HEALTHCARE EXECUTIVE

The Magazine for Healthcare Leaders
MAR/APR 2025
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Pathways to Improved Quality and Safety

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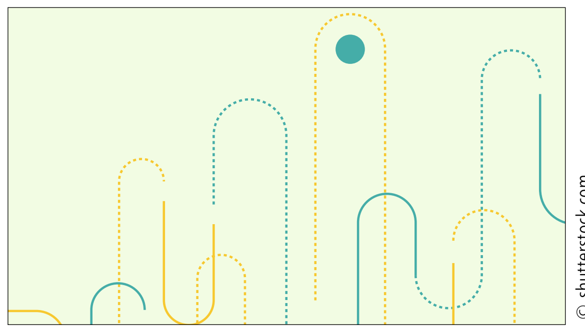

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Organizations are innovating and producing tangible outcomes on an impressive array of fronts.

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Michele K. Sutton, FACHE, will assume office as Chair of ACHE March 22. She is president/CEO, North Oaks Health System, Hammond, La.

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Fresh, Exclusive Content

Read the following article only at **HealthcareExecutive.org/WebExtras**:

5 Examples of How Leaders Can Bring the Organization's Mission and Values to Life

There are many ways that leaders can bring an organization's mission and values to life in their everyday work. One example includes every time a leader is asked to address an individual or group inside or outside of the organization, he or she begins and ends their comments by quoting the mission in some fashion, weaving in how the subject being addressed helps the organization to deliver on it.

Recent *Healthcare Executive* Podcasts

You can find the following interviews and more at **HealthcareExecutive.org/Podcast** or search for "Healthcare Executive" in iTunes or your podcasting app of choice:

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In "Empowering Women in Healthcare: Leadership and Insights," **Jessica Long**, COO, and **Rachel Thompson**, MD, CMO, Core Clinical Partners, discuss their career journeys, the future of healthcare leadership for women and the essential skills needed to be successful in the field.

In "The Future of Work in Healthcare: 2025 and Beyond**," Peter Miscovich**, executive managing director/global future of work leader, JLL, discusses the future of work in healthcare in 2025 and beyond.

HEALTHCARE EXECUTIVE

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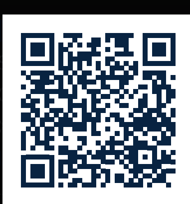

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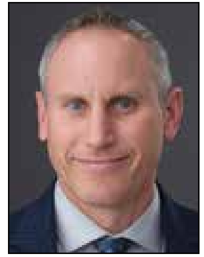

Randy F. Liss

What's Working on Our Quality and Safety Journey

If you ask experts what the next big breakthrough in quality and patient safety might be, most quickly point to artificial intelligence and the promise it holds in transforming care delivery. For example, a recent report by Wolters Kluwer Health includes the outlook of its CEO, Stacey Caywood, who believes that this year we'll see "AI solutions that go deeper into live health data to identify disconnects in care that are often overlooked and can impact patient safety." It's an exciting prospect, to be sure.

Also instructive is studying what's working today, and our cover story, "Pathways to Improved Quality and Safety" (Page 20), dives into three efforts that have made tangible care delivery improvements in their respective communities. By leaning into education, technology and processes, these health systems are taking significant steps forward to ensure positive outcomes for all patients.

Also in this issue, get to know Michele K. Sutton, FACHE—ACHE's Chair as of March 22. Our annual profile of the incoming Chair (Page 10) offers a view of her unique career journey, her leadership style and her priorities for her 2025–2026 term.

Thank you so much for reading. 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

The Value of Mentoring

It's an important part of any leadership journey.

As leaders, people are at the center of our work. How we influence, motivate and guide people and teams can determine success—theirs and ours. In fact, one could argue that investing in others is the secret sauce that fuels engagement and satisfaction, which often extends positively to those receiving care.

As a professional society, mentoring others has been the bedrock of ACHE, and thousands of leaders have volunteered their time to help others and shape healthcare management. It's no surprise then that our own core value of leadership states, "We lead through example and mentoring and recognize caring must be a cornerstone of our professional interactions."

In a world that is increasingly complex, mentors can be an important part of growing leaders by sharing experiences and insights. Mentors also benefit from learning across generations, disciplines and settings. These relationships don't replace job experiences; they add to them and expand our points of view.

The traditional premise of mentoring is a partnership between a seasoned professional (the mentor) and lesser experienced individual (the mentee). While still true and needed, the health industry is far from linear, suggesting that we, too, could expand our thinking. When executives build relationships with intention with those across the care spectrum, we embellish our mutual understanding and effectiveness as leaders. We both benefit.

Following suit, mentoring relationships are also taking on new forms. For example, peer mentorship offers a more informal approach in which professionals can glean expertise from colleagues with a similar level of experience. Mentoring circles go beyond the typical one-on-one approach and lean into mentors to provide a more diverse and rich experience in a small-group setting. Reverse mentoring flips the traditional mentor-mentee relationship and can focus on closing intergenerational gaps in communication.

Given today's constant change, leaders need a collaborative, open and growth-oriented mindset. Building relationships that cross traditional boundaries allows us to learn and see new possibilities in ourselves and in our work. Being open to others in experiences and conversations can strengthen our insights and contributions.

As Laurie Baedke, FACHE, writes in her book, *Mentor, Coach, Lead to Peak Professional Performance*, "broadening our perspective and definition of mentorship gets to the very heart of what these efforts aim to do in the first place—to propel us forward as professionals and leaders." Those interested in pursuing a mentoring relationship have various resources available.

ACHE's Leadership Mentoring Network matches professionals with an ideal mentor based on career level, business function, leadership competencies and goals. It can be accessed at **ache.org/Mentoring**. Also, our recently refreshed Mentor-Mentee Guide offers tips, exercises and insights on how to ensure a productive mentoring experience and is available at **ache.org/Mentor-MenteeGguide**. Additionally, the ACHE Policy Statement "Responsibility for Mentoring" is newly revised and available at **ache.org/Responsibility-for-Mentoring.**

At the local level, many chapters offer their own mentoring programs that can help you make connections closer to home. To locate your chapter, you can use ACHE's Chapter Directory at **ache.org/Chapters**.

On a global scale, the International Hospital Federation is conducting a mentoring circles pilot project this year. The project features four small regional groups designed to foster growth through dialogue and mutual learning. ACHE and The Equity Collaborative are providing support, and we look forward to sharing our experiences with you as they evolve.

Mentoring can be an important part of any leadership journey, one that helps both sides learn and grow. By prioritizing mentoring as a tool to develop and help others, we can embrace the richness of our uniqueness and cultivate a new generation of leaders. We look forward to supporting your journeys as we shape a stronger, more collaborative healthcare leadership workforce. ▲

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

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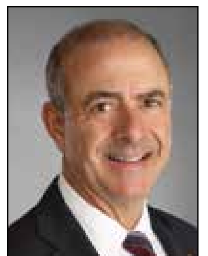

William "Bill" P. Santulli, FACHE

Moving Forward Together

ACHE's Outgoing Chair reflects on his term.

Serving as Chair of ACHE during the past year has been one of the top highlights of my professional journey. It has been a privilege to support our more than 50,000 members, who are deeply committed to advancing healthcare leadership. As I reflect on my term, I am grateful for so many things.

High on the list is the opportunity to partner with some incredible professionals. My talented colleagues on ACHE's Board of Governors, as well as ACHE President/CEO Deborah Bowen, FACHE, CAE, and her world-class leadership team, have been extraordinary. In addition, the nearly 1,900 volunteers who share their talents with members of our 76 Chapters have my sincere gratitude. Every time I visited with one of our Chapters, I was inspired by their tireless efforts to offer outstanding education, networking and recognition events at the local level.

I also am grateful for the tremendous amount I've learned during the past 12 months. For example, I had the opportunity to attend the International Hospital Federation's 47th annual World Hospital Congress in Rio de Janeiro, Brazil. The Congress was an awesome venue to meet and share ideas with healthcare leaders from around the globe. We all face many of the same challenges as we endeavor to improve the health status of the patients and communities we are privileged to serve. Interacting with healthcare leaders from Europe, Asia and South America helped widen my aperture. We have so much to learn from our global colleagues.

Additionally, leading the Board of Governors' work to develop ACHE's 2025–2027 Strategic Plan has been greatly rewarding, and I'm very proud of where we have landed as well as our process for getting there. Working with the Chartis Group LLC, we took feedback from you—our members—and other thought leaders across the country and the continuum of care to establish a clear path forward for ACHE. The result is a new Strategic Plan that positions us to best support you and our field in our shared commitment to advance health for all.

