innovation; however, they adopt technology through a data-driven and cost-efficiency lens. Adopting cost-effective and empirically proven technologies can position the hospital for long-term growth and market differentiation.

On the ground, the COO champions technology, such as asset tagging systems, wearable devices for patient monitoring, robotics, touchless security systems and AI-powered predictive analytics tools to optimize patient flow, reduce wait times and improve operational efficiency.

Process optimization: A COO improves hospital-wide operations by identifying inefficient workflows and interdependent processes that impact patient care. The COO must be willing to walk throughout the hospital, across campus grounds and parking locations designated for patients and visitors. By reengineering workflows and processes, COOs can significantly enhance the efficiency of clinical, operational and administrative functions, ultimately improving outcomes and reducing costs.

In this case, the COO champions cross-functional collaboration through structured huddles or rapid improvement events (e.g., Lean Six Sigma) to identify pain points and implement workflow solutions driven by the front line.

Grit: The Singular Competency That Can Set You Apart

If most workdays overwhelmingly involve virtual and in-person committee meetings, then a COO is simply "working" the ranch, not "running" the ranch. COOs are change agents. It takes grit and tenacity to run day-to-day operations in a highly complex organization effectively.

There will be times when the COO fails in the short term. Despite such setbacks, COOs must be resilient, leave the safe confines of their executive offices and accept the gifts of being scrutinized and judged. The COO must reevaluate or pivot in their approach to a problem only after visiting and conversing with managers and front-line staff. Being visible and accessible require time and energy. This type of grit separates effective leaders from mediocre leaders.

The practice applies when faced with a significant staffing shortage. For instance, the COO works long hours alongside department heads to reassign resources, recruit temporary staff and implement retention strategies, refusing to give up until patient care standards are stabilized.

Power (or Soft) Skills

The practical application of power skills is equally as important as professional experience. For example, be kind and patient, actively listen and seek understanding.

Many also refer to these skills as soft skills, which can be refined by engaging and leading cross-functional employees. Make it a point to conduct your leadership rounds to connect rather than inspect. Show and explain, rather than direct, by sharing stories that illustrate organizational priorities. As a meeting facilitator, allow people to bring their perspectives

forward. Ask open-ended questions.

How you show up for work determines how your colleagues and team members perceive you. Accordingly, self-regulation and self-awareness (emotional intelligence) are perhaps the most advanced power skills. Some examples include:

- Listen carefully during a tense one-on-one meeting rather than interrupting.
- Praise employees after noticing their effort and improvement.
- Set a steady example with composure during a crisis.
- Be aware when a colleague is overwhelmed, and offer support and goodwill.
- Use professional body language when exposed to adverse interpretations and misinformation.

Finally, remember your purpose—your why—and carry it with you. Employees and patients are your essential and most vulnerable stakeholders. Treat them well and nurture them. There is no better work than leading human beings, running day-to-day operations and making it easier for providers to deliver exceptional care. Your community is counting on you. ▲

Kofi A. Cash, DSc, FACHE, is a seasoned hospital operator and executive director of operations in the Greater Boston area.

ACHE MEMBER UPDATE

Ethics Committee Update

ACHE's Ethics Committee is responsible for reviewing member grievances and recommending actions to the Board of Governors on allegations regarding *Code of Ethics* violations. During the 2024–2025 committee year, the Ethics Committee did not need to consider any issues involving ACHE members.

The Ethics Committee is also responsible for conducting annual evaluations of ACHE's *Code of Ethics* and Grievance Procedure and recommending updates.

Ethics Committee members are ACHE Fellows who are appointed by the Board of Governors; they serve confidentially, with the exception of the committee chair, whose name is made public. The *Code of Ethics*, Ethical Policy Statements and other ethics resources are available at **ache.org/Ethics**. The Ethics Self-Assessment, a tool to help members evaluate their ethics-related leadership and actions and address potential red flags, can be found at **ache.org/EthicsSelfAssessment**.

PEOPLE

American Hospital Association Recognizes ACHE Members

During the AHA's 2025 Annual Membership Meeting in May, two members of the American College of Healthcare Executives were among those who received awards for their service to the healthcare field and for innovative approaches to providing care.

Board of Trustees Awards

Phyllis Cowling, former president and CEO of United Regional Health Care System, Wichita Falls, Texas, and **Ron Werft, LFACHE**, former president and CEO and now president emeritus of Cottage Health in Santa Barbara, Calif., received AHA's 2025 Board of Trustees Award. The award is presented to individuals or groups who have made substantial and noteworthy contributions to the work of the AHA on behalf of the hospital field.

