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4 Strategies for Financial Success in 2025

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1. The Joint Commission. Sentinel events reviewed by year, by source. Jan 2005 to Dec 2021. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sentinel-eventgeneralinformation-and-2021-update.pdf. Published 2021. Accessed Sep. 2022.

Cover Story

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Financial strategy and planning experts share their views of how hospitals and health systems can shore up their bottom lines in the year ahead.

Feature

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The rise in chronic diseases drives the use of novel therapies.

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A Landmark—and a Recommitment to Our Readers

Mid-decade is officially upon us, and with it comes a milestone: *Healthcare Executive* turns 40 this year.

Since this magazine's debut in 1985, the team behind it has worked to arm readers with leading and timely solutions, strategies and best practices—straight from providers and industry experts—that can help them lead their organizations through the biggest challenges. Our commitment to that continues today—and with this first issue of 2025—as we dig into the financial pressure that hospitals and health systems continue to face.

What can leaders do to keep their organization's bottom lines in the black at a time of rising labor costs and lower reimbursements? Two financial strategy and planning experts from Kaufman Hall offer guidance in our cover story, "4 Strategies for Financial Success in 2025" (Page 8). From cost reduction to capital investment, their suggestions can help leaders decide where to place their chips to return the most value to their organizations and communities in the year ahead.

A subset of today's financial challenges is treating patients with chronic disease, an expensive proposition given the extremely high cost of some medications. In our second feature, "Improving Patient Outcomes Without Breaking the Bank" (Page 16), pharmacy leaders offer approaches to keep costs down by improving patient access to novel but pricey medications through partnerships, patient advocacy and better coordination, among other things, all with the goal of generating better outcomes over time.

As *Healthcare Executive* begins its fifth decade, consider this anniversary our recommitment to you—our readers. We strive to provide you with the best healthcare leadership guidance the industry has to offer, and it's a privilege and an honor to do so.

As always, if you'd like to share any feedback about this issue or the magazine in general, just send me a note at rliss@ache.org. ▲

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Deborah J. Bowen, FACHE, CAE

Shaping the Future of Healthcare

A refreshed Strategic Plan further defines ACHE's role as Catalyst, Connector and Trusted Partner.

The new year is always a time for reflection. A time to look back and reflect on achievements and lessons learned, and to make a plan to prioritize our intentions for the upcoming year. This past year the ACHE Board of Governors has followed suit, refreshing the Strategic Plan to guide our efforts over the next three years.

In doing that, the Board reflected on the challenges ahead, including the evolving nature of the healthcare provider enterprise and the accelerated pace and velocity of change. The Board also considered how these challenges will impact leaders who increasingly will emerge from nontraditional paths and will desire different professional development experiences. At the same time, our industry is growing, and one thing remained clear: ACHE has never been in a stronger position to embrace this future by helping leaders navigate change.

Launched Jan. 1, the ACHE 2025–2027 Strategic Plan will guide our efforts to create new experiences for leaders across career stages, disciplines and settings. It emphasizes our support for leaders through education and resources that can help them address the complexities of today's ever-changing environment. The plan underscores the importance of our relationships and community. At the core of our community is a belief that when leaders come together with passion, a desire to collaborate and the right tools to succeed, we create a powerful ripple effect that helps all those we serve.

In taking a "deep dive" into the plan, the Board last year sought input from members, chapter leaders, Regents and other thought leaders across the country and continuum of care. The feedback offered a clear path forward and further defines our roles as Catalyst, Connector and Trusted Partner, as detailed below.

In our role as *Catalyst*, ACHE commits to achieve our highest calling to advance and innovate health for all while driving toward zero preventable harm and health equity. To achieve this, ACHE reinforces its commitment to leading for health equity and safety by creating essential leadership resources and tools to advance health. Showcasing innovative approaches and solutions will be a central feature of how we can make a meaningful difference for patients.

In our role as *Connector*, ACHE commits to grow and strengthen our professional community of leaders—ensuring every leader finds value nationally and locally. To better connect leaders, ACHE will expand its support for chapters so they can remain the vibrant, local nucleus of our learning community. Building on the growth of other engagement channels, such as through social media, we will build sustainable communities across the multiple dimensions of leaders in our field. Connecting people is the core of who we are.

In our role as *Trusted Partner*, ACHE commits to expand our reach and impact by helping leaders reach their highest potential. Cultivating leaders remains a priority for ACHE. While we grow and expand our professional community, we will ensure that we stand for the highest standards in delivering education and the FACHE® credential. Creating new ways to support employers in taking care of patients, while supporting future leaders as they advance in their career, will be important. At the core of our support is executing a digital-first strategy to create unparalleled, personalized experiences for leaders and provide seamless access to our thought leadership, resources and offerings.

Fundamental to the new Strategic Plan is our shared pledge to healthcare leadership excellence and our commitments to integrity, lifelong learning, leadership, and diversity and inclusion. Of utmost importance is our service to you and our field. We hope you find as much excitement, inspiration and optimism from the plan as we did in developing it. Shaping a new future will require our individual and collective commitments to help each other and our organizations advance health for all. We look forward to the journey with you. ▲

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

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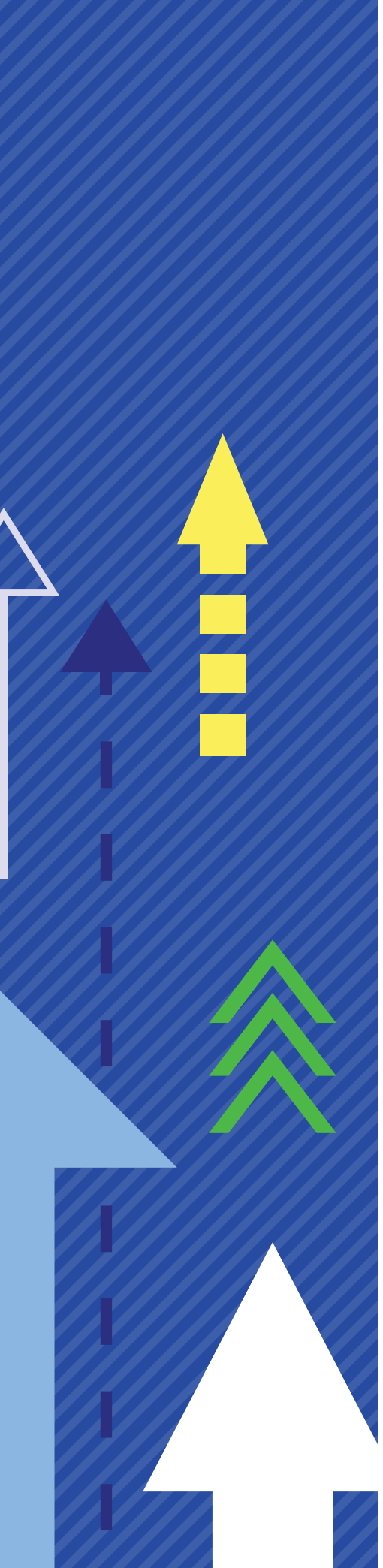
4 Strategies for Financial Success in 2025

By Karen Wagner



Financial strategy and planning experts share their views of how hospitals and health systems can shore up their bottom lines in the year ahead.

As hospitals and health systems continue to strengthen their financial health, today's environment is often referred to as the "new era of healthcare."

But, is it? Well, yes … and no.

Securing financial success into the future requires a continued focus on traditional cost and revenue areas, balanced with an understanding of how industry changes during the past few years have impacted the way cost reduction and growth opportunities are approached, say Dawn Samaris and Lisa Goldstein, financial strategy and planning experts with Chicago-based Kaufman Hall, a healthcare financial advisory firm.

For many hospitals and health systems, this may be easier said than done.

Historically, hospitals and health systems haven't asked the tough financial questions, says Samaris, a managing director and member of the firm's Strategic and Financial Planning practices. "But I think it does create real opportunity for organizations to try to focus their resources and make their investments where they're most likely to get the highest return and create the most value for their communities."

Here, Samaris and Goldstein weigh in on four strategies—from cost reduction to capital investment—that can shore up the financial

4 Strategies for Financial Success in 2025

foundation of a hospital or health system in this both old and new era of healthcare.

Maximize Value and Identify Growth

Some hospitals focus on one strategy or the other—either maximizing opportunities in existing markets or identifying emerging markets and revenue streams. Samaris and Goldstein say both are essential in today's environment. Juggling them is challenging, however, because they require different skill sets, mindsets and even culture.

First, assessing the value of existing markets requires a different approach from the one-size-fits-all method healthcare leaders have traditionally used. Samaris says such opportunities should be re-evaluated for their *business* value, as well.

"Health systems, particularly multi-site health systems, have a tendency to 'copy and paste,' doing the same thing in many different locations," Samaris says. "And increasingly people are looking hard at, 'Can I really afford to do that in five different locations? Or if I consolidated that particular service to three and did different things in the other locations, would that save on costs?'"

That's why looking at opportunities to optimize portfolios and service lines is so important these days, Samaris says, noting that for many hospitals and health systems, that's where the cost-saving opportunities are. But the metrics used to assess these areas are very different than, for example, the number of full-time equivalents per adjusted occupied bed measure that healthcare leaders would usually review on their dashboard of key performance indicators.

Samaris says some of the toughest questions tear at the core of a hospital's reason for being: Should we just not be offering that service? Is our oncology program truly distinct? Why would people choose it above the one offered by the other academic medical center in town?

"Nonprofits have a legacy of being there for their community, providing a broad set of services to their community and viewing that as their mission," she says. "And, we very much appreciate and recognize that as a mission. However, there's a balancing act."

"It's just a new day," adds Goldstein, a managing director and member of the firm's Treasury and Capital Markets practice. "Maybe not-for-profit healthcare cannot do it all. There's a financial reality to it that I think our clients in the industry are coming around to. That's a change in thinking. 'We do it best, we must do it all, and we do it ourselves.' Maybe those three mantras are changing in this kind of new economic reality we're in."

On the other end of the spectrum is assessing new opportunities.

Samaris notes that many hospitals and health systems have recently experienced operating volatility and a decline in cash reserves, limiting their ability to invest. At the same time, the environment is becoming more competitive, particularly for ambulatory care, which is generally considered a high-margin area, she says.

"And so while health systems are taking a little bit of a pause in investment, there are new players in the market who are very actively trying to redirect patients in certain segments away from the legacy not-for-profit health systems," Samaris says.

One of the distinguishing skill sets of these players, such as Amazon and CVS Health, versus traditional organizations, is their risk agility. These large retailers have the size and magnitude to take risks in entering segments of the healthcare market and then quickly reverse course. However, that sort of agility is generally not in a hospital or health system's playbook.

"I think just from a cultural perspective, they have a much harder time backtracking once they start down the road of making an investment," Samaris says.

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1. Ricciardi R, Seshadri-Kreaden U, Yankovsky A, Dahl D, Auchincloss H, Patel NM, Hebert AE, Wright V. The COMPARE Study: Comparing Perioperative Outcomes of Oncologic Minimally Invasive Laparoscopic, da Vinci Robotic, and Open Procedures: A Systematic Review and Meta-Analysis of the Evidence. *Ann Surg*. 2024 Oct 22. Online ahead of print.

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Hospitals and health systems also differ in their nonprofit status and operating model, which may translate to different strategies and priorities, including an exit strategy.

That's why, Samaris says, organizations need a specific and well-thought-through framework and approach for evaluating opportunities for capital investment.

"Organizations need to think long and hard about whether they have the tools, methodology and data that they need to be able to really inform that decision-making," she says. "Can they truly compare and contrast very different types of projects or investment opportunities relative to one another?"

Historically hospitals and health systems have focused their capital investments on buildings, so comparing a new tower to less tangible opportunities, such as improvements to value-based care capabilities or creating better access to a physician platform, can be unfamiliar, she says.

How to quantify and compare that type of investment to building a new building is the question at hand, Samaris says. "And, have you really thought through what types of metrics, data and information you would need to build out those pro formas to inform your management team and have that educated conversation about how you prioritize and sequence investments?"

For instance, if the consideration is whether to enter a new market, Goldstein says there needs to be a detailed financial plan that shows the return on investment accompanied by milestones for hitting determined targets. That's in addition to contingency planning for the "what-if" scenarios that must be considered and planned for, she says.

"The management team that takes on this type of assessment needs to possess a pioneering skill set," Goldstein says. "It's a culture that has to be ingrained in the team. There are not historical budgets or revenues to fall back on because it's a new market. It's all about what do we expect to happen and how do we make it happen."

"I think there is a new sense of urgency that needs to be incorporated in these business plans," Goldstein says, adding that such planning also requires the tough conversations about making corrections mid-course. "There seems to be, coming out of the pandemic, a greater urgency than I think we saw pre-pandemic."

Separate Benefits From Bond Ratings

Another area that may require a new mindset for hospital and healthcare leaders is the status of the mighty bond rating. Although bond ratings are considered the gold standard, Goldstein says hospitals and health systems should be wary of sacrificing their futures to protect today's rating. She says it may be time to let go of the desire to protect the bond rating and balance sheet at all costs, and instead weigh the benefits of the low-cost debt versus a lower bond rating. And if the financing results in a rating downgrade, that's probably OK.

"The difference in the cost of an A1 versus an A2, when markets are functioning well, it's negligible. Don't let that bond rating dictate your strategy and your future," she says.

Goldstein says some healthcare leaders are concerned that financing a new tower or expanding services, and then taking on new debt, is going to make the organization financially weaker in the short term. Yet, the result may not necessarily be a lower bond rating, she says.

Rating agencies are not short-term thinkers, she says. Hospitals and health systems should be prepared to defend their growth strategy with a solid business plan that shows a cost-benefit analysis and specific time frame for a return on investment, Goldstein says.

"The organization may be downgraded. But if there's a rational plan with an ROI, off ramps that can be activated if things aren't going well, sequencing, modulating, that's what they want to hear," she says.

Additionally, bond ratings aren't the only factor in determining a loan's interest rate, Goldstein adds. Loan issuers look at the entire balance sheet—liquidity, cash, long-term investments, receivables and assets, such as real estate, current market conditions and the security package that will be pledged.

The key, of course, is not to be downgraded too far. "You don't want to be below investment grade or what the market considers high yield," Goldstein says. "There's a bright line there. And, you don't want to be close to that border, either."

It all depends on the starting point. So, going from AA to AA- or A+ may be considered acceptable, she says.

"So it's more, you've broadened your thinking to be more than just debt to fund capital, but all sources of the balance sheet. And ratings are a big part of that but should not be the driver of going forward on strategy," Goldstein says.

Track Cost and Efficiency

For years, hospitals and health systems have been focusing on areas such as labor, supplies and purchased services for cost improvement opportunities. Similarly, the revenue cycle and clinical documentation have been targeted for revenue improvement, while length of stay and patient throughput have been areas where margins can suffer greatly from inefficiency.

"At this point, the majority of organizations have kind of squeezed that lemon, if you will, to the degree that they can," Samaris says. "Most organizations have done a lot of work on the traditional cost management areas. Still, I would argue that every organization has some opportunity in historic areas."