It has been an honor to be part of several major accomplishments and initiatives that ACHE achieved during the past year, including the following:

- Hosting a 2024 Congress on Healthcare Leadership that was ACHE's largest and most successful ever, and positioning our 2025 Congress for even greater success in Houston.
- Strengthening partnerships with our chapters, as evidenced by the offering of a pilot program to support 10 Chapters this year with administrative compliance services.
- Leveraging new technologies, including a customer engagement platform and refreshed website that will be unveiled later this year, to improve your experience with us.
- Significantly growing interest in ACHE online, reaching more than 200,000 followers on LinkedIn.

In the coming years, our industry will continue to transform and change at an accelerated pace. Our aging population, emerging technological solutions and new drug discoveries are just a few drivers of that. Against this backdrop, ACHE is committed to fully supporting its members every step of the way as we move forward together.

Thank you for this incredible opportunity to help lead the very best healthcare leadership development organization in the world. It has been an honor and a privilege. ▲

William "Bill" P. Santulli, FACHE, is ACHE's 2025–26 Immediate Past Chair and operating partner, Water Street Healthcare Partners, Chicago. (bill.santulli@waterstreet.com)

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A Profile of ACHE's 2025–2026 Chair

By Jennifer K. Ahearn

Armed with a strong work ethic, Michele K. Sutton, FACHE, began her career in bank marketing, but it wasn't until a family member became ill and was admitted to the local community hospital that her career trajectory made a major shift.

Sutton had heard the hospital didn't have the best reputation, but to her surprise, she and her family had a *great* experience. Sutton witnessed the compassion and intentionality with which staff dealt with her family, and she began thinking to herself that this facility had a story to tell. She wanted to be the person to tell it.

"After what I had just experienced, somebody needed to tell their story; the hospital staff were amazing," shares Sutton. She felt so strongly that she could use her marketing skills to help the hospital that she reached out to the marketing director. When she learned that the director was getting ready to retire, Sutton applied for the job.

Despite having many connections through her involvement with numerous community, business and civic organizations, she didn't even get an interview. Sutton says she was "mortified."

Undeterred and still wanting to make an impact, Sutton reached out a few weeks later to the person they hired, who happened to be new to the area. Sutton offered to introduce the director to the community, and soon the newcomer joined her at various community meetings.

Six months later Sutton received a phone call that the new marketing director was leaving the hospital. Eager not to miss the opportunity, Sutton put her application in again. She

Michele K. Sutton, FACHE

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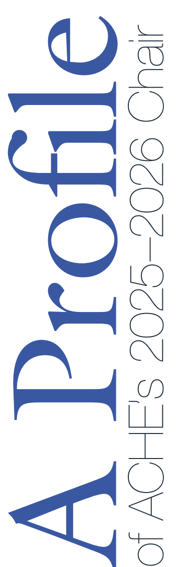

> "Michele is a committed, caring and visionary leader who lives out the values and benefits of her ACHE involvement on a daily basis."
>
> **—David Pearson, FACHE**
> **American Hospital Association**

not only secured an interview, she got the job. "I was a one-person administrative director of marketing," says Sutton.

Over time, Seventh Ward General Hospital, Hammond, La., that small community hospital, started growing. It was doing well, and every time the CEO asked for volunteers from the executive team to head up this or that new department, Sutton raised her hand. As she says, "I was young, energetic, and I'd say, 'I'll take it.'" Because she lacked a background in healthcare, Sutton wanted to go work in those departments to truly understand how to lead them.

When confronted by a medical acronym she didn't readily understand, she took a course to become certified as an emergency medical technician. "This course was the quickest way for me to get an infusion of healthcare education and gain credibility while doing my clinicals in our emergency department and with the local ambulance service. I knew I never wanted to be in a position to be embarrassed again if I could prevent it through education." Sutton's depth and breadth of knowledge now extends to every department at what, in 1993, was renamed North Oaks.

And that small facility grew into the North Oaks Health System, of which Sutton—now president and CEO—oversees daily operations. The system includes: North Oaks Medical Center, North Oaks Rehabilitation Hospital, North Oaks Physician Group, three outpatient rehabilitation and sports performance centers, an ambulatory surgery center, two outpatient diagnostic centers, a hospice agency, a dietetic internship program, graduate medical education residency programs and a school of radiologic technology.

Sutton is proud of the more than 3,000 employees who work at North Oaks Health System and the quality of care they provide to the community. As she says, "We take our role as the leading healthcare provider in our region very seriously."

Healthcare Is a Calling

Key aspects that define Sutton's leadership style are what actually propelled her from marketing director to leading North Oaks: a positive attitude, highly ambitious, fearless when faced with a challenge and a lifelong love of learning.

"Michele's depth of understanding of all aspects of the healthcare industry is evident in her proven experience and comprehension of the value of every team member supporting the highest quality healthcare outcomes," says William S. Wainwright, PhD, president, Southeastern Louisiana University.

For instance, Sutton proudly reminds the North Oaks environmental services staff that they are part of the healthcare

WORK HISTORY

2017–Present
North Oaks Health System, Hammond, La.
President/CEO

2008–2016
North Oaks Health System, Hammond, La.
Executive Vice President/COO

2006–2008
North Oaks Health System, Hammond, La.
COO

1992–2006
North Oaks Health System, Hammond, La.
Community Resources Officer

1988–1992
Seventh Ward General Hospital, Hammond, La.
Administrative Marketing Director

1985–1988
First Guaranty Bank, Hammond, La.
Marketing Officer

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team and just as important as the surgeons. "In the OR, surgeons perform lifesaving techniques, but once patients are moved to our surgical intensive care unit, how well that area is cleaned contributes to whether or not patients live. So, when you ask one of my environmental services staff members what do they do here, they'll tell you they save lives—and in my view, they absolutely do," says Sutton.

Sutton's expertise in team building extends beyond her organization. Paul A. Salles, president and CEO, Louisiana Hospital Association, has seen her in action as she worked with experts across academia and healthcare to evaluate options and make recommendations for reforming healthcare workforce training and development in Louisiana. "Michele is a proven collaborator who is skilled at bringing diverse groups to consensus," says Salles.

Sutton sees this as a crucial skill. "When you combine a diverse group of professionals who have built a relationship forged in trust, this is when leaders soar and greatness is achieved," she says.

Sutton views healthcare as a calling, and it's clear in the way she leads her organization. "It's an opportunity for us to make a difference in somebody's life, a meaningful lasting impression," she says. "People come to us at their worst, most vulnerable times of crisis. And how we act will be with them for the rest of their life."

An example of this was at the start of the COVID-19 pandemic, when a tragic accident occurred involving a state trooper who was transported to North Oaks in critical condition. The governor's stay-at-home order was in place, but the trooper's young wife, family members and 60 state troopers arrived at the hospital wanting to see the injured man. Sutton made the decision to honor the wishes of the family and the troopers and allow them to visit—albeit masked and one at a time—because she knew how important it was to those grieving. She would have to deal with the governor later.

When Sutton learned that the trooper's wife was seeking a third opinion outside her organization, she reached out to her ACHE network because she knew transporting such a critically injured patient wasn't an option. Her connections led her to the medical director at LSU's neuroscience department. The neurosurgeon reviewed the chart and came to the same heart-wrenching conclusion as the physicians at North Oaks. But

1991 and 1998–2004

Southeastern Louisiana University College of Business, Hammond, La.
Adjunct Faculty

ACHE HISTORY

Chair, 2025–2026
Chair-Elect, 2024–2025
Governor, 2020–2023
Regent for Louisiana, 2015–2018
Southeastern Louisiana Chapter President, 2013 and 2014
Southeastern Louisiana Chapter Vice President, 2011 and 2012

EDUCATION

MBA, Southeastern Louisiana University, Hammond, La.
BA, Southeastern Louisiana University, Hammond, La.
EMT, Northshore Technical Community College, Hammond, La.

CURRENT AFFILIATIONS

Louisiana Hospital Association
Louisiana Emergency Response Network Commission
LHA Trust Funds Board
Northshore Healthcare Collaborative
Northshore Business Council
Women's Healthcare Executive Network (New Orleans Chapter)
Community Hospital Coalition

CURRENT COMMUNITY INVOLVEMENT/SERVICE

Hammond Rotary Club
Lion Athletics Association
FeLions Chapter
Southeastern Louisiana University Alumni Association
Lifetime Member of the Alumni Association
Southeastern Louisiana University College of Business Advisory Board
Tangipahoa Chamber of Commerce
Committee of 100 for the State of Louisiana

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"Michele's depth of understanding of all aspects of the healthcare industry is evident in her proven experience and comprehension of the value of every team member supporting the highest quality healthcare outcomes."

—William S. Wainwright, PhD
Southeastern Louisiana University

instead of delivering the news over the phone, the director flew by helicopter to North Oaks to speak with the trooper's wife in person. As difficult as it was, this provided her the peace she needed to take her husband off life support. Today, the trooper's wife sits on North Oaks' Council of Family Advisors to provide Sutton feedback to help other families in similar situations.

As a leader, Sutton also believes in developing the talents and skills of those around her. One of her favorite quotes from Eleanor Roosevelt reflects this guiding principle: "For your own success to be real, it must contribute to the success of others."