Member-Led Organizations Receive Gallup Exceptional Workplace Award

Four ACHE member-led organizations received the 2025 Gallup Exceptional Workplace Award, which recognizes employee engagement. They are:

- Children's Health of Texas, Dallas, led by **Christopher J. Durovich, FACHE**, president/CEO (four-time winner).
- Exact Sciences Corp., Madison, Wis., led by **Kevin Conroy**, president and CEO (two-time winner).
- Hendrick Health, Abilene, Texas, led by **Brad D. Holland, FACHE**, president/CEO (18-time winner).
- Sarasota (Fla.) Memorial Health Care System, led by **David Verinder**, president/CEO (four-time winner).

A total of 70 organizations in a variety of industries received the award.

In Memoriam

ACHE regretfully reports the deaths of the following ACHE members as reported by the Department of Executive Engagement:

Carl S. Chitwood, FACHE
Virginia Beach, Va.

Loressa Cole, DNP, FACHE
Peterstown, W.Va.

Kathy E. Schumacher, FACHE
Bloomfield Hills, Mich.

LEADERS IN ACTION

To promote the many benefits of ACHE membership, the following ACHE leader spoke recently at the following events:

Michele K. Sutton, FACHE
2025-2026 Chair
American Hospital Association
Annual Membership Meeting
ACHE Breakfast Meeting
May 5, 2025

ACHE-New Jersey
C-Suite Roundtable
March 4, 2025

ACHE STAFF NEWS

Postgraduate Fellow and Diversity Intern Announced

Lynard V. Gardner Jr. has been selected as the 2025–2026 Stuart A. Westbury Jr. Postgraduate Fellow. Gardner graduated in 2025 with a master's degree in health administration from the Medical University of South Carolina. He has worked most recently as a patient care technician at MUSC in Charleston, S.C. ACHE established this fellowship in 1991 to further postgraduate education in healthcare and professional society management.

Arthur T. Edwards has been selected as the ACHE Diversity Intern through the Institute for Diversity and Health Equity's Summer Enrichment Program. Edwards is pursuing a master's degree in health services administration from Xavier University, Cincinnati.

Both the yearlong fellowship and the three-month internship offer exposure to a broad range of association management issues through interactions with senior-level executives and rotations through each of ACHE's departments.

Addressing Registered Nurse Shortages in Hospitals

Results by ACHE's Executive Office, Research

In January 2024, ACHE conducted a survey of hospital leaders to learn more about causes of shortages and how hospitals are addressing them. Of the 1,633 who received the survey, 350 responded for an overall response rate of 21%.

Hospital CEOs were asked to name the top three staffing shortages they were experiencing. They reported their top staffing shortages as follows: 71% of responses indicated a shortage of registered nurses, 50% identified a lack of medical technicians and 35% mentioned a shortage of physicians. Among physicians, 18% specified a shortage of specialists and 17% of primary care physicians.

The reason for registered nurse shortages in hospitals, as reported by survey respondents, are listed in Table 1. The most common ways in which hospitals are addressing these shortages are listed in Table 2.

ACHE wishes to thank the leaders who responded to this survey for their time, consideration, and service to their profession and to healthcare leadership research.

Table 1. Reasons for registered nurse staffing shortages.

Reason for Shortage of Registered Nurses	Percentages or Numbers Indicated by CEOs (N=248)
Competition from other hospitals	77%
Competition from agencies	64%
Staff retirement/leaving	59%
Insufficient number of staff graduating from schools	56%
Hospital location makes it hard to attract staff	44%
Nurses moving to advanced practice	44%
Staff burnout	43%
Competition from other non-hospital providers	40%
Competition from non-healthcare employers	16%
Other	3%

Table 2. How organizations are addressing registered nurse staffing shortages.

Strategies to Address Shortage of Registered Nurses	Percentages or Numbers Indicated by CEOs (N=248)
Focusing on staff recruitment	92%
Focusing on staff retention	90%
Filling in with contract (agency) staff who are travelers	72%
Altering care models to reduce need for the position	47%
Filling in with contract (agency) staff who work on a per diem basis	38%
Reducing services that require this position	12%
Other	8%

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American College *of* Healthcare Executives®

The American College of Healthcare Executives congratulates members who recently received awards recognizing their contribution to healthcare leadership.

Brianna N. Anduss received the Regent Award from the Regent for Oklahoma.

Angela N. Athmann received the Regent Award from the Regent for Veterans Affairs.

Col Brian J. Bender received the Career Achievement Award from the Regent for Army.

Mark J. Bittle, DrPH, FACHE, received the Lifetime Service Award from the Regent for Maryland.

Andrea Botero-Tompkins received the DEI Leader award from the Regent for New Mexico & Southwest Texas.

Hailey Bruining received the Early Careerist Award from the Regent for Texas—Southeast.

Joseph J. Cafferty, FACHE, received the Early Careerist Award from the Regent for Veterans Affairs.