The fact that the disruption of the past several years has resulted in double-digit increases on the cost side that haven't been duplicated on the revenue side offers the opportunity for different approaches to cost and revenue management, Samaris says.

"Doing what we've been doing in slightly different ways is in most cases probably not going to move the needle in the way that people need it to be moved, given the disruption and very different trajectory that revenue and expenses have taken over the last couple of years, right?" Samaris says. "And so you have this real fraction between the two that is a fundamental problem."

For example, because the post-acute care industry was so impacted by the pandemic, the challenges with length of

A Leader's Financial Checklist

Maximize Value and Identify Growth. Both strategies are essential in today's environment.

Lower Bond Ratings. Weigh the benefits of the added debt vs. a lower bond rating.

Track Cost and Efficiency. Every organization still has opportunities to reduce costs and at the same time ask itself, "Is my revenue cycle up to par, and is it as sophisticated as it really needs to be in today's environment?"

Secure Financial Success. Look for opportunities that provide durable, long-term value, not short-term gain.

4 Strategies for Financial Success in 2025

stay are different post-pandemic, Samaris says, but still costly to an acute care hospital.

While she's not advocating that hospitals and health systems acquire post-acute care operations, Samaris does suggest the need to review relationships with post-acute care partners to ensure productive collaboration, and perhaps looking more in-depth at formalized partnerships with post-acute providers or home health services as a way to reduce length of stay and associated costs.

"I think the home health industry is moving slower than anyone would like it to. But finding ways to address the length-of-stay challenge is much more likely to materially move the needle on cost at this point than some of those more traditional things," she says.

On the revenue side, Samaris believes there are opportunities for reducing denials and the general friction that seem to be inherent in many payer relationships, particularly within Medicare Advantage contracts.

"Being really thoughtful about and asking, 'Is my revenue cycle up to par, and is it as sophisticated as it really needs to be in today's environment?' is another area that we encourage folks to look hard at, as well," she says.

Secure Financial Success

Beyond these specific strategic financial areas, Samaris and Goldstein highlight the broader strategies that hospitals and health systems should be employing to secure their financial futures.

Fundamentally, Samaris says it's important to understand the risk points, the key levers that impact financial success or challenges.

"What is the magnitude of those? And then, where can you control them and where can you not?" she says.

Transparency is also critical, Samaris says. Healthcare leaders should be transparent about these risks with the governing board, physicians and the executive leadership team because these stakeholders have control or influence over strategic decision-making or implementation of strategies.

"It's helping them to understand, 'Look, our plan is contingent upon these four things really working for us, and this is what we need from you to make sure that that is successful,'" she says, adding that the corollary is the conversation about the potential impact and options for offsetting the impact when strategies don't work out.

"So, if you are embarking upon building a Medicare Advantage plan and one of the key strategies in your plan is grow membership by X amount, and then be able to get your primary care network to manage costs for that group of individuals, that can be a really big bet for some organizations," she says.

"Having some of that transparent conversation with those who can really influence and have control over your ability to be successful in those areas is an important thing to do," Samaris says.

Overall, Goldstein says organizations should strive for building financial resiliency by focusing on opportunities that provide durable, long-term value, not short-term gain, such as the sale of assets.

"I think we lost a little ground during the pandemic, and things didn't quite snap back perhaps as quickly as we thought," Samaris says. "Recovery has been a little bit slower, and that keen focus on operations and efficiencies, I think is paramount."

Karen Wagner is a freelance writer based in the Chicago area.

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Improving Patient Outcomes Without Breaking the Bank

The rise in chronic diseases drives the use of novel therapies

By Ed Finkel

About three-quarters of all drugs approved by the U.S. Food and Drug Administration in 2023 were considered specialty drugs, and seven of the top 10 most expensive drugs have been approved in the past two years, according to statistics compiled by pharmacy finance authority IPD Analytics.

This huge influx of novel therapies has accompanied the rise of chronic disease in recent decades. They promise to improve outcomes—if providers can help patients locate and afford them. Creative solutions such as partnerships with manufacturers, payers and pharmacy benefit managers can help improve access to these specialty medications, drive down costs and ensure more comprehensive care over time.

Healthcare Executive compiled an array of solutions from three industry leaders: Mohammad "Mo" Kharbat, RPh, FACHE, vice president and chief pharmacy officer, Ascension Health, Milwaukee; Nilesh Desai, RPh, chief pharmacy officer, Baptist Health, Louisville, Ky., an ACHE Member; and Phil Brummond, PharmD, FASHP, president, health system pharmacy consultancy Visante, St. Paul, Minn.

"Cell and gene therapies are very, very expensive," Kharbat says. "Some of these treatments cost more than a million dollars per dose. Now, many of them promise to be a single-dose regimen, with these gene therapies." Such

Improving Patient Outcomes Without Breaking the Bank

medications "bring with them hope for many patients who otherwise would have no viable treatment options," he adds. "But at the same time, they come at a steep cost."

Desai says this class of drugs has been changing the face of medicine for 15 to 20 years, since biotherapy drugs were first available in the oncology suite. However, they're also now prevalent in other areas, such as neurology and in treating rare specialty diseases.

"If you think about your pharmacy budgets, the top 20 drugs are about 60% to 70% of it," says Desai. Biotherapy drugs "were very expensive, and they were on a regimen that you get it every three weeks, six weeks, whatever it was, for 'X' number of cycles." In addition to the high cost, he adds, "managing those medications also became a challenge."

Brummond sees greater focus around controlling and managing those costs, forging improved patient outcomes through value-based, coordinated care for targeted, curative, lifelong therapies. "The amount of pressure to keep costs down for the U.S. healthcare system is going to continue to rise. The care models associated with specialty care and curative therapies are going to continue to expand," he says. "They're making sure that the patients they're managing who are at-risk—the populations they've contracted for—are able to receive coordinated care inclusive of medication management."

"The amount of pressure to keep costs down for the U.S. healthcare system is going to continue to rise. The care models associated with specialty care and curative therapies are going to continue to expand."

Phil Brummond, PharmD, FASHP
Visante

Marshaling Advocates and Evidence

Desai recommends enlisting patients as advocates in making these novel therapies more affordable and easier to access. "Because at the end of the day, it's all about positive outcomes and better quality of life for our patients," he says. "They really drive a lot of these decisions. During this process, the payers approve these medications for treatment."

For example, when chimeric antigen receptor cell therapy first became available to battle blood cancer about six years ago, the inpatient costs reached millions of dollars, Desai recalls. "Well, fast-forward, and CAR-T therapy can be provided on an outpatient basis and really save patients' lives and be more cost effective," he says.

Desai says a strong clinical presence in managing these therapies is paramount to getting the best return on investment. "Clinical monitoring is very, very important, and all the safety parameters are very, very important," he says. "The financial piece will follow if your clinical and safety parameters are manageable."

Kharbat agrees. He says implementing evidence-based guidelines by

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*Based on 2022 USA single-year census estimates for ages 45-85 inclusive and the percentage of unscreened subjects. Does not account for variable screening rates across age ranges.[1,2]

†These data are from a 2019 retrospective analysis of Kaiser Permanente healthcare system patients who died of CRC between 2006 and 2012 (n=1750).[3] EHR=electronic health record.

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offering treatments that match the patient's clinical condition does help lower prescription prices. In some cases, that can mean starting with a less expensive option to see if it works. "And then, if they fail on those, we advance patients to higher-end products that come at a higher cost," he says. "In our hospitals, we dispense more affordable treatment options—generic medications. We use similar alternatives when possible [and] when clinically appropriate."

In addition to convincing payers to cover the higher-cost medications should they be necessary, these steps help patients stay under their insurance plan prescription cap for the year, Desai says. "You want to stay within those parameters of caps," he says. "When possible, always look at biosimilars versus branded drugs as long as those indicators are there."

Forging Key Partnerships

Optimizing relationships with manufacturers, payers and pharmacy benefits managers can make a major difference, although usually not when a company first comes to market with a branded drug, Desai says. "Typically you don't have a lot of room for negotiation on pricing unless you have competition in the market or there are alternative agents," he says. "When the drug runs off patent is when the alternatives come to the market or there are generics and biosimilars. This results in companies providing lower prices, and there are actually conversations."

Even with newly introduced therapeutics that will be on patent for a while, collaborations can sometimes get at least limited results, Kharbat says. "We can explore options for patients who cannot afford their medications," he says. "Manufacturers typically offer financial assistance programs, co-pay assistance programs, free drug programs—even for patients who meet certain income requirements. So that's where health systems work with manufacturers to improve access to these therapies and regimens."

Payers set medication coverage policies that determine what is in the formularies and thus available to beneficiaries, Kharbat adds. "We work with them to make sure that these medications are available and affordable for our patients," he says. "It's a team effort between the health system, the physician, the payer and the manufacturer. We're all working in concert to take care of the patient."

"The health system is best suited to take care of the patient because it's our patient to begin with. They see the provider there. They get their lab work there. … And when they cannot afford their medication, we, as the health system, then work with manufacturers to get co-pay assistance programs or free drug programs for certain patients."

Mohammad "Mo" Kharbat, RPh, FACHE
Ascension Health

That "team effort" does not involve all these parties sitting around a table to directly discuss how they are going to care for the patient, he explains; rather, it's a matter of each one playing their respective role—manufacturers investing time and research to bring the new drug to market, insurance companies helping to finance the process of making medications available, and physicians and health systems prescribing the drugs and otherwise taking care of patients day to day.

Brummond agrees that a coordinated approach in which patients receive therapy and get the best outcome at the lowest price point is the optimal scenario. This will prove especially crucial in managing the wave of gene and other high-cost therapies, which can run into the hundreds of thousands to millions of dollars but usually have few patients, many of whom also require labs or other types of clinical services to achieve best results.

For health systems to be successful in this regard, they need sufficient investments in people, process and care models. Once that infrastructure is in place, they need to forge partnerships with pharmaceutical manufacturers and payers around programs and outcomes for the disease state management, Brummond says.

"That will inevitably provide data on real-world benefits within these patient populations," he says.

"Everybody wants to understand if the cost for these therapies is achieving optimal outcomes and improving the quality of life for patients. Data-sharing agreements are being established across the market to make sure there's access to these limited distribution drugs, with the ability to be an in-network pharmacy provider from the payer perspective."

Relationships between the health-system pharmacy and drug manufacturers are becoming increasingly important in getting access to limited distribution medications and covering them in payer contracts, Brummond says.

"A focused, holistic approach includes everything from acute care needs to ambulatory needs to lab needs to pharmacy needs," he says. "Many organizations haven't developed a coordinated approach to be in-network for these high-cost specialty therapies with large payers. If the health system doesn't have access [to insurance payments], therapies are being provided at a financial loss, which is extremely challenging."

From the manufacturer's standpoint, a limited number of organizations have the accreditation and care models to provide their particular therapies in the first place, Brummond says. "These aren't therapies that every pharmacy should have access to dispense, but those health system specialty pharmacies that have high-quality outcomes and established care models should be

How to Care (Affordably) for Chronic Disease Patients

Value-based, coordinated care will be necessary to keep costs under control for targeted, curative, lifelong therapies. Among the key points to consider:

- Partner with manufacturers, payers and pharmacy benefits managers to improve access and cut costs, although this is challenging, of course, when a company first comes to market with a new drug.
- Enlist your patients as advocates and implement therapies using evidence-based guidelines.
- Develop internal pharmacy expertise in specialty drugs to coordinate care; working with outside pharmacies can lead to headwinds as stakeholders work at cross-purposes.
- Make sure care isn't fragmented between pharmacy and the rest of the organization and/or siloed between departments.
- Value-based care keeps the organization focused on the fact that while specialty care may be expensive, long-term effects of improperly treated chronic disease can be significantly pricier.

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able to provide these therapies for their patients," he says.

Leveraging the In-House Pharmacy

Dispensing novel therapies directly through the health system's own pharmacy spares the patient from having to go in search of them while keeping care as integrated as possible, Kharbat says.

"The health system is best suited to take care of the patient because it's our patient to begin with," he says. "They see the provider there. They get their lab work there. … And when they cannot afford their medication, we, as the health system, then work with manufacturers to get co-pay assistance programs or free drug programs for certain patients."

Though pharmacies traditionally have been thought of as simply the place to get medications, high-cost specialty therapies require expansive monitoring over a period of potentially months to years that the patient is taking them, Brummond says.

"Health systems have established internal pharmacy expertise," he says. "Most of these specialty therapies are associated with high-cost disease states—rheumatology, GI, oncology—and these patients can have many comorbidities as well."

Over the past decade, vertical integration with insurers, providers and pharmacies has been challenging for health systems to ensure care for patients with chronic conditions, according to Brummond.

"There are headwinds around the management of those patients," he says. "Payers want the lowest cost and best outcome. On the health system front, they want to be able to provide comprehensive care for their patients in coordinated fashion."

Specialty pharmacies unaffiliated with health systems are looking to get into this channel and manage those patients, but the lack of coordination can be challenging when it comes to safety, effectiveness and outcomes, Brummond says.

"We're seeing more and more health systems making a significant investment in their internal pharmacy operations and pharmacy enterprise," he says, "to be able to scale and provide care locally in their regions for patients, encompassing specialty care as well as the traditional retail pharmacy business."

Brummond believes health systems are well-positioned to coordinate (and thus enhance) care among patients' various providers through their EHR systems, linking to ancillary services like lab and imaging to assess whether the therapy plans developed by pharmacists and providers are having the desired outcomes. "Whether it be a cure—we hope that we cure cancer and other chronic outcomes we face as a society—but at a minimum, we're getting a higher quality of life for patients and allowing them to be their best selves," he says.

Moving to Value-Based Care

Forging partnerships with pharmaceutical manufacturers and payers around managing patients holistically opens up the potential for moving to value-based care, Brummond says. "Not having access to these specialty therapies to provide a continuum of care, and relying on somebody else outside the health system to manage patients, increases the likelihood that patients could be admitted into the hospital and become high utilizers of other high-cost services," he says. "That makes it challenging to manage risk-based contracts."

Every organization is at a different stage in terms of the ability to provide high-cost specialty therapies, although the vast majority of such prescriptions

are being ordered by health system providers, Brummond says.

"When it comes to relationships around clinical outcomes and monitoring, integration with providers and the pharmacy service is optimal for being able to provide the best results," he says. "Having the ability to offer those services for these patients that have high costs associated is critically important when contracting in the future state of value-based care."

Systems that have their own plan are managing it their own way, Brummond says, while commercial contracts related to value-based care and the concomitant impacts on costs and outcomes for patients are evolving region by region and health system by health system.

The use of "sophisticated specialty pharmacies" and the ability to provide infusion helps manage patients more holistically, achieving the desired outcomes on behalf of payers, pharmaceutical manufacturers, the health system and, ultimately, the patient, he says.