Though Sutton didn't serve an internship or fellowship in healthcare, she finds time to nurture the talents of those entering the field. Trey Holmes counts himself lucky to have been placed at North Oaks as part of a residency program for his MHA. "I was inspired and driven in Michele's vision for me, her team and the entire region," says Holmes, now associate director, Transformation & Strategy, Optum Health Intake Operations.

Kassandra Brooks, who participated in ACHE's mentorship program as a graduate student under Sutton's tutelage, says, "The most gifted mentors are those who help unveil the talent and ability within you and introduce you to a world in which anything is possible. Michele has a remarkable ability to stimulate a drive toward excellence with everyone around her."

ACHE: A Trusted Partner

Sutton, who will assume her role as ACHE's Chair on March 22 during this year's Congress on Healthcare Leadership, is excited to have the opportunity to pay it forward and share her story of healthcare leadership and partnership. She wants everyone to know how valuable her ACHE membership has been to her.

"I didn't come the traditional route, with a Master of Healthcare Administration. I learned by the seat of my pants with a trusted partner, which was ACHE," she says.

Sutton's on-the-job training was bolstered by knowledge, tools and resources from ACHE. "They're all tested. They're vetted. And then I just get to apply them here," she says, "so that I come out looking like a shining star."

It wasn't until Sutton was transitioning to the role of COO at North Oaks and sitting on a statewide committee of CEOs from across Louisiana, in a large hospital service district, that she started noticing five letters after everyone's name. She quickly realized that she needed to join ACHE and earn the coveted FACHE® credential. She considers it her mini-MBA in healthcare.

At her first Congress she attended the COO Boot Camp session. That eight-hour, daylong course was an infusion into healthcare operations, finance and everything she'd worked with during her career. It also filled in the few gaps in her background.

Sutton recalls a previous hospital CEO who didn't believe in giving advice. Instead, he wanted to see people take initiative. When Sutton was offered the opportunity to take on her first construction project, she didn't hesitate. She admits she didn't know what a white box was, how many K watts was needed for a particular

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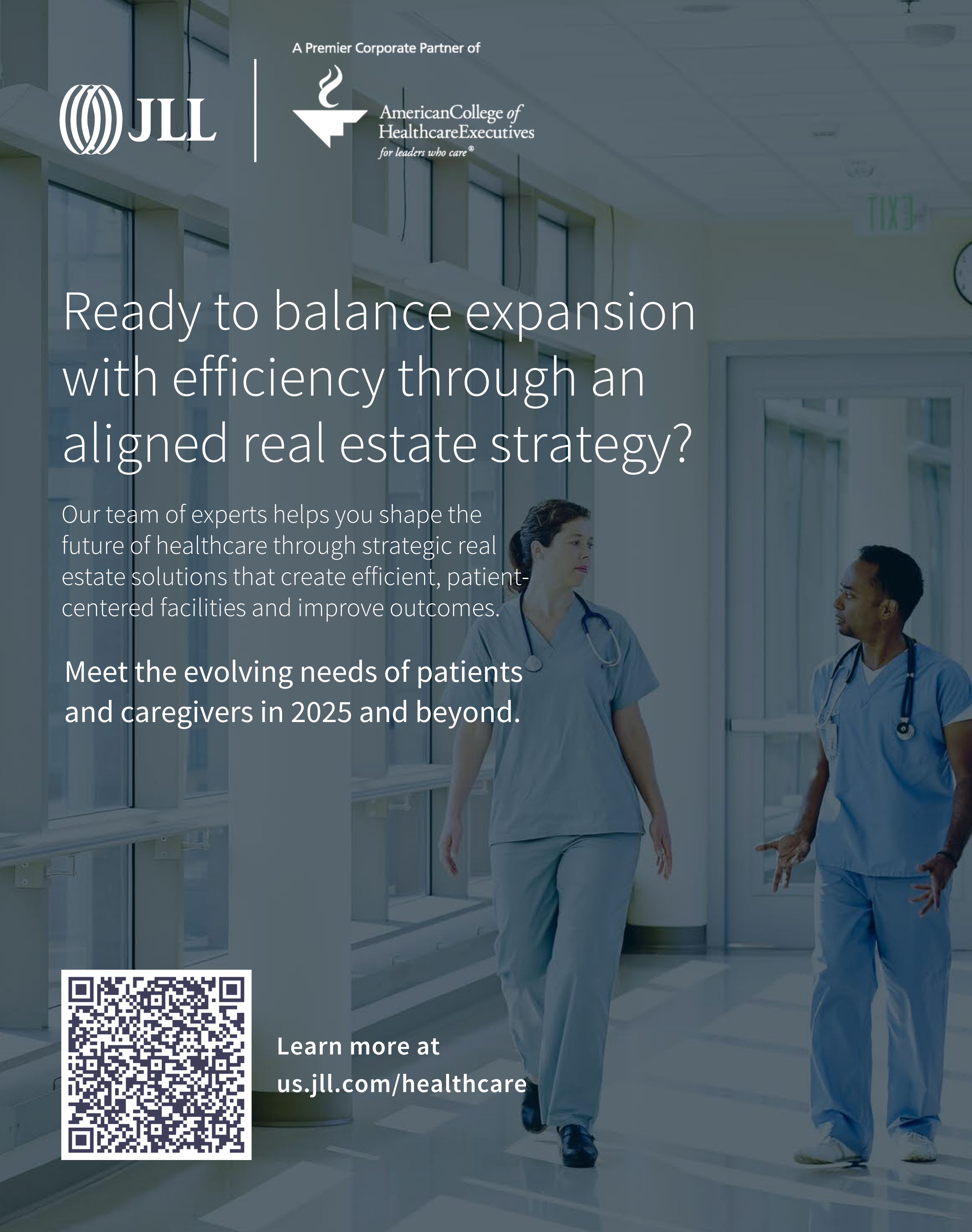

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generator, or how much steam came out of the boiler. But she jumped in with both feet because she knew her ambition, paired with ACHE resources, would show her the way.

"Michele is a committed, caring and visionary leader who lives out the values and benefits of her ACHE involvement on a daily basis," says David Pearson, FACHE, regional executive, American Hospital Association. Pearson notes that Sutton's colleagues have come to look to her for her deep knowledge and thoughtful insights.

Sutton gives credit to ACHE, saying there's not one person who hasn't gone above and beyond to connect her with the right people. "Partnering with ACHE, which had all the subject-matter experts so I could just pick up the phone and call a friend, was the best blessing," says Sutton.

"Now my hospital is recognized as one of the top financially best-performing healthcare systems in the United States," she says. "I couldn't have done that and turned this place around culturally and financially had it not been for all the ACHE education that I received."

A Catalyst for the Future

Sutton believes that going forward, ACHE can capitalize on its educational offerings to increase value to its members. She sees ACHE as a one-stop shop for all leadership education, core competency education and digital learning modules. "With constricting budgets, many of us are searching for comprehensive solutions," says Sutton.

She would also like to provide more turnkey services for local chapters and investigate offering sub specializations for members to differentiate themselves in the marketplace.

Sutton acknowledges that the past several years have been extraordinarily challenging for healthcare professionals, as many have left the industry. Yet, she also sees opportunity. Other sector leaders view healthcare as a stable career choice and want to enter the field. She sees herself as a perfect example of what ACHE can offer new members coming from outside healthcare.

"A lot of people are entering our industry because it's stable. I can show how you can transcend and be successful," says Sutton.

Sutton wants to share how ACHE has impacted her healthcare leadership efforts and the lives of so many others. One way is through self-reflection and intentionality.

North Oaks had set a goal of hiring individuals who reflected the communities they served, but those weren't the applicants they were seeing. Sutton did some self-reflection and asked herself the tough question: "Are you being intentional in changing the face of your organization?" She and her staff came up with a plan.

Sutton met with the local community college about developing a demonstration project whereby 26 of North Oaks' best medical assistants, from disadvantaged backgrounds, would participate in a yearlong, accelerated licensed practical nurse program. Instead of working as medical assistants, they instead would attend school full time, receiving free tuition and maintaining their current salary and benefits. At the end of 2023, upon graduation, the medical assistants would give North Oaks a five-year work commitment as LPNs in the North Oaks hospitals.

"In just 12 months, North Oaks gained 26 new nurses," says Sutton. "They had a 100% graduation rate and 100% state board passage. We had a lot of single mom students who could never have afforded to go to school because they had to provide for their child. It was the proudest day of my life when I went to their graduation, to know we changed that many lives. They tripled their annual wage."

The plan worked so well that the second cohort began earlier this year. "I don't know whether I would have been looking for opportunities and truly, intentionally focused if it hadn't been for the ideas that I got by being a part of ACHE."

"I can think of no better way to repay the tremendous benefits I have received through my membership and engagement with ACHE," says Sutton, "than to take this next step as Chair and leverage my talents to ensure others' successes."