Stephani Campion received the Mid-Careerist Award from the Regent for Florida—Eastern.

Richi A. Chaudhry, FACHE, received the Mid-Careerist Award from the Regent for Texas—Southeast.

Petrus A. Christiaans received the Mid-Careerist Award from the Regent for Florida—Eastern.

Elizabeth A. Cloyd, DNP, FACHE, received the Women in Healthcare Award from the Regent for Texas–Southeast.

Jason E. Cobb, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Louisiana.

Bianca N. Daswani received the Early Careerist Award from the Regent for Texas–Southeast.

Katie Delaney received the ACHE Health Studies Student/ Administrative Fellow Leadership Award at the Chicago Health Executives Forum Annual Meeting.

Jill L. Donaldson, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Maryland.

Daniel L. Ducker received the Commitment to Service Award from the Regent for Veterans Affairs.

Thomas Charles Ferguson, MD, FACHE, received the GHATP Preceptor of the Year Award from the Regent for Veterans Affairs.

Timothy M. Foggin, MD, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Canada.

HM1 Breanna Funderburk received the Enlisted Healthcare Executive Award from the Regent for Navy.

Arturo Garza, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for New Mexico & Southwest Texas.

Dominic Gonzalez received the Early Careerist Award from the Regent for Maryland.

Patricia L. Hall, PhD, FACHE, received the RAC Excellence Award from the Regent for Veterans Affairs.

John Dillon Harris received the Early Careerist Award from the Regent for Mississippi.

Want to submit?

Send your "Member Accolades" submission to he-editor@ache.org. Due to production lead times, entries must be received by July 13 to be considered for the Sept/Oct issue.

American College of Healthcare Executives
for leaders who care®

Official Notice

for the 2025–2026 Council of Regents Elections

This official notice serves as the beginning of the election process to select new Regents to serve on the American College of Healthcare Executives' Council of Regents, the legislative body that represents ACHE's 51,000 members. Service as a Regent is a unique opportunity to exercise your leadership ability, share innovative ideas and support the mission of ACHE.

All Fellows who wish to run for election must submit an electronic letter of intent to elections@ache.org by Sept. 12, 2025. If you submit your letter of intent and you haven't received confirmation by Sept. 15, 2025, contact Jennifer Frantom at jfrantom@ache.org.

Please visit **ache.org/RegentElection** for more details.

Please note:

- To be an eligible Regent candidate, Fellows must work and reside in the Regent area they would represent.
- Elected Regents will serve a three-year term on the Council of Regents beginning at the close of the March 2026 Council of Regents meeting during ACHE's Congress on Healthcare Leadership.

For additional information about Regent responsibilities and eligibility, please contact Jennifer L. Connelly, FACHE, CAE, at (312) 424-9320 or jconnelly@ache.org.

ELECTIONS WILL BE HELD IN THE FOLLOWING JURISDICTIONS:

Arizona
Army
California–Southern
Colorado
Florida–Northern and Western
Georgia
Illinois–Metropolitan Chicago
Maryland
Michigan & Northwest Ohio
Minnesota
Mississippi
Navy
Nebraska & Western Iowa
New Hampshire
New Jersey–Northern
New York–Northern and Western
North Carolina
North Dakota
Ohio
Pennsylvania
Pennsylvania–Southeast & Southern New Jersey
Puerto Rico
Rhode Island
South Carolina
Tennessee
Texas–Southeast
Virginia–Central
Washington
Wyoming

Scotte Ray Hartronft, MD, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Veterans Affairs.

Claire Hick, FACHE, received the Middle Careerist Award from the Regent for Louisiana.

Patricia A. Hildebrand, FACHE(R), received the Senior-Level Healthcare Executive Award from the Regent for Texas—Southeast.

Maj Austin Howard, FACHE, received the Mid-Career Healthcare Leadership Award from the Regent for Air Force.

Diane Marie Howard, PhD, FACHE, received the Career Achievement Award from the Regent for Metropolitan Chicago.

Gayatri Jaishankar received the Early Careerist Award from the Regent for Tennessee.

J. Ronald Johnson, FACHE, received the RAC Excellence Award from the Regent for Veterans Affairs.

Benson Kumenda received the Student Award from the Regent for Texas–Southeast.

Amanda Kunash, APRN, received the Senior-Level Healthcare Executive Award from the Regent for Metropolitan Chicago.

Mary T. Lessard, FACHE, received the Faculty Award from the Regent for California—Southern.

Margaret A. Marlatt received the Senior-Level Healthcare Executive Award from the Regent for California—Southern.

Daniel C. McGuire, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Rhode Island.

Jenna K. Merlucci, FACHE, received the Mid-Careerist Award from the Regent for Florida—Eastern.

Maj Cody R. Morcom, PharmD, received the Early Careerist Award from the Regent for Air Force.