Too often, however, coordination is hampered by care fragmentation and departmental silos when it comes to who owns what, Brummond says, not just between the pharmacy and other parts of the organization but even between service lines like cardiology and oncology. This requires hospital executives, including the pharmacy executive, to forge a thoughtful strategy that lays out pharmacy's role in adding new provider services and contracting, based upon "understanding synergies related to value-based contracts important to outcomes, at the right cost, with access to therapies and provider insurance networks for these patients."

Though specialty medications are extremely expensive, the benefits patients receive often outweigh the costs of complications they face later on, which the value-based care model clarifies, Kharbat says.

For example, he notes that a therapeutic course for Hepatitis C could last eight to 12 weeks and costs about $30,000, but 1% to 2% of patients develop liver cancer without the right regimen—and in some cases, the only treatment is a liver transplant that could cost up to $1 million. "So yes, the medication may be expensive," he adds. "But if given in a value-based system, that's how we can drive costs down in the long term."

Desai cites the example of today's popular glucagon-like peptide-1 receptor agonists class of drugs for diabetes and weight loss. "Everybody wants to use GLP-1s," he says. "But the cost of these medications is so high that it's not affordable for many plans. And you're seeing more and more of these drugs being dropped from coverage."

That results in compounding pharmacies trying to formulate alternatives that may or may not meet safety standards, according to Desai. "We really need to have complete data to look at the end-to-end spectrum for use of these medications, and people will react very differently," he says. But since dropping weight might reduce hospitalizations for heart disease or diabetes, pharmacies and health systems need to examine medications and utilization "very scientifically," he adds.

Kharbat notes that in 2023, according to figures from the American Society of Health System Pharmacists, Ozempic took the top spot on the list of highest-spending-outlay drugs in the U.S., besting rheumatoid arthritis medication Humira, which had been No. 1 on that list for about two decades. Along with competitors like Trulicity (fourth on the AHSP list) and Wegovy, this class of drugs "are becoming very, very in demand," he says. "And not only for diabetes—in many cases, for weight loss—and that, if anything, puts it even more on us, as health systems, to find ways to make these medications affordable."

Every organization faces its own challenges and issues along this journey, according to Brummond, who adds that some are offering specialty-pharmacy care services directly to employers. "If they are able to offer those services, they can contract directly with employers to be able to provide care models at price points, to be able to drive down the employer spend."

Ed Finkel is a freelance writer based in Chicago.

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A Forward-Thinking Approach to Financing Capital Equipment

Due to current economic conditions, healthcare executives must find innovative ways to protect the financial health of their institutions.

In today's healthcare environment, institutions are facing unprecedented financial challenges. Interest rates are at their highest levels in nearly two decades, impacting borrower cash flow, asset valuations, and refinancing abilities. Federal funding cuts, rising labor costs, and inflation continue to strain the budgets of hospitals and specialty clinics. Amid these pressures, rapid technological advancements, particularly in medical imaging and AI, drive the need for cutting-edge medical equipment, which presents a unique financial hurdle.

Acquiring the latest imaging equipment is critical for healthcare institutions looking to stay competitive and deliver excellent patient care. However, 39% of healthcare providers failed to maintain positive margins,[1] and 63% face significant hurdles in funding long-term capital needs.[2] This is where Canon Medical Finance is a key partner, offering customized, flexible financing solutions to meet healthcare organizations' financial and technological demands.

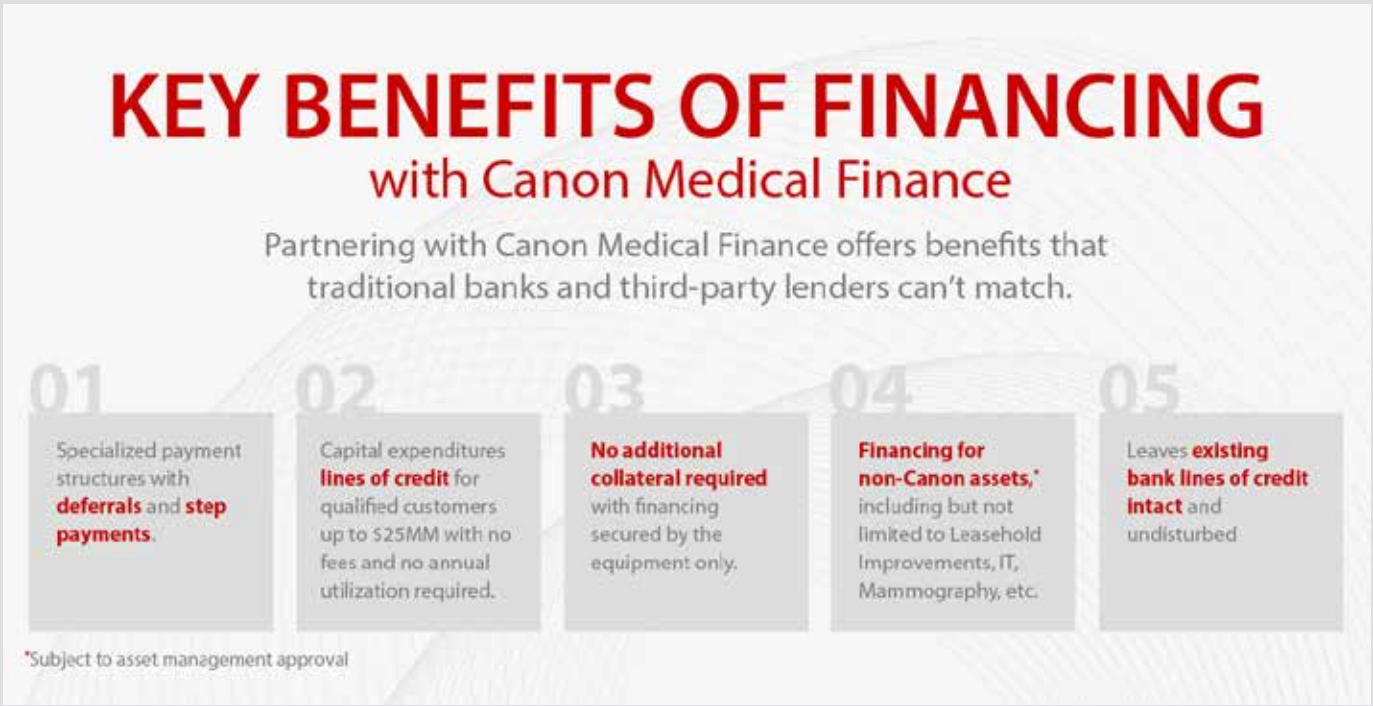
How OEM Lenders Can Outperform Third-Party Lenders

Working with an OEM lender, like Canon Medical Finance, has some key advantages that set it apart from traditional banks or third-party financing companies. OEM lenders have in-depth knowledge of the equipment they finance, allowing them to offer terms and conditions that third-party lenders cannot match.

"At Canon Medical Finance, we believe flexibility and customization in financing is key," states Trish Malone, Senior Director, Canon Medical Finance. "Our healthcare finance experts partner with healthcare organizations to provide a range of financing solutions, including extensive financing product offerings, competitive interest rates, and prompt credit decisions. This approach ensures customers get the right financial plan to meet their cash flow needs," says Malone.

This unique advantage results in more favorable financing options, seamless upgrade paths, and comprehensive support throughout the equipment's life. OEM lenders can customize their approach to healthcare institutions and create financing plans that address specific budgetary and operational requirements. Jay Darley, Senior Zone Manager at Canon Medical Finance, adds, "Although the placement of Canon imaging equipment is our main focus, we can also offer solutions for non-Canon assets, such as leasehold improvements, IT, and lines of credit."

Conversely, third-party lenders typically offer generalized financing that needs more flexibility to meet healthcare-specific needs. They may require healthcare organizations to pay off an entire existing lease before financing a new upgrade, or they might inflate buyout costs at the end of a lease term. Canon Medical Finance eliminates these concerns by offering transparent, predictable financing terms that simplify upgrading to newer technology.



Canon Medical Finance coordinates with Canon's sales and service departments, ensuring their clients receive comprehensive support from equipment delivery throughout its entire operational life. "The coordination with our internal departments allows us to offer unparalleled service, making the transition to new equipment smoother and more cost-effective," adds Malone.

Adapting to Current Financial Realities

Healthcare providers operate in a challenging financial climate. Nearly 78% of hospital CFOs anticipate financial health becoming increasingly important over the next three years.[2] Rising interest rates, inflation, and high labor costs make it more difficult for healthcare institutions to meet their cash flow needs. Acquiring capital equipment, such as medical imaging technology, is becoming a greater financial challenge.

"We're seeing healthcare facilities face rising costs, shrinking margins, and the need for continuous technological upgrades, so financial flexibility, resources, and support are becoming more necessary to thrive in this challenging environment," says Malone. "We see ourselves as a partner in your institution's mission to not only deliver high-quality care but to help you maintain your financial health with your next diagnostic imaging equipment purchase."

Canon Medical Finance is wholly owned by Canon USA and is a top 50 Finance Company in the U.S., funding over $1B annually. Canon Medical Systems USA is one of only two manufacturers in diagnostic imaging with an in-house financing arm giving them the freedom and resources to do more for their partners.

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Contact Trish Malone, Senior Director of Financial Programs, to explore how Canon Medical Finance can help you meet your unique challenges and achieve your financial goals. tmalone@us.medical.canon

Jason Lesandrini, PhD, FACHE

Values-Based Debt Collection

A five-step framework for healthcare organizations.

Aggressive medical debt collection practices have brought increased scrutiny to the healthcare field in recent years. News headlines regularly feature stories about lawsuits against low-income patients, wage garnishments, property liens and damaged credit scores. These practices have led many to ask a fundamental question: Have we strayed too far from the essential mission of healthcare, which is to care for and heal patients, regardless of their ability to pay?

Healthcare leadership teams find themselves at the intersection of financial responsibility and moral obligation. On one hand, they must ensure the financial viability of their organizations to continue providing care. On the other, they must stay true to the mission, vision and values that form healthcare institutions' foundations. The need to balance these often-conflicting demands is becoming increasingly urgent.

The Debt Collection Problem: How We Got Here

The financial landscape is growing more complex for healthcare organizations. Rising operational costs, decreasing reimbursement rates, and the need to invest in cutting-edge technologies and modern facilities have put immense pressure on hospitals and clinics. Leaders are tasked with managing these realities while upholding commitments to the communities they serve, including providing care to the most vulnerable populations.

Healthcare leadership teams find themselves at the intersection of financial responsibility and moral obligation.

At the same time, the burden of medical debt weighs heavily on patients. It's estimated that 100 million Americans—41% of all adults—carry medical debt, according to *Diagnosis: Debt*, an ongoing reporting project by KFF Health News. This issue spans income brackets, affecting not only the uninsured and underinsured but also people with stable incomes. The impact is particularly devastating for those with long-term medical needs, such as cancer patients, 25% of whom have faced bankruptcy or eviction, according to KFF Health News.

There is a growing need for organizations to adopt a values-based perspective on debt collection, one that emphasizes ethical decision-making and a compassionate approach to the financial aspects of healthcare. Here is a five-step framework to guide your organization's value-based debt collection practices.

1. **Bring Ethics to the Boardroom**
   Board members play a pivotal role in ensuring that every practice, including financial decisions, aligns with the organization's mission, vision and values. It's critical for the board to recognize that debt collection, like any other business function, reflects the ethical principles that define the institution.

   To ensure alignment, it is vital that all board members undergo training in ethical decision-making, focusing on how to identify and navigate conflicts between organizational values and financial imperatives. Instead of initially considering initiatives that are based on whether they are financially feasible, board members can first ask management, "Is this initiative consistent with who we say we are as an organization?" and "What tensions with our organizational values does this create, and how do we navigate them?"

   Training board members to ask these questions will prompt a deeper analysis of how debt collection policies affect patients. For example, when considering whether to pursue aggressive debt collection tactics, weigh the potential harm to patients against the financial benefits. The board can ask questions such as, "Will this course of action

improve or worsen a patient's health outcomes?" or "Does it align with our commitment to compassionate care?" If the answer to either of those questions is "no," it may be time to explore alternatives that uphold both financial and ethical responsibilities.

Additionally, boards can actively participate in shaping patient-centered debt collection policies that place patients' overall well-being at the forefront of every decision. When boards support a culture that prioritizes ethical considerations, the entire organization will more likely remain true to its values, even in challenging financial circumstances.

2. **Adopt Proactive Financial Counseling**
One of the most effective ways to address ethical challenges related to medical debt is prevention. Many health systems across the country use proactive financial counseling programs, which identify patients who may face financial challenges early in the care process.

In addition to traditional resources, such as employing financial counselors to discuss with patients the anticipated costs of their care, integrating artificial intelligence can further enhance financial counseling programs. AI tools can help identify patients who are at risk of falling into debt by analyzing their financial histories and healthcare use patterns. By harnessing AI, healthcare organizations can streamline financial counseling and make it more accessible to those who need it most.

3. **Embrace Compassionate Commerce**
In many healthcare organizations, maintaining financial solvency requires debt collection practices, but they can include an ethical and compassionate mindset. Compassionate commerce acknowledges that financial transactions in healthcare are not just about the bottom line—they are about people.

Leaders who embody this compassionate approach view debt collection practices through a values-based lens and ensure that staff members are trained to engage with patients about payment, whether they are in-house staff or external vendors. Empathetic communication is a core part of the training. When staff approach patients with understanding and compassion, the results are trifold: It shows that organizations really care about their communities, likely improves collection efforts, and reduces frustration amongst patients, and potentially complaints, related to billing.

This empathetic approach is particularly important in healthcare, where patients are often dealing with significant stress and anxiety due to their medical conditions. By showing empathy, staff

can build trust with patients, making it more likely that they will engage in conversations about their financial obligations and work toward solutions. The importance of empathetic communication extends beyond the organization's walls; outsourcing collections does not absolve organizations of their responsibility to ensure ethical practices. Healthcare leaders should ensure all third-party vendors involved in debt collection adhere to ethical standards and treat patients with respect, compassion, and dignity, which ultimately leads to better outcomes for both patients and the organization.

4. **Engage Patients to Co-create Solutions**
When creating or updating debt collection policies so they reflect ethical and practical considerations, engage patients in the policy development process. Patient engagement not only improves policies, but it also ensures the voices of those most affected by debt collection practices are heard.

   One effective way to involve patients is through patient-family advisory councils, which provide a forum for patients and their family members to offer feedback on healthcare policies, including debt collection practices. By consulting with patients who have experienced the debt collection process, healthcare organizations can gain valuable insights into what works, what doesn't and how the process can be made more humane and effective. Engaging with patients on debit collection practices also helps build trust between the organization and community, reinforcing the idea that healthcare is a partnership between all those involved.

5. **Implement a Continuous Improvement Feedback Loop**
To ensure debt collection practices remain aligned with organizational values over time, implement a continuous feedback loop using ethics audits, which serve as a mechanism for evaluating whether debt collection practices are truly reflective of the organization's mission and values.