Jennifer K. Ahearn is publications editor with Healthcare Executive.

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Doing More With Strategic Partnerships

Collaborative relationships lead to laboratory excellence.

Today's healthcare organizations are being tasked to do more with less. This reality makes strategic partnerships more appealing for organizations seeking to gain efficiencies in key operational and financial areas.

When it comes to operating a streamlined laboratory, collaborative relationships play a vital role in delivering safe, quality and cost-efficient care. These partnerships can allow labs to do more with more.

Strategic partnerships can offset some of the pressures healthcare organizations face today, including financial challenges and workforce shortages, says Michael Lukas, senior vice president, Health Systems, Quest Diagnostics, Secaucus, N.J. They can also expand organizations' access to new and evolving technologies and drive and accelerate standardization, he adds.

As organizations look to form collaborative relationships to enhance and evolve their labs, following are several qualities to keep in mind.

Find a "Partner," Not a "Vendor"
A great lab partner listens to the organization's needs and understands its vision for the laboratory program.

"A partner works to solve your challenges and meets you where you're at," Lukas says. "The customer dictates the areas that they want to work on and in what order they want to work on them. This is where your partner should really listen to you. Ultimately, it's your lab, your hospital, and you know more about the local environment than we do, so having your partner meet you where you are is critical."

A strategic lab partner should also be flexible to a changing marketplace. One way to ensure this is through a shared governance model. Such a model, in which dedicated teams and committees work together to execute agreed-upon concepts, actions and priorities, allows Quest to maintain close alignment and collaboration with its health system partners and to quickly address emerging concerns.

Committees comprise stakeholders from both the health system and Quest and cover areas such as supply chain, finance, technology and physician relations. The health system maintains control throughout the governance process with guidance and execution support from Quest. All committees meet regularly.

"Having a governance model in place that facilitates change easily is incredibly important because we all know things are going to change," Lukas says. "During the pandemic, for example, each of our strategic lab partnerships required uniquely different responses. Our deployment of flexible models to address each scenario was crucial to success."

Seek a Partner That Aligns on Mission

All healthcare organizations have a mission, and a good strategic lab partner should be aligned with it.

When Quest Diagnostics reviews an organization's lab, whether helping it define its strategy, perform network optimization, grow its outreach business or reduce its costs, Quest supports that organization's mission, says Lukas.

For instance, Quest recently partnered with New Jersey-based St. Joseph's Health, and keeping the organization's mission of taking care of the underserved in the Paterson, N.J., community front and center was essential.

"What they do in that community is really important," Lukas says. "There should be no compromise on the service their patients can expect. Therefore, every element that we incorporated to help St. Joseph's provide word-class care while remaining profitable had to support that mission."

Factors Lukas and his team considered while tailoring laboratory solutions to meet St. Joseph's needs included driving down costs, improving lab service across the health system, bringing in new technology capabilities and improving overall care. Never asking the health system to compromise on its mission has been a hallmark of the relationship.

"From the beginning, we felt confident that Quest shared our dedication to outstanding service," says Lisa Brady, senior vice president/interim COO, St. Joseph's Health. "That commitment to excellence provides our patients with the same efficient and accurate testing they rely on."

"It's about making sure we're creating an environment where we're facilitating their mission and delivering solutions in a way that the health system is going to spend less money without compromising on the service their patients should expect," Lukas says.

Make Sure the Partnership Brings Value

When St. Joseph's partnered with Quest Diagnostics, "It had a great laboratory," Lukas says. But the health system needed a partner to get even more value out of its lab services—and to help it reduce lab costs, increase efficiencies and fill staffing gaps.

Lukas and his team approached these concerns on multiple fronts. One key to creating more value was an emphasis on lab stewardship—making sure the care team was offering "the right test to the right patient at the right moment in time," Lukas says.

Quest Diagnostics deployed its Lab Stewardship solutions, which use real-time lab data to assess lab test utilization. The insights gleaned are used to improve test use, driving evidence-based care, which helps reduce costs.

A strategic lab partner looks for opportunities to increase efficiencies, which includes focusing on care standardization and reducing over- and under-utilization of lab tests to better serve patients, according to Lukas.

"Organizations should consider questions such as, 'Should a test have been ordered based on these circumstances to potentially diagnose the patient faster and begin to treat them more quickly?'" he says. "Knowing this has positive benefits such as patients having their issues addressed sooner or experiencing shorter lengths of stay."

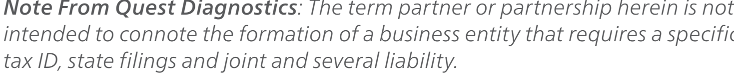
Finally, in addition to bringing technology capabilities and tools, a strategic lab partner ideally should come with a lot of experience working with a variety of health systems. Lukas' team is continuously learning from and leveraging that experience to improve others' labs.

"We have completed numerous test stewardship engagements and high value-added projects, and we're developing quite a playbook around how to execute this knowledge in the areas of underutilization, overutilization and care variation," he says.

That breadth of experience pushes Quest Diagnostics to continuously seek ways to enhance healthcare organizations' lab programs.

"We're constantly finding ourselves stretching to find new value-enhancing ideas and solutions for our partners," Lukas says.

For more information, please contact Michael Lukas, senior vice president, Health Systems, Quest Diagnostics, at HealthSystems@QuestDiagnostics.com.

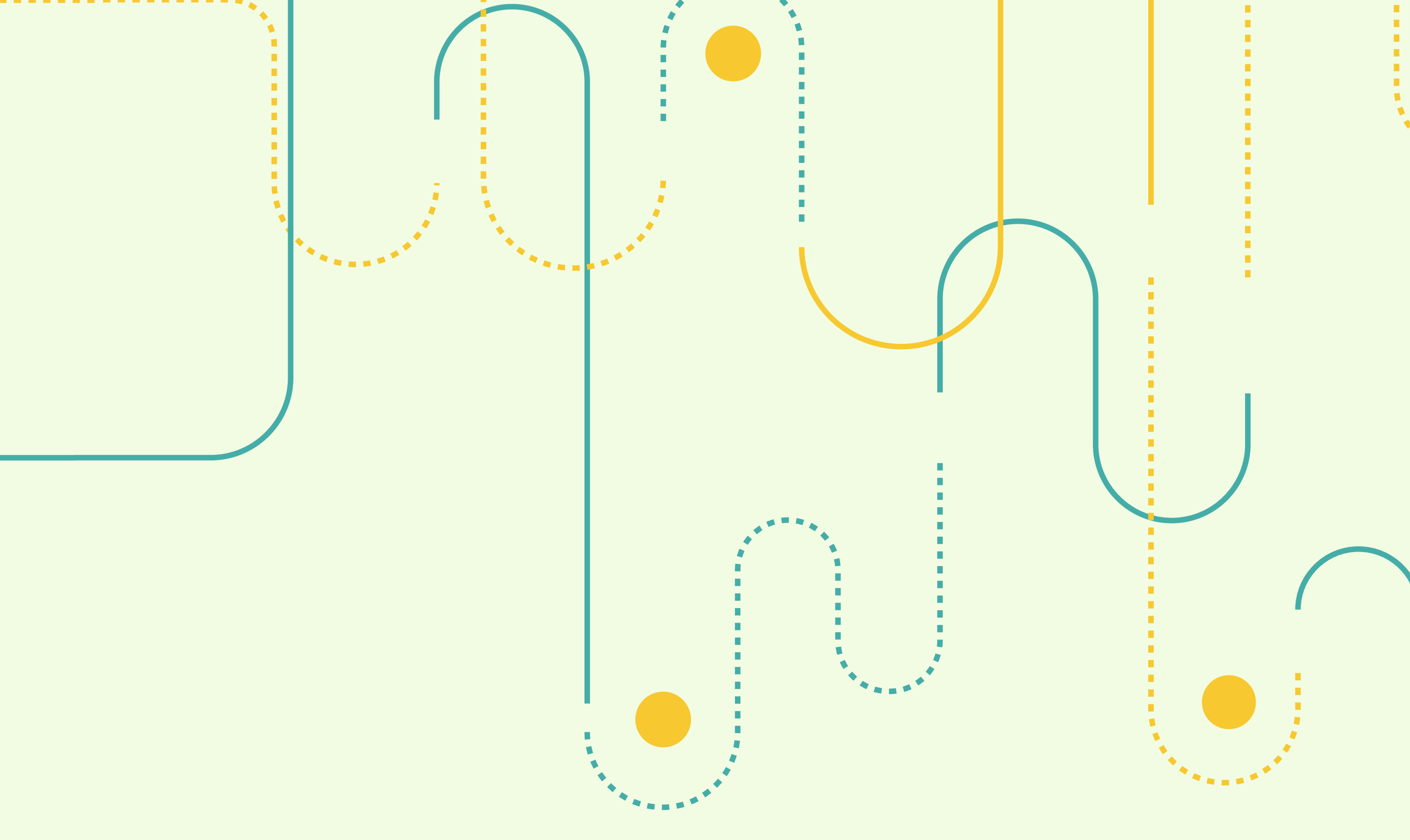


***Note From Quest Diagnostics**: The term partner or partnership herein is not intended to connote the formation of a business entity that requires a specific tax ID, state filings and joint and several liability.*

Pathways to Improved Quality and Safety

By Susan Birk

When it comes to healthcare's leading priority, and given the increasing complexity of care delivery, organizations are innovating and producing tangible outcomes on an impressive array of fronts.