Capt Marcy Marita Morlock, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Navy.

Laura-Kathryn Neal, DM, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Florida—Eastern.

Phyllis A. Peoples received the Rick Henault Spirit of Mentorship Award from the Regent for Louisiana.

Rush University Health Systems Management received the ACHE Health Studies Student/ Administrative Fellow Leadership Award at the Chicago Health Executives Forum Annual Meeting.

Jose Rafael Sanchez received the Career Achievement Award from the Regent for Metropolitan Chicago.

Sameer Shah, PharmD, FACHE, received the Senior Leadership Award from the Regent for Metropolitan Chicago.

Kyle E. Sinclair received the Senior-Level Healthcare Executive Award from the Regent for Texas—Central & South.

Traci Lynn Solt, FACHE, received the Leadership Development Award from the Regent for Veterans Affairs.

LT Amia Joseph Stec received the Early Careerist Award from the Regent for Navy.

Debra L. Touchette, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Texas—Central & South.

Sara Turley, FACHE, received the Mid-Careerist Award from the Regent for California—Southern.

Denisse Vega received the Early Careerist Award from the Regent for California—Southern.

Maj Tiara Walz, PhD, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Army.

Melissa Warde received the Regent Award from the Regent for Oklahoma.

Janell Williams received the Early Careerist Award from the Regent for Florida—Eastern.

Madison D. Workman, FACHE, received the Mid-Careerist Award from the Regent for Florida—Eastern.

Travis Zoss received the Early Careerist Award from the Regent for Army.

Do you know how influential you are?

In 2024, more than 2,000 healthcare leaders joined ACHE or became board certified in healthcare management as an ACHE Fellow (FACHE®) because of encouragement from members like you. Thank you.

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Deirdre A. Blaus to chief administrative officer, Robert Wood Johnson University Hospital Somerset, Somerville, N.J., from interim chief administrative officer.

Cindy Bo, FACHE, to inaugural chief, UVA Health Children's, Charlottesville, Va., from senior vice president/chief strategy officer, Boston Medical Center Health System.

DeAnn Bullock, MD, FAAEM, FACHE, to CMO, Nashville (Tenn.) General Hospital, from medical director, Emergency Department.

Ann Marie Creed, FACHE, to president, University of Michigan Health–Sparrow Lansing (Mich.), from vice president, Henry Ford Health System, Detroit.

Bradley Goettl, DNP, DHA, FACHE, to CNO, the American Nurses Enterprise, Silver Spring, Md., from co-executive director/chief clinical officer, the Emergency Nurses Association, Schaumburg, Ill.

Brad Griffin, FACHE, to CEO, Fairview Park Hospital, Dublin, Ga., from COO, Doctors Hospital of Augusta (Ga.).

Victoria Hanson, PhD, FACHE, to regional president/CEO, Avera Sacred Heart Hospital, Yankton, S.D., from vice chair, Administration, Southwest Minnesota Region, Mayo Clinic Health System, Rochester, Minn.

Kelly Haynie, DHA, FACHE, to CEO, Ochsner Medical Center–West Bank Campus, Timberlane, La., from vice president, Operations, MedStar Southern Maryland Hospital Center, Clinton, Md.

Chris Howe, FACHE, to vice president/COO, Friendship House, Scranton, Pa., from CEO, Wilkes-Barre (Pa.) General Hospital.

Kelton Jeffery, DHA, to professional support services officer, Texas Health Presbyterian Hospital Kaufman, part of Texas Health Resources, Arlington, Texas, from director, Surgical Programs, Children's Health, Dallas.

Thomas Lanni Jr., FACHE, to Michigan Market CEO, Solaris Health, Troy, Mich., from president/CEO, SanoCare Services LLC, Washington, Mich.

Pierre Monice, FACHE, to president/CEO, Holy Cross Health, Fort Lauderdale, Fla., from president, MacNeal Hospital, Berwyn, Ill.

Lillian Montoya to senior vice president for the New Mexico region, CHRISTUS Health, Santa Fe, N.M. She will also continue in her current position as president/CEO, CHRISTUS St. Vincent Health System in Santa Fe.

Sean Patterson, FACHE, to CEO, Portsmouth (N.H.) Regional Hospital, from CEO, TriStar NorthCrest Medical Center, Springfield, Tenn.

Karen Pinsky, MD, FACHE, to CEO, Penn Medicine Chester County Hospital, West Chester, Pa., from interim CEO.

Luis Prado, MD, FACHE, to senior consultant, Queensland Health, and chief academic officer, Australian Institute of Health Executives, from CMO, St. John of God Health Care.

Danielle Werner, FACHE, to vice president/executive director, Clinical Practices, University of Pennsylvania Health System, Philadelphia, from COO.

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