   An ethics audit involves several steps. First, feedback is collected from patients about their experience with the organization's debt collection process. Next, the data is reviewed to ensure no patient groups are being disproportionately affected by debt collection practices. For example, an organization might discover that lower-income patients or those with chronic conditions are more likely to face aggressive collections. Finally, organizational leadership regularly reexamines debt collection policies from an ethics perspective, assessing whether they are still aligned with the organization's values.

   This type of post-implementation evaluation is critical because it reveals how policies are functioning in real-world settings. It also ensures that financial sustainability is not achieved at the expense of patient trust and access to care. It's one thing to draft an ethical policy, but another to ensure that the policy is being lived out in day-to-day operations.

By viewing debt collection through a values-based lens, organizations can strengthen community trust, improve patient outcomes and secure their long-term sustainability.

Balance Financial Responsibility With Values

As healthcare costs continue to rise and financial margins shrink, healthcare leaders may feel pressure to adopt aggressive debt collection practices. By viewing debt collection through a values-based lens, however, organizations can strengthen community trust, improve patient outcomes and secure their long-term sustainability. As the healthcare landscape continues to evolve, the future belongs to those who can balance financial responsibility with compassion and integrity. ▲

Jason Lesandrini, PhD, FACHE, is assistant vice president, ethics, advanced care planning and spiritual health, Wellstar Health System, Marietta, Ga., and founder and principal of The Ethics Architect (jlesandr@gmail.com).

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Tim Slocum, FACHE

'Jaw in a Day' Surgery

A case study on how innovation, collaboration restored a teen's quality of life.

As regional healthcare leaders, Methodist Le Bonheur Healthcare and the University of Tennessee Health Science Center are dedicated to providing the Mid-South region with the most advanced surgical care, ensuring patients receive cutting-edge treatment close to home. This commitment to innovation, excellence and patient-centered care is evident in a recent surgical case that represents incredible skill, collaboration and truly impactful patient care.

500 METICULOUSLY coordinated steps required to successfully complete the "Jaw in a Day" surgery

8 HOURS to complete the jaw reconstruction surgery

17 the age of the patient who benefited from a life-changing, collaborative surgery

A Life-Changing Surgery

Last year, James Wynn, a 17-year-old Memphis, Tenn., resident, noticed that his jaw was growing at an unusual rate. Alarmed, his mother, Alysha Wynn, sought medical help, only to learn that James was suffering from a rare benign tumor called an ameloblastoma. Though not malignant, the tumor was progressively degrading James' facial bones and impairing his vision.

For James, the stakes were high—the tumor had to be removed. The traditional surgical method would have required multiple surgeries spaced out over several months, with significant recovery periods in between. The thought of prolonged disfigurement and extended discomfort was concerning to both James and his mother.

Fortunately, a team of surgeons from UTHSC and Methodist Le Bonheur Healthcare had been researching, training and preparing over many years to perform this type of operation—and to do so in a single day.

Dubbed "Jaw in a Day," this procedure uses 3D imaging technology and medical precision to treat patients with complex head and neck cancers, benign tumors or related facial injuries. Under meticulous microscopic guidance, a highly skilled multidisciplinary clinical team removes abnormalities and recreates facial, mouth and jaw skeletons using bone segments and blood vessels from other parts of the patient's body. Prosthetic dental implants are then fitted to the reconstructed jaw.

The evolution of "Jaw in a Day" began with developments in osseointegrated implants, which were first used in head and neck reconstructions. This laid the foundation for the procedure, which requires advanced surgical expertise and specialized infrastructure and technology. Methodist University Hospital's state-of-the-art operating rooms, pioneering surgical technology and expert staff provided the ideal environment to make such a complex surgery possible.

The collaboration of surgeons from multiple specialties was essential for the operation's success. Additionally, the involvement of a local medical device company, which developed the implants, provided efficient and cost-effective access to the materials needed for the operation.

James was an ideal candidate for "Jaw in a Day," as the approach reduces the time typically required for complicated reconstructive operations from several months or even years to just one day. This accelerates healing and transforms the quality of life for patients.

500 Steps in Eight Hours

In total, James' surgery required more than 500 meticulously coordinated steps, including the removal of the tumor as well as the maxilla, or upper jaw, and the orbital floor (the bottom of the eye socket), both of which had been compromised by the tumor.

The surgical team recreated the jawbone and other facial structures by grafting a vascularized fibula flap made up of bone and blood vessels harvested from James' leg. The 3D imaging technology's precision allowed the surgical team to fit prosthetic dental implants into the new jaw structure during the same surgery, which enabled them to complete the entire reconstruction in only eight hours.

By prioritizing teamwork, leadership ensured that complex procedures like this could be executed efficiently.

James' operation marked the first time this complex procedure had been performed in Tennessee, and Methodist University Hospital played a pivotal role in making it possible. By fostering innovation and collaboration across various specialties, Methodist Le Bonheur Healthcare has created a supportive environment where highly skilled surgeons bring advanced techniques and technologies to patient care.

All of this has led to Methodist University Hospital becoming a trailblazer in groundbreaking operations like "Jaw in a Day," along with others such as organ transplants, robotic surgeries, and advanced neuro and orthopedic surgeries.

Takeaways From a Cutting-Edge Procedure

James' surgery highlights the collaborative culture at Methodist University Hospital, where the partnership between Methodist Le Bonheur Healthcare and UTHSC enables knowledge, innovation and expertise to converge for improved patient outcomes.

As part of Methodist Le Bonheur Healthcare's network, Methodist University Hospital is laser-focused on advancements in medical research and community, while maintaining its commitment to providing high-quality patient care. Its team has cultivated this by prioritizing multidisciplinary partnerships among specialties like facial plastics, ENT, oral-maxillofacial and surgical oncology.

Methodist Le Bonheur Healthcare's ongoing partnership with UTHSC, spanning over two decades, has enabled groundbreaking procedures like "Jaw in a Day." Its investment in teaching and training the next generation of healthcare providers further strengthens this cooperative spirit, passing down valuable

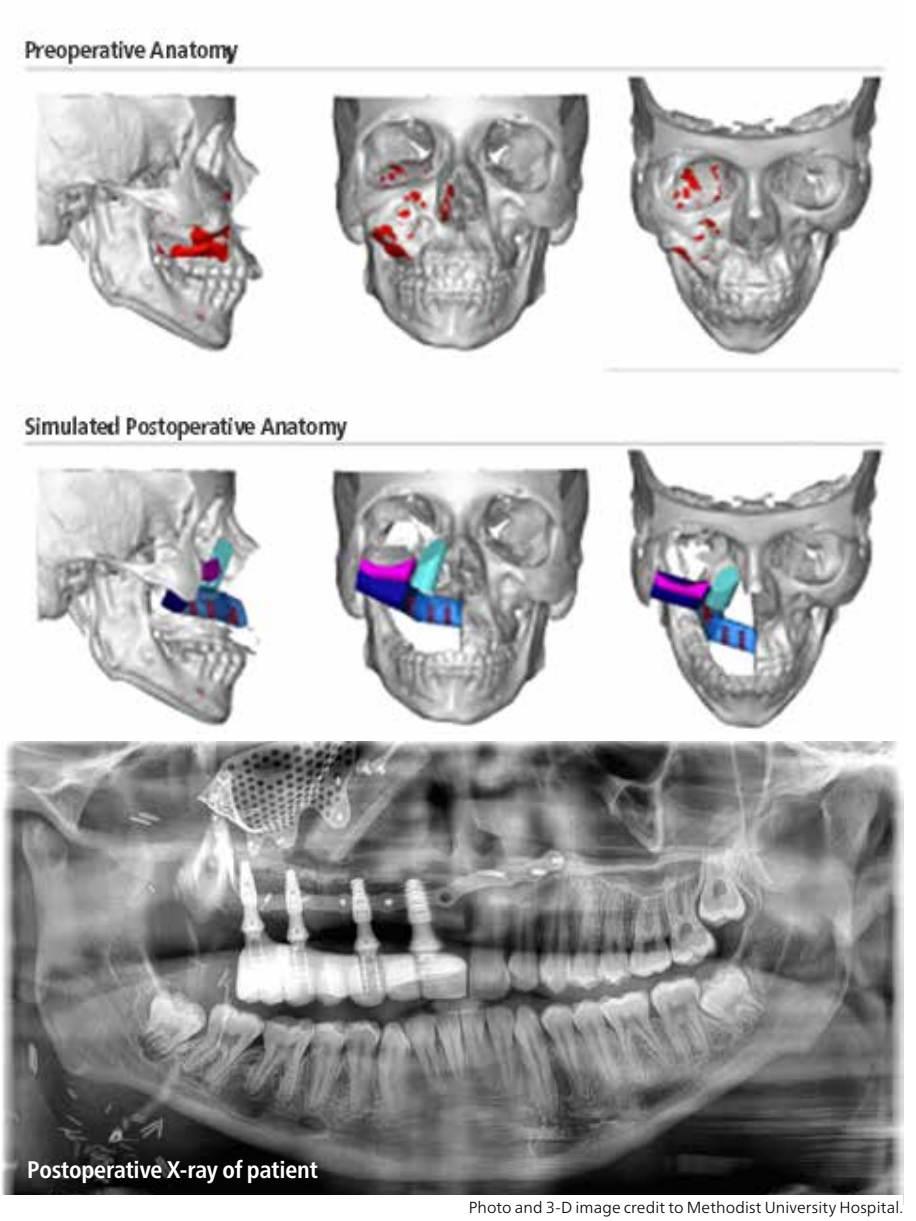


Photo and 3-D image credit to Methodist University Hospital.

knowledge to future medical professionals.

Methodist Le Bonheur Healthcare remains deeply committed to serving the Mid-South region, even as it expands its reach. The system's longstanding presence in Memphis exemplifies its dedication to providing high-quality healthcare to all.

Such accomplishments like "Jaw in a Day" are a direct reflection of the hospital's skilled teams and their resolve to deliver outstanding care. This level of recognition cements Methodist Le Bonheur as a pioneering, innovative healthcare system, both regionally and nationally.

The success of the "Jaw in a Day" surgery highlights the importance of open communication and seamless cooperation across specialties. Methodist University Hospital facilitated this by fostering a culture of multidisciplinary teamwork and investing in advanced technology and infrastructure. Its strategic partnerships with academic institutions like UTHSC further nurtured innovation.

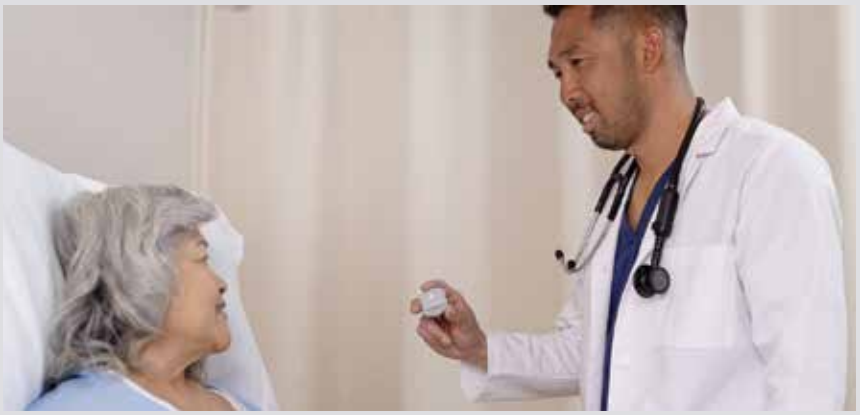
By prioritizing teamwork, leadership ensured that complex procedures like this could be executed efficiently, offering a model for other healthcare providers looking to enhance patient outcomes through innovative practices and teamwork.

Procedures like "Jaw in a Day" are simply the beginning for Methodist University Hospital. With strong leadership, strategic partnerships and a commitment to excellence, the hospital is well-positioned to drive innovation in patient care. By encouraging interdisciplinary collaboration and leveraging the resources of Methodist Le Bonheur Healthcare and UTHSC, Methodist University Hospital remains at the forefront of medical advancement, ensuring that patients receive cutting-edge, compassionate care. As a result, Methodist Le Bonheur is poised to lead the way in shaping the future of healthcare in the region. ▲

Tim Slocum, FACHE, is president, Methodist University Hospital, Memphis, Tenn., (tim.slocum@mlh.org).

The best predictor of patient decline is the least measured vital sign

Krista Logue and John Brewer, Medtronic Acute Care & Monitoring



Did you know respiratory rate is one of the two most reliable early indicators for detecting deterioration in low-acuity patients?[1]
And that manual methods of assessing and documenting respiratory rate are not a dependable measurement for predicting potential complications?

Yet, manual measurement remains the most common way of capturing respiratory rate as vital sign in non-critical areas of care today. Despite manual collection making accurate and consistent respiratory rate reporting a challenge.

Considering the importance of reliable respiratory rate monitoring and the difficulties care providers face when it comes to manually collecting respiratory rate, clinicians need a standardized approach for measuring and recording this important vital sign.

Capturing an early indication of respiratory rate increases may help clinicians predict adverse events in hospital wards. Among isolated vital signs, maximum respiratory rate is the most accurate predictor of in-hospital cardiac arrest.[2]

But manual respiratory collection practices complicate detecting abnormal respiratory rates early enough:

- Spot checking respiratory rate values at certain time intervals throughout the day only captures a momentary snapshot of a patient's condition. [3,4]
- Manually measuring respiratory rate is time-consuming and overwhelming.[5]
- Respiratory rate is the most infrequently recorded vital sign, documented five times less frequently than blood pressure.[6]
- There is a greater risk for human error with subjective capture of vital signs.[3,4]
- Manually recorded respiratory rate may be inaccurately recorded with bias toward normal respiratory rate.[7,8]

Prioritizing respiratory monitoring as a vital sign for early detection of patient deterioration begins with accurate assessment and consistent documentation. Respiratory rate monitoring tools can streamline the collection and transmission of respiratory rate measurements.

Using medical-grade wearable devices like the BioButton®* multi-parameter wearable† help provide continuous monitoring. Among other FDA-cleared parameters and biometrics, it includes automated monitoring of resting respiratory rate, which captures more accurate data than manual respiratory rate collection. The BioButton®* can also provide trends of respiration rate over time.

Capnography promotes continuous monitoring of respiratory rate, too, by turning a subjective value into an objective one.

The key advantage of capturing respiratory rate with capnography monitoring devices like Microstream™ is that it measures ventilation directly at the airway. Ventilation is the process of inhalation of oxygen from the atmosphere into the lungs, gas exchange at the alveoli, resulting in carbon dioxide (CO_2) gas, then expelled during exhalation.

Continuous monitoring of CO_2-derived respiratory rate and etCO_2 play an important role in helping detect life-threatening conditions.[9] Capnography continuously delivers both values accurately and objectively.[10-13]

With Microstream™ capnography plus Nellcor™ pulse oximetry rolled into the **RespArray™ patient monitor**, clinicians have a continuous way to monitor changes in respiratory status on the medical-surgical floor — to help detect respiratory compromise in its early stages.[14,15]

† BioButton® is not intended for critical care monitoring.