Between April 2023 and March 2024, safety improvements enabled an estimated 200,000 patients to survive episodes of care they wouldn't have in 2019, according to the American Hospital Association. The AHA also highlights reductions in central line-associated bloodstream infections and catheter-associated urinary tract infections in the first quarter of 2024 compared with the first quarter of 2019.

Underlying much of that progress is the growing understanding of the value of a quality and safety culture driven by senior leadership and grounded in a comprehensive framework that sees the interconnectedness among disparate elements of quality and safety across disciplines and systems. Initiatives developed by the Institute for Healthcare Improvement through the National Action Plan to Advance Patient Safety and ACHE through its *Leading A Culture of Safety: A Blueprint for Success* have helped guide the way.

The following three quality and safety profiles show what can happen when an organization puts vision, imagination and a far-reaching, un-siloed mindset into practice.

Northwestern Medicine's Academy for Quality and Safety Improvement

Launched 10 years ago by the Department of Medicine to address a need for quality improvement education, Northwestern Medicine's Academy for Quality and Safety Improvement trains interdisciplinary teams of clinicians to solve specific quality and safety problems in their units and departments, with an eye on sustainable results.

Kevin J. O'Leary, who oversees the Academy for Quality and Safety Improvement as vice president of quality for Northwestern Memorial HealthCare, says AQSI helps fill gaps in specific improvement techniques professionals may not have received during their education and postgraduate work.

A 2021 study published in the *Joint Commission Journal on Quality and Safety* revealed measurable improvements in care and a high level of subsequent involvement in QI among clinicians following AQSI participation.

Based on the DMAIC, or Define Measure Analyze Improve Control methodology, training across AQSI's

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seven-month term also incorporates instruction in core quality and safety topics such as patient-centered care and change management.

After its start in the departments of Medicine, Emergency Medicine and Surgery at Northwestern Medicine's flagship Chicago campus, AQSI expanded its offerings to the system's 11 hospitals and 200 locations five years ago.

Interested teams go through a competitive but inclusive application process, with final selections made by a steering committee. In both classroom and experiential learning settings, mostly on-site but also remotely, the selected teams receive ongoing support from a performance coach/Six Sigma expert, a data analyst and access to IT expertise, as well as education in change leadership taught by Northwestern Medicine's CMO.

"AQSI gives clinicians opportunities to tackle aspects of care that might otherwise fly under the radar."

—Kevin J. O'Leary
Academy for Quality and Safety Improvement
Northwestern Memorial HealthCare

Midway through the term and again at completion, teams present their work and share feedback with each other, while an Improvement Council of seasoned quality officers and performance improvement leaders from across the system lead some of the classes and provide deeper critiques and guidance. "The two sources of feedback offer a blend of complementary input that helps teams fine-tune their work in a more meaningful way," O'Leary says.

At the height of the opioid epidemic five years ago, AQSI gave an interdisciplinary team of physicians, nurses and allied professionals the opportunity to reduce opioid overuse in the ED using DMAIC. The team developed modifications in discharge medication orders and protocols that led to significant and lasting reductions in unnecessary opioid prescriptions, reducing the risk of opioid dependence among patients after leaving the ED.

Another team of clinicians used their AQSI training to improve timely access to bedside interpreters for patients with limited English proficiency. The team developed a system to help Northwestern's Interpretation Services Department readily identify the location and preferred language of limited English proficiency patients and coordinate their schedules with rounding clinicians so they could be there when needed. "The system offers a timely alternative to calling interpreters on the phone or having to move ahead with care without an interpreter at the patient's side," O'Leary says.

AQSI complements Northwestern Medicine's standard quality assurance reporting because "those measures don't represent anywhere near the full scope of the care that we provide," O'Leary notes. "AQSI gives clinicians opportunities to tackle aspects of care that might otherwise fly under the radar."

Follow-up surveys show sustained improvement in two-thirds of AQSI projects at 18 months. "If it were 100%, I'd worry that the teams weren't tackling the hardest problems, but if it were lower, I'd be disappointed that we weren't having more success. Two-thirds seems about right," O'Leary says.

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O'Leary believes other health systems can and should embark on comparable QI training initiatives. "It takes resources, but the benefits to patients and staff offer a return on investment," he says. "After 10 years, we still have no shortage of people who want to participate because they've heard about all the great work done by people before them."

Kaiser Permanente Northern California's Advance Alert Monitor

Kaiser Permanente Northern California's homegrown automated Advance Alert Monitor has significantly reduced ICU admissions among hospitalized patients during the eight years since its introduction, addressing an important quality and safety need across the region's 21 hospitals, according to Robin Betts, RN, vice president of safety, quality and regulatory services.

> "We felt that many of these ICU transfers could be prevented, so we wanted to see if we could move upstream to anticipate problems earlier."
>
> —Robin Betts, RN
> Kaiser Permanente Northern California

A study of the region's data revealed significantly higher mortality rates among patients following transfers to the ICU from the medical/surgical units than among direct admissions to the ICU from the ED (58% and 22%, respectively). Delays in care led to most of the disparity.

While patients who transfer to the ICU are a small proportion (about 3%-4%) of the system's hospital admissions, these patients represent an oversized burden, accounting for 20%-25% of hospital deaths and ICU admissions.

The data showed that 50% of those ICU transfers happened within the first 24 hours and 80% within the first 48 hours of admission to the med/surg units. In addition, many of the ICU transfers stemmed from conditions that were present on admission but not detected until the patient had already begun to deteriorate.

"We felt that many of these ICU transfers could be prevented, so we wanted to see if we could move upstream to anticipate problems earlier," says Betts.

Researchers at the Kaiser Permanente Northern California Division of Research developed a predictive algorithm which, combined with a standardized workflow, enables clinical teams to identify hospital patients at risk for deterioration, giving a 12-hour lead time that allows them to intervene and adjust care plans sooner.

"The beauty of this algorithm—and what makes it unique among early warning systems—is that it's very sensitive to small changes in the patient's physiology," notes Betts. The Advance Alert Monitor analyzes more than 100 clinical variables hourly as well as the interplay between those variables, creating a dynamic picture of the patient over time.

That sensitivity, fueled by the rich datasets available through Kaiser Permanente Northern California's integrated delivery system, shifts the clinical escalation pathways for med/surg patients from reactive to proactive intervention.

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To reduce distractions for nurses on the floor, and after pilot testing various models, the region found that embedding a dedicated team of virtual nurses with quality expertise to proactively monitor the system's dashboard offered the best workflow. The automated tool delivers hourly scores 24/7, triggering an alert if a patient's score exceeds a potentially problematic predictive threshold.

In the event of an alert, a virtual nurse reviews the patient's history, labs and vital sign trends, and communicates with a rapid response team nurse, who assesses the patient at the bedside and shares the information with a hospital-based physician. The physician evaluates the care plan, reviews the possible pathways of clinical deterioration and writes new orders as appropriate. The nurse continues to round, advocate for the patient and coordinate with social work and palliative care staff, while the clinical care team monitors the patient's response to the revised care plan.

A 2020 *New England Journal of Medicine* study reported that the Advance Alert Monitor was responsible for preventing 520 deaths per year over a three-and-a-half year period. Patients in the intervention cohort had significantly lower ICU admission rates than the control (17.7% versus 20.9%), shorter lengths of stay (6.5 days versus 7.2 days), and lower mortality rates within 30 days of an alert (15.8% versus 20.4%).

Effective change management during the system's initial rollout focused on making sure that clinicians understood that the Advance Alert Monitor was there to strengthen their capabilities, not to check up on them, says Betts.

Kaiser Permanente Northern California is now using some of the same datasets to develop predictive models around readmissions and labor and delivery, she reports. A perinatal early alert system is being piloted in five locations. "We will continue to build predictive models to strengthen our ability to anticipate rather than react. We're invested in thinking about how our data can be used to augment our capabilities," she says.

Betts encourages organizations to tap their EMRs' existing capabilities to help improve outcomes. "Many current EMRs have built-in early warning systems," she says. "Why not take advantage of these predictive tools to help clinicians and enhance patient care?"

Veterans Health Administration Pauses to Protect Frail Patients

Frailty among surgical patients is a major risk factor for serious postoperative complications, poorer outcomes, readmissions, longer hospital stays and higher mortality. Those risks, combined with the rapid aging of the population, have pushed frailty to the fore as a focus of quality and safety initiatives involving older patients.