Patient monitoring technologies should not be used as the sole basis for diagnosis or therapy and are intended only as adjuncts to patient assessment.

For sources, scan the QR code.

William F. "Marty" Martin, PsyD

Navigating the Tensions Between DEI, MEI

It is a strategic imperative for healthcare leaders.

Managing and valuing diversity has long been at the forefront of organizational strategy, especially in the wake of affirmative action and equal employment opportunity initiatives. DEI has driven much of this focus in recent years, championing inclusion and equity across sectors. However, with the 2023 U.S. Supreme Court ruling banning race-based college admissions, Merit, Excellence and Intelligence (MEI) is emerging as a compelling counterpoint—or perhaps a complement—to DEI. Healthcare leaders now face a pivotal question: Can DEI and MEI coexist in a way that enhances both high standards and inclusivity, or will one ultimately overshadow the other? This evolving dynamic presents a unique opportunity to rethink how you, your board, your leadership and your organization adapt to these shifting sands of change.

Adaptive leadership informs leaders to differentiate technical challenges from adaptive problems and to get on the balcony to gain perspective. Using "getting on the balcony" as a metaphor for health leaders, the evidence reveals "business as usual" is showing us how perniciously sticky health disparities tend to be.

Disparities Continue in Health, Healthcare and Leadership?

The disparities in healthcare access and outcomes are stark. For instance, a 2022 study published in *Health Affairs*, "Structural Racism In Historical And Modern US Health Care Policy," found that Black and Hispanic patients are significantly more likely to experience barriers to accessing affordable care compared to their white counterparts.

Healthcare leaders now face a pivotal question: Can DEI and MEI coexist in a way that enhances both high standards and inclusivity, or will one ultimately overshadow the other?

According to the American Hospital Association's 2023 podcast, "Addressing mental health disparities among racial and ethnic minorities," over 25% of Black and Hispanic patients reported difficulties in accessing specialty care, which is essential for managing chronic conditions and preventing severe outcomes.

Morbidity and mortality rates also reveal significant inequities. The Centers for Disease Control and Prevention reported in 2022 (most recent data available) that Black Americans have a life expectancy that is about 3.6 years shorter than that of white Americans.

Turning to the leadership demographics within healthcare organizations, a 2023 survey by the American College of Healthcare Executives revealed that only 15% of hospital CEOs are from minority backgrounds, and similar figures hold true for CFOs and CMOs. Furthermore, the composition of health system and hospital boards reflects a lack of diversity, with 38% reporting no ethnic minorities on the board in 2021, according to "A Seat at the Table: An Examination of Hospital Governing Board Diversity, 2011–2021," published in the March/April 2023 issue of the *Journal of Healthcare Management*. This underrepresentation at the highest levels of decision-making can impact organizational culture and the effectiveness of diversity and equity initiatives.

Reflection, Articulation and Courage

Today, healthcare leaders are at a crossroads. On one side of the debate stands DEI, emphasizing diversity, equity and inclusion. On

the other side is MEI, focusing on merit, excellence and intelligence. Some have framed DEI as "definitely earned it" and MEI as "make entitlement institutional."

As a healthcare leader, where do you stand? More importantly, where do your stakeholders expect you to be? The stakes are high: Remaining neutral might risk alienating both sides. The challenge is to lead with clarity and courage, guided by your organization's vision, mission and values rather than personal beliefs or external pressures.

Rather than viewing DEI and MEI as opposing forces, consider them complementary components of a holistic approach. Envision integrating DEI and MEI into a unified framework, which might be termed DMEEI: Diversity, Merit, Excellence, Equity and Inclusion. This model fosters an environment where diverse perspectives and rigorous standards coexist and reinforce each other.

As a thought experiment, the opposite of DMEEI could be represented by HFMPE: Homogeneity, Favoritism, Mediocrity, Partiality and Exclusion. This framework illustrates the risks of sidelining either DEI or MEI, which could lead to a detrimental organizational culture.

Healthcare leaders must navigate these complex dynamics with a strategic lens, ensuring that their approach to DEI and MEI aligns with both organizational values and stakeholder expectations. The goal is not to choose sides but to forge a

path that integrates these principles into a cohesive and effective strategy for advancing organizational excellence and equity while also recognizing that the failure to manage disparities in healthcare results in unnecessary death and suffering.

Rather than viewing DEI and MEI as opposing forces, consider them complementary components of a holistic approach. Envision integrating DEI and MEI into a unified framework, which might be termed DMEEI: Diversity, Merit, Excellence, Equity and Inclusion.

Recommendations for Healthcare Leaders

1. ***Promote Inclusive Leadership:*** Ensure that leadership teams and boards reflect the diversity of the communities served. This representation can enhance decision-making and improve organizational effectiveness. Reflect upon when the language of "qualified candidate" is used. Is it used for all candidates or just some? Reflect upon whether "qualified" and "fit" are filters to include some and not others based upon a host of homogenizing factors, ranging from graduating from the same MHA program or being over 6 feet tall.

2. ***Integrate DEI and MEI Strategies:*** Develop and implement policies that balance DEI and MEI principles, creating an environment where diverse perspectives and high standards drive organizational success. Reflect upon whether those people who are not represented in certain positions within the organization need "more credentials" than others.

3. ***Invest in Data Collection and Analysis:*** Regularly collect and analyze data on healthcare disparities within your organization. Use this data to inform strategies aimed at reducing inequities in access and outcomes. Reflect upon how healthcare is embracing data-informed decisions, targets and KPIs but that these same concepts are reflexively reframed as quotes when applied to DEI.

4. ***Foster a Culture of Accountability:*** Ensure progress is tracked and outcomes are reported transparently. Reflect upon responses such as "we can't find qualified diverse talent" or "we will have to pay them more" as reasons to avoid accountability.

5. ***Engage Stakeholders:*** Actively engage with patients, staff and community leaders to understand their perspectives and expectations. Use this feedback to guide DEI and MEI efforts and build trust within the community. Reflect upon not just listening to the various views of stakeholders but also crafting responses, recognizing that the power of stakeholder groups is dynamic, not static.

6. ***Evaluate the Impact of Policies and Programs:*** Assess how changes in DEI and MEI policies impact patient care and organizational performance. Strive for a balance that advances both equity and excellence. Reflect on designing ways to quantitatively use data to evaluate the impact of existing DEI initiatives while being attentive to the resourcing of such policies and programs.

7. ***Communicate Transparently:*** Maintain open and transparent communication about DEI and MEI goals and progress. Transparency helps build trust and demonstrates commitment to both principles. Reflect upon how you feel as a leader as if you are in a vice grip, with pressures to double down on DEI initiatives but also dismantle them. Where do you stand as a healthcare leader? Given your formal power and authority, where does the organization stand? These tasks cannot be delegated or automated. Remember, silence is not a panacea.

8. ***Prepare for Resistance:*** Be prepared to encounter resistance from various stakeholders. Develop strategies to address concerns and foster a constructive dialogue about the value of integrating DEI and MEI. Reflect on the reality that turbulence will occur, but clarity in purpose, direction and organizational values may make it a bit less distressing than bouncing all over the place untethered. ▲

William F. "Marty" Martin, PsyD, is professor of management & entrepreneurship, faculty director, and Research & Innovation Leadership Fellow at DePaul University, Chicago (martym@depaul.edu).

ACHE Policy Statement Updates

In 2024, the ACHE *Code of Ethics*, *Statement on Diversity*, and the following six policy statements were updated to better align with our changing times.

- Adopting a Systematic Approach to Bringing Healthcare Executives Into a New Position or Organization
- Decisions Near the End of Life
- Organ/Tissue/Blood/Blood Stem Cells Donation Process
- Responsibility for Mentoring
- The Role of the Healthcare Executive of a Nonprofit Entity in a Change in Organizational Ownership or Control
- Strengthening Healthcare Employment Opportunities for Persons With Disabilities

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American College *of* Healthcare Executives®

Paul H. Keckley, PhD

Medicare Advantage Changes on the Horizon

What leaders should consider when evaluating contracts.

Medicare Advantage, also known as Medicare Part C, is one of two major options for seniors seeking health insurance coverage when reaching the age of 65. Offered by private insurance companies that contract with Medicare, these plans usually include Part A (hospital insurance), Part B (medical insurance) and sometimes Part D (drug coverage). Plans may also offer some extra benefits that original Medicare doesn't cover.

54% OF MEDICARE ENROLLEES have chosen Medicare Advantage.
Source: Centers for Medicare & Medicaid Services

Historically, the majority of Medicare Advantage enrollees have opted for plans that do not require a premium payment, marketed as "free coverage." Medicare Advantage plans afford enrollees an option of lower out-of-pocket costs in exchange for enrollee willingness to use services and providers designated by the plan. Enrollees agree to allow the Medicare Advantage plan to bill Medicare directly for their medical costs, with the option of paying an additional $30-$40/month for supplemental services.

One reason that Medicare Advantage's popularity has soared among lower- and middle-income seniors is that these plans feature low or no monthly premiums and supplemental benefits not available under original Medicare, including access to fitness facilities, prophylactic dentistry, transportation and more.

Medicare Advantage has been the option of choice for 54% of Medicare enrollees, and the Centers for Medicare & Medicaid Services has forecast it to reach 64% by 2034. Enrollment in Medicare Advantage plans increased from 31% of Medicare eligible adults in 2014 to 51% in 2024. Notably, enrollment in special needs and employer-sponsored Medicare Advantage plans has grown faster than the individual Medicare Advantage market, which is subject to open enrollment periods. Satisfaction appears high (69% of members do not shop for another plan during open enrollment periods), and member churn is low, according to KFF.

Participation in the Medicare Advantage program has been successful for private insurers. The Medicare Payment Advisory Commission concluded that Medicare Advantage plans receive payments from CMS that are 122% of spending for similar beneficiaries in traditional Medicare, on average, translating to an estimated $83 billion in higher spending in 2024, per Medpac.gov.

As post-pandemic normalcy returned, the landscape changed for Medicare Advantage and regulatory scrutiny of coding practices intensified. In 2023, CMS adopted tougher audit standards specific to diagnosis codes used by private Medicare Advantage plans to bill Medicare on behalf of its enrollees. Audits conducted by the U.S. Department of Human Services' Office of Inspector General, applying these new standards, found the majority of private Medicare Advantage plans guilty of upcoding and thereby causing overpayment by Medicare.

Healthcare price sensitivity among consumers and employers has spiked. Consumer out-of-pocket obligations for hospitals, prescription drugs and insurance premiums were issues for voters in 2024. Household medical debt is a major concern to lawmakers. Employers saw their costs increase 7% in 2023 and 9% in 2024—well above the GDP and medical inflation. Healthcare affordability, including consumer out-of-pocket obligation for hospitals, prescription drugs and insurance premiums, was a key issue in the 2024 elections.

CMS base payments to Medicare Advantage plans remained stable, but medical costs for seniors and unit prices paid for hospital, specialty care and prescription drugs hurt Medicare Advantage margins.

According to CMS' 2025 Rate Announcement, federal payments to Medicare Advantage plans are expected to increase on average by 3.70%, or over $16 billion, from 2024 to 2025.

Tension between Medicare Advantage insurers and providers intensified in 2023 and 2024. As health insurers saw their margins slip, negotiations with providers became more aggressive; prior authorization and claims denials increased; and supplemental benefits, such as transportation, alternative health programs and fitness benefits, were cut.

Four Considerations for Leaders

Based on recent trends, several changes are likely for the Medicare Advantage market for 2025 and beyond.

1. ***Fewer choices and fewer supplemental benefits for enrollees.*** In 2025, prescription drug provisions in the Inflation Reduction Act of 2022 will lower out-of-pocket costs for all Part D enrollees, including a new $2,000 cap on out-of-pocket spending starting in January. In response, Part D plan sponsors may make changes to plan premiums, formularies and cost sharing—making it especially important for beneficiaries to compare their prescription drug options during open enrollment.

2. ***Lower profitability and increased consolidation in the Medicare Advantage insurer market.*** The relative market share for large national Medicare Advantage sponsors will increase, strengthening their leverage in contracts with providers. Consolidation among Medicare Advantage insurers will increase.

3. ***Increased financial pressure on hospitals and physicians who participate in Medicare Advantage plans.*** Negotiations between providers and Medicare Advantage plans will be difficult, leading many providers to cancel Medicare Advantage participation and leaving enrollees in limbo.

4. ***Increased regulatory oversight of Medicare Advantage business practices.*** CMS will seek more accountability from Medicare Advantage sponsors and lower its payments to plans based on key metrics like coding accuracy and prior authorization practices.

In light of these conditions in the Medicare Advantage market, healthcare leaders should reevaluate their contracting strategies in three areas:

- ***Determinations about participation in Medicare Advantage plans.*** Declining reimbursement by private Medicare Advantage insurers will exacerbate already tense relationships. Leaders must seek more-favorable terms and conditions around network adequacy, prior authorization, claims management and clean payment turnaround, Part D formulary design and drug pricing, coding adjudication and rates, and much more. And leaders must insist on access to plan data for enrollees cared for in their organizations.

- ***Education, empowerment of Medicare Advantage enrollees.*** The overwhelming disinclination among Medicare Advantage enrollees to shop plans is an advantage to insurers and a disadvantage to providers. Leaders should consider Medicare Advantage education a potential mechanism for influencing enrollee choices between plans and expectations about their use. Empowering seniors to be informed users of the system should be a priority for leaders before and perhaps during open enrollment periods.

- ***Advocacy challenges.*** Lawmakers are keen to reduce provider frustration about prior authorization, claims denial and growing bad debt. Advocacy focused on educating lawmakers about the direct relationship between insurer business practices and these outcomes is necessary to policy changes desirable to providers. But in tandem, providers must be proactive about business practices for which there's culpability, such as price transparency and executive compensation.

Though Medicare Advantage is firmly positioned as the centerpiece of senior care for the foreseeable future, financial pressures facing the program will result in more aggressive actions by insurers toward providers. Careful analysis of how seniors are choosing and using their Medicare benefits, and the role Medicare Advantage plans play in shaping their use of hospitals, physicians and other services, is mission critical. ▲

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

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Andy Hillig, FACHE, PCC (ICF)

Navigating Your Career in the AI Age

Leaders must balance human-centric skills with technological proficiency.

The rise of artificial intelligence is reshaping how businesses operate and redefining how professionals navigate their careers. From automating routine tasks to enhancing decision-making processes, AI is becoming an indispensable part of the modern workplace and prompting the healthcare field to rethink what skills are needed and how they are learned.

According to the World Economic Forum's *The Future of Jobs Report 2023*, 85% of the organizations surveyed expect to increase adoption of "new and frontier technologies" to drive organizational transformation. Adaptability is crucial in this environment, and professionals must continuously update their skills to stay relevant. The rapid rise of AI will no doubt require businesses to consider the concept of AI as a coworker that helps shape how work gets done; improves productivity; and elevates human intelligence, creativity and innovation. At the same time, the intersection of AI and humanity will necessitate working together better, including increased emphasis on human connections, communication, collaboration, change and creativity.

As technical proficiency has become more important for leaders so, too, have the uniquely human skills that machines cannot replicate. Professionals today need to know how to communicate effectively, collaborate and handle conflict among their team members, adapt to changes in various settings and new environments, bounce back from setbacks, overcome barriers, and creatively innovate and solve problems.

3 Essential AI Career Advancement Skills

1. **Communication**
   Communication has always been a key leadership skill, but it takes on new dimensions in the AI age.
2. **Collaboration**
   In an AI-driven workplace, the ability to collaborate is about leveraging the strengths of both AI and human intelligence to drive growth and innovation.
3. **Change Resiliency**
   Building resiliency for change requires using leadership behaviors such as communication, flexibility and making personal connections to help teams transition through a change successfully.

The following are three examples of essential skills that leaders can hone to keep in stride with the changes AI is driving in the workplace and career advancement.

Professionals who can balance technological proficiency with the ability to connect and inspire others will be best positioned to succeed in this new era.

1. **Effective Communication**
   Communication has always been a key leadership skill, but it takes on new dimensions in the AI age. In addition to communicating with AI systems, leaders must be able to clearly and effectively communicate with each other—and across diverse audiences and channels—using the outputs AI tools generate. This requires not only clarity in conveying thoughts and ideas but also an understanding of how to interpret and act on insights, especially AI-generated insights.

   Leaders can consider using AI-powered speech analytics tools (such as Yoodli) to improve their communication skills. For example, a leader might engage with these tools, which can provide insights into speaking pace, clarity, use of "filler" words and audience engagement, when preparing a presentation or talking points for a meeting.

2. **Foster Collaboration**
   In an AI-driven workplace, the

ability to collaborate is not just about working well with others; it's about leveraging the strengths of both AI and human intelligence to drive growth and innovation. Collaborative skills allow professionals to share insights, build trust in AI systems, optimize their use in decision-making processes and innovate.

In collaborative environments, leaders allow healthy, respectful conflict, prevent groupthink and ignite creative solutions. These safe and inclusive environments allow teams to reconsider approaches or come up with new ways of thinking. AI tools can provide an abundance of data, information and insights that require careful interpretation. They also offer the team an avenue for considering new ways of thinking, which can become fertile ground for collaboration and creative solutions to persistent challenges.

One strategy, for example, may include using AI to generate market forecasts but then bringing the team together to discuss the implications of those forecasts and how they align with the community's healthcare needs. In this case, AI provides the initial insights for the team so it can focus on fully understanding the findings, take time to appreciate other team members' perspectives with empathy, be aware of their own emotions and triggers, and work to foster positive relationships and promote a culture where collaboration is valued over competition.

3. **Build Change Resiliency**
Change is as much a part of life as breathing, and healthcare leaders and organizations have had plenty of experience and awareness on the subject, long before the advent of the AI era. Change as a constant, however, can be a challenging reality for professionals to cope with and work through.

Author William Bridges' research on change transitions emphasizes the emotional and psychological elements that come to the forefront when leading through change. According to the Bridges Transition Model, as people pass through the phases of change, it's important that leaders appreciate the narratives formed in the human brain and the experiences that shape individuals' beliefs and biases and drive behaviors. When changes don't go as planned, it's typically because of the various narratives and experiences that people have. Building resiliency for change requires using leadership behaviors such as communication, flexibility and making personal connections to help teams transition through a change successfully.

AI tools such as sentiment analysis (used on platforms such as Microsoft Viva or Slack) can help leadership teams analyze the emotional tone of communications from staff, like emails and survey responses. These tools can detect shifts in mood and stress levels. Having this information helps leaders proactively ease anxiety and foster trust when transitioning from old to new ways of doing things.

Consider a leader overseeing an EHR migration. This leader uses AI to assess employee feedback in internal communications and detects a rise in negative sentiment or frustration among team members about the migration. Based on this, the leader can organize additional training sessions or Q&A meetings to alleviate concerns.

Harness AI … but Keep Humanity at the Center

AI is a powerful tool for enhancing creativity, offering new ways to approach problems and generate ideas. However, the creative process itself remains a fundamentally human endeavor. Leaders who can harness AI to augment their team's creativity will have a significant advantage in the workplace.

As AI continues to transform the workplace, the importance of the skills described here will only grow. Professionals who can balance technological proficiency with the ability to connect and inspire others will be best positioned to succeed in this new era. By embracing this dual imperative, leaders can not only navigate their own careers more successfully, but they can also more effectively guide their organizations through the challenges and opportunities that lie ahead. ▲

Andy Hillig, FACHE, PCC (ICF), is a leadership and executive coach with LAK Group, Sussex, Wis., (andy@andyhillig.com).

Patricia A. McGaffigan, RN, CPPS

New CMS Measure Aims to Advance Safety

What must healthcare leaders know about the new Patient Safety Structural Measure?

The Centers for Medicare & Medicaid Services has introduced a new attestation-based measure—the Patient Safety Structural Measure—that reinforces practices to strengthen foundational elements associated with safe care. The measure is applicable to acute care hospitals that participate in CMS' Hospital Inpatient Quality Reporting Program and the PPS-Exempt Cancer Hospital Quality Reporting Program. What must hospital leaders know, and how can they leverage existing safety strategies to prepare for this new measure?

Focus of the Patient Safety Structural Measure

While many quality measures reflect the performance and improvement of healthcare processes and outcomes, structural measures assess features of a healthcare organization that are relevant to its capacity to provide good care. The Patient Safety Structural Measure focuses on the environment of care and its related administrative processes and policies that are expected to make a significant impact on safety. This will enable hospitals to assess and attest whether they demonstrate a structure, culture and leadership commitment that prioritizes a systems-based approach to safety.

The new measure comprises five domains that reflect the most salient, evidence-based foundational areas deemed important for safety, as listed below. Its domains and activities are informed by *Safer Together: A National Action Plan to Advance Patient Safety*, developed by the 27 members of the National Steering Committee for Patient Safety convened by the Institute for Healthcare Improvement, including the American College of Healthcare Executives.

1. **Leadership commitment to eliminating preventable harm:** Addresses the importance of senior leadership and the governing board setting the tone for commitment to patient safety and the essential leadership practices for safety.
2. **Strategic planning and organizational policy:** Addresses how hospitals use their strategic planning cycles and internal policies to demonstrate a commitment to safety.
3. **Culture of safety and learning health system:** Addresses whether hospitals integrate evidence-based practices and protocols that are fundamental to cultivating a safety culture and learning system within and across hospitals.
4. **Accountability and transparency:** Supports accountability for outcomes and transparency around safety events and performance—cornerstones for ensuring safety.
5. **Patient and family engagement:** Supports the effective and equitable engagement of patients, families and caregivers in their own care and in the co-design of safe systems.

Hospitals must assess and affirmatively attest to their performance across five activities within each of the domains. The initial reporting period for the Patient Safety Structural Measure runs through December 2025, with hospitals submitting their scores from April 1 through May 15, 2026. Scores will be publicly reported on the CMS Care Compare website in the fall of 2026, and hospitals that fail to submit data will be subject to payment penalties in fiscal year 2027 (October 2026 through September 2027).

Alignment With Existing Safety Strategies

Historical approaches to safety have frequently placed a disproportionate emphasis on reacting to harm in attempts to improve human performance at the point of care, often through remedial education and reinforcement of policies. The Patient Safety Structural Measure incentivizes leaders to move beyond understanding safety as merely a set of projects focused on improving human performance, and instead use safety science principles to engineer better systems and foster safe cultures. This mindset shift will both optimize human performance and

move emphasis upstream to identify and mitigate safety risks that could result in harm.

While hospitals are not penalized for low Patient Safety Structural Measure scores, public reporting on CMS Care Compare offers consumers a look into whether hospitals have structures and processes in place that are necessary for safety. In subsequent years, this will provide insights on whether and how hospitals are improving their scores. The publicly available scores may guide and influence consumer decisions and selection about where to receive care. Members of the healthcare workforce are likely to consider scores in their selection of future employers, given the desire to work in organizations that have a demonstrable and sustainable commitment to patient safety, and especially because of the inextricable links between patient safety and workforce safety and well-being.

Hospital leaders who embrace and operationalize high-reliability principles (a preoccupation with failure to anticipate and mitigate risk before harm occurs; co-creation and reinforcement of safety systems and practices with the expertise and engagement of patients, families, and the workforce; fostering safety cultures to ensure psychological safety, reporting, transparency, and continuous learning and improvement) in their daily work will find alignment with the intent and focus of the Patient Safety Structural Measure. Its domains and related activities mirror these principles and recognize safety as a real-time, emergent property of a complex healthcare system.

How Hospital Leaders Can Prepare

During the inaugural reporting period, healthcare leaders have a time-sensitive opportunity to establish and refine practices to enable them to achieve higher attestation scores. The Patient Safety Structural Measure is highly aligned with the Safer Together National Action Plan, which addresses the foundational areas of culture, leadership and governance, patient and family engagement, workforce safety and well-being, and the learning system. The companion organizational self-assessment tool provides a freely available platform to conduct a systemwide assessment of a hospital's readiness for the new measures. Recommendations include the following:

- Review, communicate and socialize the intent, domains and attestation requirements of the measure with leadership colleagues, board members, safety and quality staff, and across the organization.
- Convene an interdisciplinary team led by an executive sponsor to assess your hospital's current state of activities compared to the Patient Safety Structural Measure.
- Conduct a systemwide assessment of safety using the Safer Together National Action Plan online Assessment Tool and User Guide, and the Patient Safety Structural Measure Attestation Guide.
- Identify and prioritize Patient Safety Structural Measure gaps and opportunities and senior sponsors for each area of focus.
- Establish action plans and resourcing to advance and sustain improvement, and measure and monitor progress and opportunities for continuous improvement.
- Participate in learning networks, conferences and educational offerings to build capability and find resources to meet Patient Safety Structural Measure activities.
- Ensure regular, transparent communications with the board and across the organization to foster meaningful engagement of patients, families and the workforce.

The new CMS Patient Safety Structural Measure marks a pivotal shift toward reporting incentives associated with best-known practices for leadership, governance, culture, engagement, and infrastructure to achieve transformational and sustainable improvement in safety. The measure reinforces the critical role of healthcare leaders in fostering systems, cultures and attention to the habitual excellence that is necessary for eliminating harm to patients, families and those who care for them. ▲

Patricia A. McGaffigan, RN, CPPS, is senior advisor for safety at the Institute for Healthcare Improvement (pmcgaffigan@ihi.org), president of the Certification Board for Professionals in Patient Safety, and an ACHE Member.

Editor's note: Additional information on the Patient Safety Structural Measure and the attestation guide are available at qualitynet.cms.gov/pch/measures/safety. For more information on the Safer Together National Action Plan, visit ihi.org/safetyactionplan or **ache.org/SaferTogether**.

David Tam, MD, FACHE

Strategic Transformation Is Hard but Necessary

Beebe Healthcare focuses on a regional approach to healthcare.

In this Q&A with David Tam, MD, FACHE, he discusses the need for change due to the impact of baby boomers approaching retirement age and concerns over Medicare funding. Tam was previously COO, Providence Saint John's Health Center, Santa Monica, Calif., and COO, TRICARE Regional Office, West, San Diego. Tam is a retired captain in the United States Navy.

Q. Why is the transformation of the U.S. healthcare system necessary?

A. Transformation is absolutely essential as we face the intersecting of significant forces. The tsunami of the aging baby boomer population is creating a tremendous need to expand health coverage. At the same time, there is unprecedented emphasis on expense reduction across the continuum of care, while technological and pharmacological interventions are more prevalent than ever before. In addition, the labor force has been changing dramatically.

Q. With the last of the baby boomers having turned 60 this year, what is their impact on your health system?

A. Bankrate's annual Best and Worst States to Retire Study recently listed Delaware as the best state to retire in the United States. With a potential influx of baby boomers moving to Beebe's market, it is our responsibility to care for them as a community health system. Baby boomers tend to be more comfortable with technology than some in the generation before them, readily using electronic health records, requesting video appointments and expecting in-home remote care visits. As such, Beebe must pivot with respect to both growth of our services as well as changing cultural demographics so we can engage all our patients in ways they are comfortable.

Q. How has Beebe Healthcare in general transformed in developing its strategic plan and the organization as a whole?

A. We have strategically focused on a regional approach to healthcare, looking at core clinical services for both volume and clinical capacity. We have partnered with large, national academic institutions to expand our clinical continuum to meet the needs of our community. We have also committed to financial and market targets to ensure independence as a regional entity.

Q. How has it transformed the executive team?

A. The strategic plan has directed the restructuring of the executive team to both execute goals and objectives while meeting the operational demands of the health system. Each executive is also a dyad partner with a board member to ensure there are multiple connection points between governance and management. Finally, we have worked hard to structurally implement a matrixed organizational approach to promote agile decision-making.

Q. How has ACHE impacted your career?

A. ACHE has been a foundational part of my growth and development as a leader. As a physician executive, I deliberately made the decision to join ACHE because of the need to learn more about being a leader and an executive. Becoming a Fellow, along with the mentorship and the training I received, were keys to my success. ▲

David Tam, MD, FACHE, is president and CEO of Beebe Healthcare, Lewes, Del.

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Kathleen D. Sanford,
DBA, RN, FACHE

Thinking Strategically

For nurses, the need for this begins sooner than you think.

To help clinical leaders think strategically, an understanding of both strategic processes and strategic thinking should be pursued long before they are promoted into leadership positions. Educating all levels of nurses is important in supporting an organization with strategic thinking.

OVER
16,000
CommonSpirit nurses took part in developing the current nursing strategic plan.
Source: CommonSpirit Health

It is a common perception that strategy is an exclusive domain of a healthcare system's top business executives. Use of the traditional model, where a formal strategy leader coordinates and leads executive teams, still seems to work well in the first and second levels of a company's strategy. Those levels are organization strategy, where it is determined what services the company should provide now and in the future, and business strategy, where it is decided how best to compete with other companies that provide similar services in the same markets.

Sometimes overlooked, or given less attention, is the third level: the functional strategy, where departments determine their specific tactics in support of the entire strategic plan. The probability of tactical success at the functional strategic level is enhanced with deliberate leveraging of the entire healthcare team's strategic thinking. For the clinical enterprise, this means more than simply communicating with team members about how their roles support the organization's success. It also calls for deliberate planning and implementation of a process to include them in determining the tactics.

The former (communication) is necessary because it's sometimes difficult in our complex systems for all team members to understand the impact of their individual endeavors to overall company success without clear explanations that connect the dots. The latter (inclusion) is essential because strategies usually include changes in how functions operate, and the experts on what could and should change are those who perform the work.

Nurses add value to an organization's strategy because their work is one of the closest to those who receive care. In business speak, they are direct providers of our "product" and can add even more value when their leaders communicate frequently and clearly about the company's mission and goals. The result is a nursing workforce that's encouraged and empowered to contribute to their functional strategy.