"Optimizing care for frail patients before and after surgery presents a key challenge for healthcare providers," says Jason M. Johanning, MD, medical director of the Veterans Healthcare Quality Improvement Program with the National Surgery Office.

That optimization can include both prehabilitation to improve fitness to undergo surgery as well as tailoring postoperative care to reduce complications.

Knowing the extent of a patient's frailty provides a critical heads-up to clinicians that can be used to plan care and inform discussions with patients and family about the risks of treatment.

Toward that end, the VA has employed a simple tool known as the Surgical Pause to identify frail patients before surgery. Widespread use of the tool in surgical units across the VA system and in private settings has significantly reduced mortality rates among this population, Johanning reports.

A QI initiative that originated at the VA Medical Center in Omaha, Neb., the practice is now in place across an estimated 75%-80% of VA facilities, he says.

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The Surgical Pause uses the Risk Analysis Index frailty tool. "If a patient is determined to be frail, the surgical team pauses to review the patient's care plan, ensuring that their goals align with the expected surgical outcomes," Johanning explains.

Both prospective and retrospective studies in VA and private settings have validated the frailty tool, and advanced statistical methods have been used to fine-tune the scoring thresholds, he says.

Numerous studies have shown the systematic frailty tool's benefits, including one published in *JAMA Surgery* that found a 33% reduction in 180-day mortality among surgical patients undergoing a palliative care consultation ordered by the surgeon.

"The frailty assessment fosters more realistic expectations among patients and families by helping to communicate that even the best surgical techniques can't always overcome the inherent risks of frailty," Johanning says.

For example, a potential colectomy patient assessed as not frail would receive standard care. However, a patient identified as frail would receive care tailored to their specific needs.

If, for example, the patient has colon cancer and resection would be potentially curative, the focus of care would shift to optimizing the surgical outcome while recognizing the heightened risk of postoperative complications.

Conversely, if the patient has a benign condition such as diverticulitis, the surgical team might discuss with the patient and their family whether to accept the surgical risks or pursue more conservative treatment such as antibiotics and watchful waiting.

The VA encourages surgeons across the system to assess frailty as part of their process. Some VA medical centers require the Surgical Pause, while others use the tool as an outgrowth of local grassroots initiatives to obtain physician buy-in, according to Johanning.

Data collected through the VA's EMR and stored in a corporate data warehouse supports continuous learning across the VA system, he says. A Surgical Pause dashboard facilitates data analysis and enables ongoing monitoring and refinement.

Johanning notes that because the Surgical Pause takes less than two minutes to complete without the need for a search through the patient's EMR, it's easy to adopt and implement. From its inception at the Omaha VA, the tool has been available without cost for use at other institutions.

In addition, the Risk Analysis Index frailty screening tool "can be applied to any context where frailty assessment is beneficial, such as predicting chemotherapy toxicity in oncology patients," Johanning says.

He encourages organizations interested in adopting the Surgical Pause to identify a surgical champion to pilot the tool in a defined clinic, collect preliminary data over 6–12 months on complication rates in frail patients and then use the results to demonstrate the tool's effectiveness locally to build broader support among clinicians.

Though there is still plenty of room for improvement in the quality and safety spheres, these examples show promise that can serve as a source of inspiration, lessons, ideas and direction for providers across the spectrum.

Susan Birk is a Chicago-based freelance writer specializing in healthcare.

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Approximately 60 million adult Americans aged >45 years are currently **unscreened for colorectal cancer (CRC).**[1]

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*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.

References: 1. Ebner DW, Kisiel JB, Fendrick AM, et al. Estimated average-risk colorectal cancer screening-eligible population in the US. *JAMA Netw Open*. 2024;7(3):e245537 **2.** Doubeni CA, Fedewa SA, Levin TR, et al. Modifiable failures in the colorectal cancer screening process and their association with risk of death. *Gastroenterology*. 2019;156(1):63-74.

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Enhancing Healthcare Provider Education

Healthcare organizations want to do everything they can to deliver safe, high-quality care. One increasingly important component of their multipronged efforts is ongoing professional development for providers.

Equipping clinicians with the latest knowledge in areas that include patient safety, emerging treatments and therapies, and clinical guidelines is a must in the modern healthcare field.

"This industry has rapid technology and medicine-based changes, and the quality of our patient care is directly tied to how well providers are staying up to date on that information," says Bonny Kneedler, vice president, Clinical Laboratory Quality, Exact Sciences, Madison, Wis. "High-quality and consistent application of healthcare happens as a result of providers' knowledge and understanding."

Overcoming Barriers to Provider Education

The benefits of continuous provider education are unquestionable. But as with other initiatives that require a piece of organizations'—and clinicians'—valuable time, there can be barriers to implementation. Three big ones, according to Kneedler, are time, capacity and money.

"Think about providers' schedules: They're overflowing with appointments and commitments and a laundry list of things they need to get done in usually well over an eight-hour day," she says. "We're all human, and after you've had a full day and week and month, the thought of adding in an additional commitment can feel overwhelming."

Another potential barrier to continuous provider education is the expenses associated with certain courses or conferences, including travel and accommodations, says Kneedler.

For all the challenges, there are a multitude of solutions. It's not a one-size-fits-all approach, however. Instead, there are incremental steps organizations can take to prioritize provider education.

To start, it's important to offer a variety of educational types to fit multiple and changing preferences among clinicians, as some learn best at a large conference or group meeting, others prefer a virtual setting, and others still may learn better one-on-one or in a smaller session.

"Having options for everyone is one of the most effective ways organizations can provide these development opportunities," Kneedler says.

In addition to hosting several conferences throughout the year, including neurology and primary care conferences and a telehealth symposium, in which providers share their

research internally and with other organizations, The Medical University of South Carolina prioritizes smaller-scale educational opportunities. That includes grand rounds within each service line, which promote learning among the organization's residents and fellows, says Anthony Poole, DMSc, PA-C, CPHQ, system director, Quality Assessment and Performance Improvement Program, The Medical University of South Carolina, Charleston. In addition, newsletters, email updates and regular meetings are key components of the academic medical center's provider education efforts.

Poole cites MUSC's initiatives around colon cancer as an example of how education has helped improve care coordination and quality.

"Our leaders and clinicians regularly share information about the work we're doing, including what screening opportunities are available, such as colonoscopy and Cologuard®," he says. "We work across service lines to say, 'Hey, Primary Care, we're tracking this initiative, but we've got to work closely with our Digestive Health department, who are doing all of our endoscopies.'"

Beyond offering a variety of education types to appeal to clinicians' diverse preferences, Kneedler and Poole have the following additional tips for enhancing provider education efforts:

Try advanced planning. Getting education on clinicians' calendars six, nine or even 12 months in advance could improve participation. "Try blocking time so that space is dedicated," Kneedler says.

Consider rotation. Not every clinician needs to attend the same development opportunity at the same time. "Maybe half go at one point, and the other half go at another point," Kneedler says.

Set aside funds in the budget or look for budget-friendly options. For those organizations that can ask for funds for professional development, they should—and they should make sure to use them, Kneedler says.

"Spend those dollars so they don't get spent on something else," she says. "And when there's no budget, I think looking into cost-friendly development opportunities, such as no-charge options or those with potentially waived fees, can alleviate cost barriers."

Make professional development a priority. It might sound simple, but "leaders have to make it a priority," Poole says. "If an organization is going to say that they want to deliver world-class healthcare, then it must be willing to invest in the development of its medical staff across the board."

Organizations should consider building professional development into providers' contracts, says Poole. "You can't have everyone budgeted at 40 hours a week of clinical time. There has to be some nonclinical administrative time that can be focused on professional development."

Lean on partnerships. Collaborating with experts in the field can bring essential knowledge to organizations and providers. "It really expedites that knowledge transfer and allows the expert to impart knowledge to multiple providers at once rather than taking a provider out of their environment," Kneedler says.

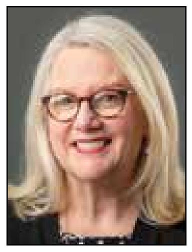
For MUSC, collaborating with Exact Sciences has helped bring education about colon cancer screening to its many providers, who are located across the state.

"Particularly in our rural and suburban areas, it is difficult for our quality leaders to always be on-site providing in-person quality support and education," Poole says. "When we collaborate with partners who are able to get out and have their teams do some in-person education on a regular basis just to keep our teams up to speed, it becomes another tool in the toolbelt of provider education."

When the partner has shared goals with providers, it can be even more meaningful, Poole says.

"Our collaboration with Exact Sciences is a lot different than a typical vendor relationship because we both have shared goals: To screen as many patients as we can for colorectal cancers, to improve the health of our communities and to prevent disease burden from colorectal cancer," he says. "It's about working together to achieve that common purpose."