The probability of tactical success at the functional strategic level is enhanced with deliberate leveraging of the entire healthcare team's strategic thinking.

A Functional Strategy: The Example of Nursing

The Nursing Enterprise of CommonSpirit Health, Chicago, is currently engaged in its fourth year of a five-year nursing strategic plan. As the largest functional area—almost one-third of the employees are nurses—nursing is an essential component of the company's operations. While the nursing strategy covers a variety of patient care, quality and patient experience goals, a major priority is mitigating effects of the existing and projected workforce shortfall. Strategies include increasing the pipeline for nurses and their teams, becoming the employer of

choice and changing care models so patients will continue to receive quality care even if we do not have the number of nurses needed in current models.

Some of the specific tactics for these three strategies include growth of an internal travel nurse program, a virtual care base center, basic and specialty residency programs, leadership development programs, new models of inpatient care, pre- and post-hospital care models, and academic partnerships. All of these came out of a strategic planning process that involved nurses at all levels who participated in developing the nursing vision and strategy.

During the planning process, nurses suggested the tactics and indicated their priorities through focus groups, voting and suggestions shared online or through staff meetings. Their input involved bold care model changes as well as smaller actions that have begun to shape the CommonSpirit Nursing culture: A monthly nursing newsletter, an annual report, belonging circles and well-being activities, to name a few.

Though many of these do not sound strategic, or even tactical, their implementation may have contributed to the results attributed to individual projects that are identified as transformative tactics. Those include a new graduate residency program, which dropped the first-year turnover of new graduate nurses to 6% from almost 50% in the first year.

Another area, the virtually integrated care model, saw similarly impressive results, which varied from region to region. Turnover on units after the model's implementations improved by 75% in one region, 66% in another part of the country and 46% in a third state. Even if these results can be partially attributed to the Hawthorne effect (the researched observation that people change their behavior because they are aware of being observed), they are dramatic enough to infer that including nurses in planning the tactics of functional strategies is a good tactic in itself.

Over 16,000 CommonSpirit nurses took part in developing the current nursing strategic plan. Most participated by voting on two versions of a nursing vision, which was developed and written by a committee of nurses from across the system who volunteered for the task. Others took part in focus groups, where tactics were proposed and then prioritized. Those who participated learned about the strategic planning process, including the need to tie functional tactics to the organization's mission, business strategy and goals.

Nurses add value to an organization's strategy because their work is one of the closest to those who receive care.

Educating Nurses

Nurses are educated to follow the nursing process: assessment, diagnosis, planning, implementation and evaluation. Though this is a systematic guide to client or patient centered care, it is not that different from strategic planning: understanding the need for a plan, setting goals, researching ways to meet objectives, choosing a plan of action and monitoring the plan's progress. Nurses involved in the five-year strategic plan were quick to grasp the similarity. They learned about strategic planning by participating in it.

Healthcare system leaders can take numerous other steps to involve nurses and other team members. These include:

- Reminding team members through staff meetings, online newsletters and function websites about the organization's mission, goals and how individual efforts contribute to the company's success.
- Including education on the system's strategic planning process and the importance of functional strategy at all levels of planning.
- Empowering and encouraging nurses as individuals and in teams to consider innovative ways to implement the nursing strategy.
- Using the word "tactics" to describe the innovations they propose.
- Connecting another set of dots: When team member tactics are adopted, communicate that these are the result of their input.

Clinicians, including nurses, have long spoken about needing more of a voice in their practice. Involving them in functional strategy gives them that voice and leverages their unique experiences for the good of their patients and their organizations. ▲

Kathleen D. Sanford, DBA, RN, FACHE, is senior executive vice president/CNO, CommonSpirit Health, Chicago.

ACHE MEMBER UPDATE

ACHE Announces Nominating Committee 2025 Slate

The ACHE Nominating Committee has selected a slate of leaders to be presented to the Council of Regents for action at its March 22, 2025, meeting. All nominees have been notified and have agreed to serve if elected. All terms begin at the close of the Council meeting in March. The nominees for the 2025 slate are as follows:

Nominating Committee Member, District 2 (two-year term ending in 2027)
Ann-Marie A. Knight, FACHE
Vice President, Community Engagement & Chief Diversity Officer
University of Florida Health-Jacksonville (Fla.)

Nominating Committee Member, District 3 (two-year term ending in 2027)
Thomas N. Shorter, JD, FACHE
Partner
Husch Blackwell LLP
Madison, Wis.

Nominating Committee Member, District 6 (two-year term ending in 2027)
Amir N. Farooqi, FACHE
Interim Director/Chief Executive Officer
VA Eastern Colorado Health Care System
Aurora, Colo.

Additional nominations for members of the Nominating Committee may be made from the floor at the annual Council of Regents meeting.

Governor (three-year term ending in 2028)
Jennifer D. Alderfer, FACHE
Western Division President
Lifepoint Health
Brentwood, Tenn.

Governor (three-year term ending in 2028)
Corwin N. Harper, FACHE
Covington, La.

Governor (three-year term ending in 2028)
Bonnie J. Panlasigui, FACHE
Akron, Ohio

Governor (three-year term ending in 2028)
Peter J. Wright, FACHE
President & CEO
Northwestern Medical Center
Saint Albans, Vt.

Chair-Elect
Noel J. Cardenas, FACHE
Senior Vice President & CEO
Memorial Hermann Southeast & Pearland Hospitals
Houston

Additional nominations for the offices of Chair-Elect and Governor may be made in the following manner: Any Fellow may be nominated by written petition of at least 15 members of the Council of Regents. Petitions must be received in the ACHE headquarters office (American College of Healthcare Executives, 300 S. Riverside Plaza, Ste. 1900, Chicago, IL 60606-6698) at least 60 days prior to the annual meeting of the Council of Regents. Regents shall be notified in writing of nominations at least 30 days prior to the annual meeting of the Council of Regents.

Thanks to the members of the Nominating Committee for their contributions in this important work:

Anthony A. Armada, FACHE
Delvecchio S. Finley, FACHE
CAPT Robert T. McMahon, III, FACHE
Stephanie M. Meier, FACHE
Harry C. Sax, MD, FACHE
Mark Schulte, FACHE
Ashley R. Vertuno, FACHE
Lori L. Wightman, RN, FACHE

ACHE Call for Nominations for 2026 Slate

ACHE's 2025-2026 Nominating Committee is calling for applications for service beginning in 2026. ACHE Fellows are eligible for the Chair-Elect and Governor vacancies and are eligible for the Nominating Committee vacancies within their districts. Those interested in pursuing applications should review the candidate guidelines for the competencies and qualifications required for these important roles. Open positions on the slate include:

- Nominating Committee Member, District 1 (two-year term ending in 2028).

- Nominating Committee Member, District 4 (two-year term ending in 2028).
- Nominating Committee Member, District 5 (two-year term ending in 2028).
- Four Governors (three-year terms ending in 2029).
- Chair-Elect.

Please refer to the following district designations for the open positions:

- **District 1:** Canada, Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
- **District 4:** Alabama, Arkansas, Kansas, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, Tennessee, Texas
- **District 5:** Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington, Wyoming

Candidates for Chair-Elect and Governor should submit an application to serve, a copy of their resume and up to 10 letters of support.

For details, please review the Candidate Guidelines, including guidance from the Board of Governors to the Nominating Committee regarding the personal competencies of Chair-Elect and Governor candidates and the composition of the Board of Governors.

Candidates for the Nominating Committee should only submit a letter of self-nomination and a copy of their resume. Due to the importance and nature of work conducted by the Nominating Committee, candidates should demonstrate effective and successful prior experience as a healthcare leader and ACHE volunteer.

Applications to serve and self-nominations should be addressed to Delvecchio S. Finley, FACHE, Nominating Committee Chair, and can be submitted electronically to Kim Rock at krock@ache.org.

All applications must be received by Monday, July 28.

Following the July 28 submission deadline, the committee may meet to determine which candidates for Chair-Elect and Governor will be interviewed. All candidates will be notified of the committee's decision no later than Sept. 26, and candidates for Chair-Elect and Governor will be interviewed in person Oct. 23 in Chicago.

The first meeting of ACHE's 2025–2026 Nominating Committee will be held Tuesday, March 25, during the 2025 Congress on Healthcare Leadership in Houston, Texas. The committee will be in open session at 2:45 p.m. Central time.

During the meeting, an orientation session will be conducted for potential candidates, giving them the opportunity to ask questions regarding the nominating process.

Immediately following the orientation, an open forum will be provided for ACHE members to present and discuss their views of ACHE leadership needs.

If you have any questions, please contact Kim Rock at (312) 424-9375 or krock@ache.org.

Internships Available Through AHA Institute's Summer Enrichment Program

Registration is open for the American Hospital Association's Institute for Diversity and Health Equity 2025 Summer Enrichment Program. The program grows and strengthens the pipeline of healthcare leaders and places graduate students pursuing advanced degrees in healthcare administration or a related field in 10-week, paid internships across the country.

ACHE and the Institute co-promote the program to increase the number of students who participate in it each year and, accordingly, increase the number of host sites. Just as students benefit from experiential learning, host sites gain the experience of mentoring, educating and collaborating with new and upcoming leaders.

Registrations are due Feb. 7, 2025. Visit **ifdhe.aha.org/summer-enrichment-program-overview** to register, or to learn more about the program in general or about becoming a host site.

For further details, contact the Institute at ifd-sep@aha.org or Anita Halvorsen, FACHE, ACHE's senior vice president, Executive Engagement, at ahalvorsen@ache.org.

PEOPLE

ACHE Chapters Recognized for Commitment to Diversity

Five chapters received ACHE's 2024 Regent-at-Large Award for their accomplishments in diversity and inclusion. To be eligible to receive an award, a chapter must actively demonstrate commitment to and successful execution of significant diversity and inclusion initiatives within the chapter, community and healthcare management field. The following chapters received the award during the annual Chapter Leaders Conference, which took place Sept. 29–30 in Chicago.

- Healthcare Leaders of New York—District 1.
- National Capital Healthcare Executives—District 2.
- Chicago Health Executives Forum—District 3.
- ACHE of Alabama—District 4.
- California Association of Healthcare Leaders—District 5.

In Memoriam

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

Charles E. Housley, LFACHE
Lexington, Ky.

Michael J. Megna, LFACHE
Round Mountain, Texas

Joseph E. Melchiorre Jr., LFACHE
Tampa, Fla.

2024 Executive Program: Where Leaders Connect, Collaborate, Innovate

Sixty-five healthcare leaders completed ACHE's 2024 Executive Program, which included executive, senior executive and clinical executive cohorts.

This in-person three-module series took place over four months, with the first module beginning in June 2024 in Houston, followed by the second in August in Chicago, and concluding with the final module in October in Atlanta.

Attendees learned from top healthcare experts, received individualized career coaching and professional leadership assessments, visited health systems, all of which offered valuable insights on the specific challenges leaders face today.

The program's goal is to foster professional growth and support organizational advancement. Participants also built lasting relationships and shared knowledge, making it a truly unique learning experience.

The 2025 Executive Program will also be held in person, with more details to follow soon.

IHF Announces 2024 Award Winners

ACHE congratulates the recipients of the 2024 International Hospital Federation Awards. These awards, which include the American College of Healthcare Executives Award for Leadership and Management, are recognized around the world as the premier awards program to honor hospitals and healthcare organizations.

The IHF announced the 2024 recipients and presented the awards during a ceremony Sept. 11 at the 47th World Hospital Congress in Rio de Janeiro, Brazil.

The ACHE Excellence Award for Leadership and Management recognizes hospitals or health service providers that demonstrate excellence or outstanding achievements in leadership and management in leading a hospital or healthcare organization.

The 2024 recipients are:

Gold:
National Cardiovascular Center Harapan Kita (Indonesia).

Silver:
King Saud Medical City (Saudi Arabia).

Bronze:
Cromwell Hospital (United Kingdom).

Honorable Mentions:

- Emirates Health Services (United Arab Emirates).
- Fundació Assistencial Mútua Terrassa (Spain).
- University Hospitals (United States).
- Tondo Medical Center (Philippines).

This year, IHF received over 500 entries from more than 37 countries and territories.

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- Unique listing in the **Healthcare Consultants Forum Member Directory**, a platform designed to highlight your area of expertise and increase your visibility with executives and other key decision-makers in healthcare organizations seeking consulting services.
- Special designation in ACHE's online Member Directory that enhances your visibility with colleagues and clients.
- Quarterly e-newsletter addressing topics relevant to you, your business and your clients.
- Access to an exclusive LinkedIn Group to network and exchange ideas.
- Dedicated staff contact to help with your ACHE membership and Forum benefits.

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Join for an annual fee of $100
in addition to your membership dues.

ACHE.org/HCForum

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LEADERS IN ACTION

To promote the many benefits of ACHE membership, the following ACHE leader spoke recently at the following in-person event:

William P. Santulli, FACHE
Chair
South Texas Chapter–American College of Healthcare Executives Healthcare Landscape Conference
Jan. 31, 2025.

ACHE STAFF NEWS

ACHE Announces New Hire and Promotion

Ibtisaam "Sam" Dalvi welcomed as data analyst, Research, Executive Office.

Molly Lowe promoted to vice president, Learning, Department of Professional Development, from director, content strategy.

Kalon Robinson-Goodman welcomed as business analyst, Business Excellence.

ACHE Staff Members Receive Service Awards

The following ACHE staff members recently received awards for service anniversaries.

25-Year Service Award
Lisa Mackins, accounting coordinator, Finance, Department of Business Excellence.

10-Year Service Award
Kimberly Rock, governance specialist, Executive Office.

Tim Tlusty, vice president, Development, Executive Office.

Five-Year Service Award
Svetlana Abramova, research assistant, Research, Executive Office.

David N. Bartholomew, FACHE, senior vice president, Learning, Department of Professional Development.

Steven M. Harris, director, Information Technology, Department of Information Technology.

Mary Howorth, education specialist, Department of Professional Development.

Aleksandr Kholod, report developer, Department of Information Technology.

Stacey A. Kidd, CAE, director, Chapter Relations, Department of Executive Engagement.

Kevin V. McCann, technical support coordinator, Department of Information Technology.

2024 Pickert Award Winners Announced

Alexa N. Calingo, program specialist, Department of Professional Development, and **Sujatha Socrates**, web content coordinator, Department of Communications and Marketing, are the 2024 recipients of the Alton E. Pickert Award, which recognizes ACHE employees who have demonstrated significant service to ACHE and its members.

The award was established by Anne M. Pickert to honor the memory of Alton E. Pickert, FACHE, ACHE Chair from 1983 to 1984. During his tenure, Pickert emphasized the important contributions of ACHE staff to the healthcare field. Calingo joined ACHE in 2023 and Socrates joined ACHE in 2022.

MARK YOUR CALENDAR FEB. 13

ACHE Day of Giving

Join us on Feb. 13 to celebrate ACHE's "birthday" with our Day of Giving! Help us further our mission to raise $1 million for the Fund for Healthcare Leadership by March 2025.