For more information, please contact Violet Gudino, Health Systems Marketing, Exact Sciences, at vgudino@exactsciences.com.



Susan A. Reeves, EdD, RN, CENP

Time for a Mission Checkup?

Reviewing mission and values should be on a leader's to-do list.

Leaders' ability to consistently make decisions and act in accordance with the organization's stated mission and values is one of the strongest predictors of whether those leaders will be judged by those they serve to be acting in an ethical manner. When leaders make decisions that are not aligned with their organization's mission and values, the consequences can be significant and far-reaching.

Many mission statements are likely inadequate at providing sufficient guidance for decision-making in today's turbulent healthcare environment.

Given that mission and values statements are so critical to a high-functioning healthcare organization, a regular review can ensure they are cogent, comprehensive and contemporary. In addition, leaders should make regular efforts to meaningfully connect their stakeholders—including patients, staff and the community—to the mission and values. In other words, leaders must make the mission and values live and breathe in the organization's everyday life. Doing so drives loyalty, engagement and trust in all who work for, and are served by, the organization.

The Significance of Mission and Vision Statements

A mission statement describes why the organization exists and is typically underpinned by a statement of organizational values, which articulate the organization's standards, morals, ideals and beliefs. Most healthcare organizations have several components to their mission statements, emphasizing areas such as the provision of high-quality care, service to the community and its role in promoting the community's health. Many mission statements, especially for academic health organizations, describe the organization's role in educating the healthcare workforce of the future, as well as its role in health-oriented research and discovery. In contrast, values statements are more variable and generally reflect the organization's culture.

Reevaluating Mission and Values Statements: Lessons From Students

Last summer, while teaching a course in organizational ethics to graduate students in a master of health administration program, I created an introductory assignment designed to explore the significance of an organization's mission and values statements in guiding leader behavior and in setting the organization's ethical guideposts. Fifteen students accessed a healthcare organization's mission and values statements and then analyzed whether the statements provided sufficient guidance to aid a leader's decision-making. In addition, the students were to identify ways, if deemed necessary, to strengthen the statements. Their findings were interesting.

The students found, and I agreed, that many mission statements were likely inadequate at providing sufficient guidance for decision-making in today's turbulent healthcare environment. Some found that instead of mission statements, the organizations they reviewed had chosen to promulgate visionary phrases to express their missions. Although these statements certainly expressed an organization's aspirations, they were more appropriate for marketing purposes versus being able to express the "why" of the organization's existence or to guide leader decision-making.

As for the values statements analysis, the students found that there

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were many common values expressed among the healthcare organizations they chose to examine. Caring, compassion, patient centricity, safety, innovation and teamwork were among the more frequently stated values.

What the students discovered to be most useful in the values statements were the instances when not only was the value stated but when the word (for example, "patient-centeredness") was accompanied by descriptive sentences that illustrated the expectation for how the values might be used to help guide leader and staff behavior as well as organizational decision-making.

Leaders must make the mission and values live and breathe in the organization's everyday life.

Mission and Vision Statements for the Future

During the class discussion, the students also astutely noted the absence of mission statement elements and values that in today's post-pandemic health system were believed to be important. Perceived to be among the more glaring omissions was the importance of stating within the organization's mission a focus on providing a safe and fulfilling work environment for the professionals and staff employed by the organization.

Another omission they documented was educating the workforce of the future, especially those that serve on the organization's front lines.

Given the projected shortages of healthcare professionals and staff that are expected to exist well into the future, it has been increasingly evident that organizations are coming to grips with the fact of their importance as "growing fields" for a future workforce, providing opportunities for career and ongoing professional development. Work environments must also be free of harassment and discrimination, and efforts to address the explosion of workplace violence in all forms must be a key focus of organizations today and moving forward.

The students also had recommendations for the addition of values they believed were key for all health organizations. The first addition suggested was the value of health equity. The adoption of health equity as a value would require healthcare organizations to focus efforts on eliminating a variety of injustices and other obstacles, such as preventable health disparities, to attain the healthiest population possible.

Another value thought to be important in our contemporary environment was a clear statement about the organization's commitment to ethical and honest business practices. The impact of clearly stating a value such as this provides explicit expectations for all who work within the organization.

One might wonder why the views of a group of health administration graduate students should spur healthcare leader actions to review their organizations' mission and values statements.

Consider two reasons: One, it is simply good leader and board practice to make sure that mission and values statements are reviewed on a routine basis (such as during routine strategic planning efforts) to make sure they continue to be current and comprehensive, and that they reflect the organization's day-to-day life.

Two, if we believe that the organization's mission and values provide the cornerstones that are necessary to guide leader decision-making, it is important that they are cogently stated in a way that helps all who work in the organization to see the mission and values as a foundation and guidance for their work—not only the top leaders but all leaders and staff.

These students were a tiny sample of those working in our field today who aspire to lead in the future.

Listening to what they (and the front-line, mid-level leaders and staff of your organization) need to help them make informed decisions aligned with the organization's mission and values seems prudent and forward-thinking. ▲

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

Editor's note: For more insights on how leaders are bringing their organizations' mission and values to life, see the Web Extra "5 Examples of How Leaders Can Bring the Organization's Mission and Values to Life" at **healthcareexecutive.org/WebExtras.**

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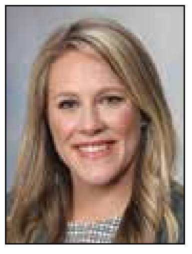

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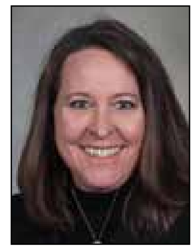
Kari Houser

Amy Van Gundy

Transforming Patient Experience With Digital Check-In

Self-service options meet patients where they are.

With continued financial pressures, a challenging workforce horizon and consumer preferences shifting toward self-service options, health systems such as Mayo Clinic are exploring and implementing advanced digital capabilities for appointment check-in and registration.

The dominance of mobile devices in daily life underscores the importance of aligning check-in options with evolving expectations and habits. Mayo Clinic's goal is to seamlessly integrate these technological advancements to enhance patient experience while optimizing operational efficiency.

A Response to Consumer Demand
In recent years, there has been a marked shift toward digital appointment solutions, driven by consumer demand for convenience and efficiency. About 97% of Mayo Clinic's patients possess a mobile device, which has been a significant factor in the organization's decision to implement mobile check-in capabilities. In response, Mayo Clinic has enabled mobile check-in for outpatient specialty departments that involve low complexity check-ins. This approach allows patients to complete their registration tasks and pre-visit information through the Mayo Clinic app before settling into the waiting room, eliminating the need to check in at the front desk.

To date, 80% of Mayo Clinic departments have been fully equipped for digital check-in for more than a year. So far, the implementation has yielded promising results. By shifting to consumer-directed registration, health system staff members are empowered to concentrate on more complex tasks and deliver an exceptional customer experience. This transition is not only enhancing operational efficiency but also aligning with modern consumer preferences.

Patient feedback highlights the ease of use, convenience, efficiency, time-saving nature and seamless experience of the mobile check-in process.

Digitally Tracking Patient Behaviors
As of March 2024, Mayo Clinic patient satisfaction surveys indicate that nearly 88% of patients were satisfied or extremely satisfied with the mobile check-in process (29 out of 33 respondents). Furthermore, 90.91% of patients expressed a high likelihood of using mobile check-in again (30 out of 33 respondents). Patient feedback highlights the ease of use, convenience, efficiency, time-saving nature and seamless experience of the mobile check-in process.

More than 700,000 patients have an online portal account with Mayo Clinic. On average, 91% of them access the portal within 14 days before their appointment, and 64% have downloaded the Mayo Clinic app. Despite high portal usage and app downloads, mobile check-in utilization has remained steady at about 3%-5% across the enterprise. Specialties that have seen increased usage of mobile check-in include areas in which patients receive text message reminders an hour before their appointment.

High-demand care areas such as women's health, psychology and psychiatry, and reproductive endocrinology and infertility have also

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demonstrated higher engagement. On-site patient education about mobile check-in, which is provided at the time of check-in, has led to a utilization increase as high as 50%. However, due to the dynamic nature of patient populations at the health system's Destination Medical Centers, this model of in-person education is not sustainable long-term.