Scholarships from the Fund help diverse, talented individuals acquire the skills and training they need to forge a career path in healthcare leadership. Make an impact by donating to the Fund on this important day in ACHE's history.

Learn more at **ache.org/DayofGiving**

We invite you to share your Day of Giving stories using #ACHEGive.


20
Happy
New
Year!

25

From ACHE's Chair Officers,
Governors, Regents and Staff

American College *of*
Healthcare Executives®

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

Rev. Deborah Addo, COO, Penn State Health, Hershey, Pa., received the Preeminent Women in Healthcare Award from the Regent for Pennsylvania.

Rosalee Allan, FACHE(R), received the Senior-Level Regent Award from the Regent for Washington.

Kyle E. Armstrong, FACHE, president, Baylor University Medical Center, Dallas, received the Senior-Level Regent Award from the Regent for Texas—Northern.

Amy Ballard, system director, Quality Analytics, PeaceHealth, Vancouver, Wash., received the Early Careerist Regent Award from the Regent for Washington.

Maria Benitez, strategic planning consultant, Hospital Sisters Health System–St. Vincent Hospital, Green Bay, Wis., received the Early Careerist Regent Award from the Regent for Wisconsin.

James A. Berg, LFACHE, received the Legacy Leader Award from the Regent for Texas—Northern.

Elwood B. Boone, III, FACHE, president, Sentara Virginia Beach General Hospital, Virginia Beach, Va., received the Senior-Level Regent Award from the Regent for Virginia—Central.

Valdez G. Bravo, FACHE, deputy director, Multnomah County Health Department, Portland, Ore., received the Senior-Level Regent Award from the Regent for Oregon.

Kimberly K. Browne, FACHE, executive director, Patient & Family Services, Stanford Medicine Children's Health, Palo Alto, Calif., received the DEI Leadership Award from the Regent for California—Northern & Central.

Juliya Buettner, FACHE, chief of staff, Office of the CEO, Children's Wisconsin, West Allis, Wis., received the Diversity Equity and Inclusion Champion Award from the Regent for Wisconsin.

Darlena D. Chadwick, RN, FACHE, executive vice president/COO, The Queens Health System, Kapolei, Hawaii, received the Senior-Level Regent Award from the Regent for Hawaii/Pacific.

Jacquelyn Cheun-Jensen, PhD, FACHE, director, Analytics, SWR Investments LLC, Reno, Nev., received the Chapter Leadership Excellence Award from the Regent for Nevada.

Abraham Cicchetti, COO, Health Career Connection, Oakland, Calif., received the Early Careerist Regent Award from the Regent for California—Northern & Central.

Travis Clegg, FACHE, COO, Straub Medical Center, Kailua, Hawaii, received the Executive Leadership Performance Award from the Regent for Hawaii/Pacific.

Chad M. Collins, FACHE, vice president, Operations, Texas Health Resources, Plano, received the Early Careerist Regent Award from the Regent for Texas—Northern.

Paulette Davidson, FACHE, president/CEO, Monument Health, Rapid City, S.D., received the Senior-Level Regent Award from the Regent for South Dakota.

Jorge E. Galva, senior consultant, Health Front Group, Vega Alta, Puerto Rico, received the Senior-Level Regent Award from the Regent for Puerto Rico.

Uvette R. Gonzaque-Francis, student, Abilene Christian University, Las Vegas, received the Outstanding Service Award from the Regent for Nevada.

Dana M. Weston Graves, FACHE, president, Sentara Princess Anne Hospital, Virginia Beach, Va., received the Outstanding Achievement Award from the Regent for Virginia—Central.

Want to submit?

Send your "On the Move" submission to he-editor@ache.org. Due to production lead times, entries must be received by Feb. 3 to be considered for the May/June issue.

- **LEADERSHIP** opportunities outside of your current position
- **NETWORKING** events with peers and mentors within your community
- **EDUCATION** opportunities that are close to home and can come to you

IMAGINE THE POSSIBILITIES

WHEREVER YOU ARE, YOUR CHAPTER IS THERE.

ACHE.org/CHAPTERS

American College *of* Healthcare Executives
for leaders who care®

Travis M. Gregg, FACHE, COO, Bryan Medical Center, Lincoln, Neb., received the Senior-Level Regent Award from the Regent for Nebraska & Western Iowa.

Keya Gupta was named a 40 Under 40 Honoree by the Greater Irvine Chamber, Orange County, Calif.

Karen E. Kent, PhD, director, MBA program, DeSales University, Center Valley, Pa., received the Leadership Excellence Award from the Regent for Pennsylvania—Southeast & Southern New Jersey.

Clair Kuriakose, FACHE, executive director, Advanced Practice, Stanford Health Care, Palo Alto, Calif., received the Early Careerist Regent Award from the Regent for California—Northern & Central.

Kimberly C. Long, DHA, FACHE, CEO, Association of California Nurse Leaders, Folsom, Calif., received the Senior-Level Regent Award from the Regent for California—Northern & Central.

Heidi May-Stoulil, director, Specialty Practices, Samaritan Health Services, Corvallis, Ore., received the Early Careerist Regent Award from the Regent for Oregon.

Carol N. Michaels, FACHE, chief transformation officer, Valley Health Partners Community Health Center, Allentown, Pa., received the Leadership Excellence Award from the Regent for Pennsylvania—Southeast & Southern New Jersey.

Ilia M. Morales-Toledo, COO, Laboratorio Clínico Toledo, San Juan, Puerto Rico, received the Early Careerist Regent Award from the Regent for Puerto Rico.

Rea Owens-Byerly, sourcing director, Vizient, Irving, Texas, received the Leadership Leverage Award from the Regent for Texas—Northern.

Anthony T. Pugsley, vice president, Marketing and Communications, Baxter Health, Mountain Home, Ark., received the Early Careerist Regent Award from the Regent for Arkansas.

Sydney M. Schoening, assistant senior living consultant, Immanuel, Lincoln, Neb., received the Early Careerist Regent Award from the Regent for Nebraska & Western Iowa.

Jimmy Seward, director, Ambulatory Operations, Monument Health Sturgis (S.D.) Hospital, received the Early Careerist Regent Award from the Regent for South Dakota.

Antonette Shockey, operations executive and site administrator, Mission Bernal Campus, Sutter Health, San Francisco, received the Early Careerist Regent Award from the Regent for California—Northern & Central.

Erika Smith, PharmD, FACHE, enterprise transformation senior principal, Froedtert Health, Milwaukee, received the Mid-Level Careerist Regent Award from the Regent for Wisconsin.

Abdullahi Somo, FACHE, chief administrative officer, University of Virginia Medical Center, Charlottesville, Va., received the Early Careerist Regent Award from the Regent for Virginia—Central.

Kimberly A. Stapelfeldt, senior director/administrator, Hospital-Based Services, Advocate Aurora Medical Group, Milwaukee, received the Senior-Level Regent Award from the Regent for Wisconsin.

Matthew E. Troup, FACHE, president, Conway (Ark.) Regional Health System, received the Senior-Level Regent Award from the Regent for Arkansas.

Dana M. Weston Graves, FACHE, president, Sentara Princess Anne Hospital, Virginia Beach, Va., received the Outstanding Achievement Award from the Regent for Virginia—Central.

Hannah Wong, administrative fellow, MultiCare Health System, Woodinville, Wash., received the Early Careerist Regent Award from the Regent for Washington.

Education and Networking Across the Country

Chapters have been busy lately.

Empowering Women in Healthcare: A Night to Remember With ACHE–NJ
ACHE–NJ hosted a Women's Leadership Panel at Atlantic Health System's Jets Training Center. Attendees gathered for an exclusive behind-the-scenes tour of the facility of the NFL's New York Jets and an enlightening panel discussion with renowned healthcare executives across New Jersey. The event was a testament to ACHE–NJ's commitment to fostering diversity and inclusivity across the healthcare sector. Attendees connected with influential voices from New Jersey, exchanged valuable insights and delved into the crucial role of women in healthcare.

The panelists shared their journeys, challenges and triumphs, offering invaluable advice to aspiring healthcare leaders. They emphasized the importance of mentorship, resiliency and continuous learning in shaping successful careers. The discussions underscored the need for more women in leadership roles, highlighting the unique perspectives and strengths they bring to executive positions in healthcare.

The event also provided a platform for attendees to build connections and foster relationships within the healthcare community. The networking session allowed participants to engage in meaningful conversations, share experiences and learn from each other well after the event.

The exclusive behind-the-scenes tour was another highlight of the evening. Attendees explored the Jets Training Center, which added an element of excitement and exclusivity to the event, a metaphor for how structure and process can impact outcomes and create high-performing teams.

The success of the Women's Leadership Panel exemplifies ACHE–NJ's dedication to empowering women in healthcare. The event not only celebrated the achievements of women leaders but also sparked conversations regarding the challenges they face around intersectionality and the solutions to overcome them.

Maryland Association of Health Care Executives
The Maryland Association of Health Care Executives Program Committee crafted an exceptional lineup of educational content for its members in 2024. The intention was to introduce a variety of new offerings designed to enhance professional development and leadership skills. Here's what took place.

Breakfast Club Series
The chapter launched its first monthly Breakfast Club series in July, which focuses on leadership topics. The inaugural session featured motivational speaker Jerry Bridge, who presented "The Leadership, Productivity and Wellbeing Course for the Healthcare Workforce." Attendees earned 1 ACHE Qualifying Education credit per session.

Lunch and Learn Series
Also in July, the chapter introduced its monthly Lunch and Learn series that covers a broad range of topics relevant to healthcare administration. The inaugural session featured speaker Debra Phairas, who presented "Understanding Work RVUs Calculation and Compensation." Attendees earned 1 ACHE Qualifying Education credit per session.

Virtual Learning Events
To further support its members' continuous learning, the chapter offered seven additional monthly virtual learning events. The first event was titled "Healthcare Compliance: Emerging Trends and Best Practices for Managing Risk." Attendees earned 1.5 ACHE Virtual Interactive Education credits per session.

Annual All-Day Educational Event
The premier event, the Annual All-Day Educational Event: Healthcare Summit of Solutions, held in September, brought together industry leaders and peers for a full day

of learning and networking. The summit featured four engaging panel sessions and a keynote presentation by Mark Bittle, DrPH, FACHE, offering valuable insights to over 100 attendees. With 10 exhibitors showcasing their innovations, the event was a tremendous success, fostering collaboration and knowledge-sharing across the healthcare community. Attendees earned 6 ACHE In-Person Education credits.

ACHE of North Texas

In 2024, with the collective effort of its dedicated members, ACHE of North Texas witnessed some of the most exciting changes in its history. During its yearly strategic planning retreat in 2023, the chapter's president, Aaron Bujnowski, FACHE, presented a challenge to the leadership: "Accelerate!" This strategic theme was not just a directive but a call to action to take this successful chapter to new heights of impact, relevance and connection. And 2024 saw a tremendous acceleration, which is a testament to the commitment and hard work of its members and leaders. Here are three examples:

Less can be more. Traditionally, there's a networking event and a separate mentorship kickoff event each year. In a move to streamline and enhance activities, the networking and mentorship committees decided to merge these events. The result was one of the most invigorating events of the year. New mentees met a wide range of members, not just their mentors. The energy and enthusiasm in the room were palpable, leaving attendees with a sense of optimism and excitement that extended into the mentorship kickoff.

More can be most. The education committee proposed a plan to collaborate with two additional chapters in Texas for a two-day event. The resulting education event had nearly 200 people registered, and the faculty and speakers were energizing and informative. The networking committee also held an event on the evening of the first day for an enhanced experience. Another two-day event is in the works for 2025.

Better Together. With the generous support of sponsors, the chapter expanded its DEI efforts by partnering with the Healthcare Financial Management Association, the Healthcare Information Management Systems Society, the National Association of Health Services Executives, the National Association for Latino Healthcare Executives, and the North Texas Association for Healthcare Quality. It also included the chapter's DEI groups, the Asian Healthcare Leaders Community of North Texas and Women's Healthcare Executives' Network. Nearly 200 attendees saw what it meant to be "better together."

ACHE of North Texas' leaders and members are finding new and better ways to live its mission to be the premier healthcare leadership organization in North Texas. ▲

To find your chapter, search the chapter directory. To discuss your ideas for chapters, contact Stacey A. Kidd, CAE, director, Chapter Relations, Department of Executive Engagement, at (312) 424-9323 or skidd@ache.org.


Dasgupta


Hayes


Lindsay


Manning


Perez-Dickens


Wong

Christopher R. Bjornberg, FACHE, to interim CEO, The Imperial Valley Healthcare District, El Centro, Calif., from CEO, Pioneers Memorial Healthcare District, Brawley, Calif.

Chris Boukas, RN, FACHE, to COO, St. Catherine of Siena Hospital, Smithtown, N.Y., from senior director, Operations, Northwell Health, New Hyde Park, N.Y.

Debasish (Debu) Dasgupta, MD, FACP, FACHE, to inpatient chief medical informatics officer, University Health System, San Antonio, Texas, from CMO, CHRISTUS Santa Rosa Hospital—Westover Hills, San Antonio.

Belinda Farmer to administrator, Mercy Hospital Carthage (Mo.) from operations director, McClinton Cancer Center, Baylor Scott & White, Waco, Texas.

Gordon B. Ferguson, FACHE, to retirement, effective end of June 2025, from president and CEO, Ascension Saint Thomas Rutherford Hospital, Murfreesboro, Tenn. We thank Gordon for his many years of service to the healthcare profession.

Shane Hayes to chief administrative officer, Deaconess Gibson Hospital, Princeton, Ind., from CNO.

Greg Kharabadze, FACHE, to senior associate dean and chief operations and finance officer, Keck School of Medicine, University of Southern California, Los Angeles, from executive director, Business Administration & Strategic Initiatives, Yale School of Medicine, New Haven, Conn.

Kelly Lindsay to CEO, HCA Florida Englewood Hospital, from COO, HCA Florida Brandon Hospital.

Nicholas Manning, FACHE, to CEO, West Valley Medical Center, Caldwell, Idaho, from COO, HCA Eastern Idaho Regional Medical Center, Idaho Falls.

Kevin Matson, FACHE, to vice president, Regional Hospitals, Southern Market, Northeast Georgia Health System, Gainesville, Ga., from vice president, Northeast Georgia Health System.

Maggy Perez-Dickens to president, Holy Cross Medical Group, Ft. Lauderdale, Fla., from senior administrative officer, University of Miami, Department of Neurological Surgery and Department of Psychiatry and Behavioral Sciences.

Jason Willliams, FACHE, to chief strategy officer, Cigna Healthcare, Birmingham, Ala., from IFP market vice president.

Quyen Wong, DNP, RN, NE-BC, to associate executive director, patient care, and CNO, Northwell Northern Westchester Hospital, Mount Kisco, N.Y., from senior director, centralized nursing and clinical operations, NYU Langone Health.

Want to submit?

Send your "On the Move" submission to he-editor@ache.org. Due to production lead times, entries must be received by Feb. 3 to be considered for the May/June issue.

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