Lessons Learned

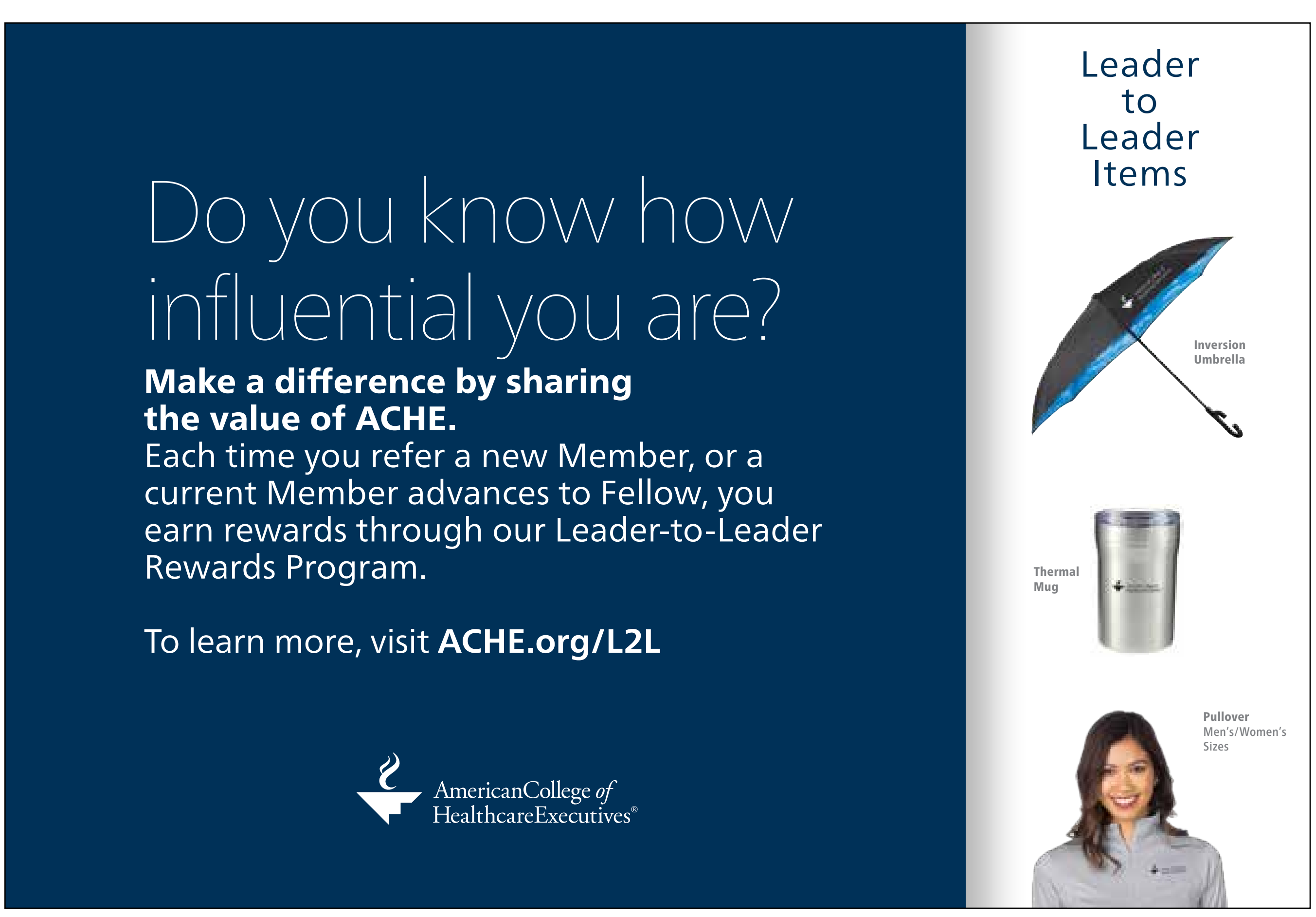
Mayo Clinic staff have learned valuable lessons throughout the digital check-in initiative in the following areas.

Patients (customers): One of the significant challenges the health system has encountered involves patient interactions with technology and the perceived impersonal nature of digital solutions. A segment of Mayo Clinic's patient population expresses concerns about technology's effect on personal interactions and job security for the health system's registration team. These concerns can influence patients' willingness to engage with new technological solutions. Mayo Clinic staff are working to address these issues by proactively using technology to encourage mobile check-in, even among patients hesitant to enable location services.

Patient feedback has been largely positive, with comments reflecting satisfaction with the convenience of self-service options. For instance, one patient noted, "I loved the kiosk check-in. I didn't have to talk to anyone or wait in line. It was fast!" Another shared, "The kiosk check-in was surprisingly easy with no wait. I went up to my appointment and was seen almost immediately. It was very efficient that day!"

Digital tools: An ongoing lesson involves finding ways to prompt patients to use mobile check-in without relying on location services, as many patients are reluctant to enable them on their mobile devices. The Mayo Clinic team is hopeful that advances in technology will allow the health system to provide prompts in a unified manner that does not require patients to disable notifications.

Cellular connectivity varies significantly across different sites due to location and carrier-specific factors, impacting the effectiveness of mobile check-in. The health system is committed to



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collaborating with cellular, Wi-Fi and telecommunication service providers to enhance connectivity and support the digital check-in process.

Environment: Mayo Clinic's lobby design encourages patient interaction at the front desk, with large reception areas, wayfinding signage and carpet insets directing people to physical desks. The team is working with facilities management staff to redesign lobbies in new and remodeled locations to promote technology use rather than visual cues that encourage waiting in line and engaging with a person.

Staff: Resistance from employees regarding the adoption of digital check-in technology has been another challenge, often rooted in concerns about job security. The Mayo Clinic team has found success by reinforcing the value of technology in supporting job security and shifting staff focus to more complex tasks.

Another message that has been useful in combatting staff resistance is having empathy for staff, as they have felt the effects of hiring shortages in the past few years. The leadership team has made a point to let employees know they are valued and needed on the most high-touch tasks for patients. This has resonated with many of our team members.

It is also crucial to raise awareness about technological advances and provide comprehensive training for all staff members—including providers, nursing staff and front desk personnel—on the digital check-in functionality. We are committed to equipping our team with the necessary tools and knowledge to assist patients effectively and enhance their engagement with mobile check-in solutions. Their input is invaluable as we continue to transform patient experience. ▲

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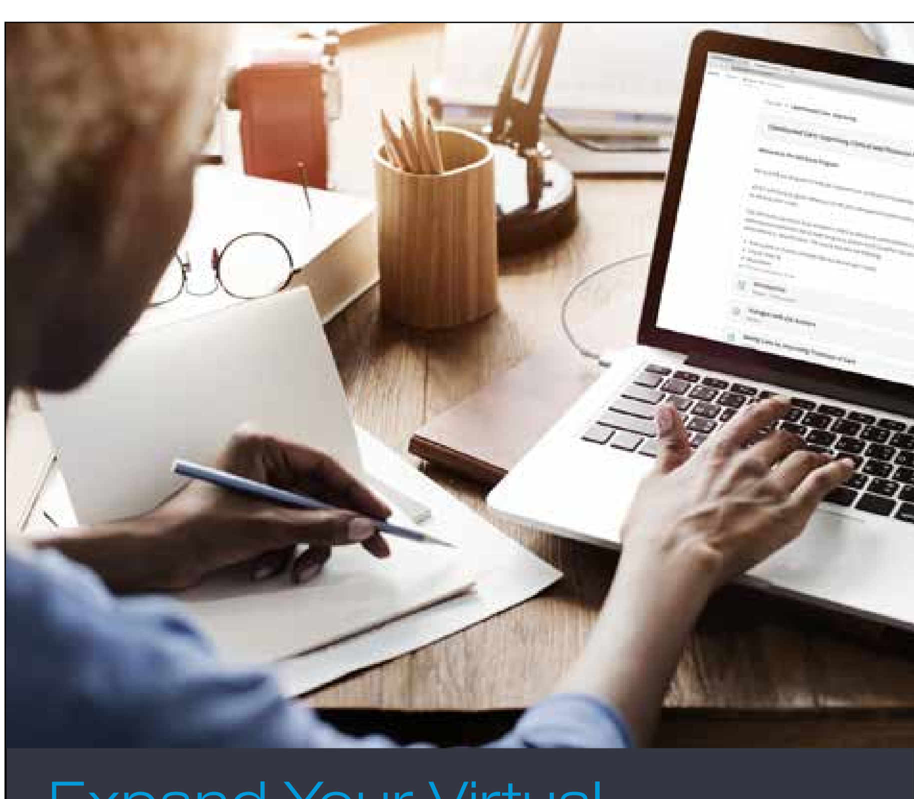

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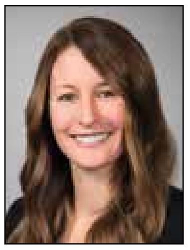

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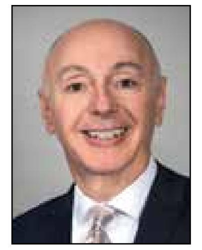

James Guliano, RN, FACHE, NEA-BC

Achieving, Sustaining Clinical Improvement

Leadership strategies help reduce sepsis mortality throughout Ohio.

Leadership's role is crucial to ensuring success throughout the multifaceted journey toward achieving improvement in a shared clinical outcome. This was the case as the Ohio Hospital Association embarked on a board-directed goal of reducing sepsis mortality throughout the state.

As a state hospital association, the Ohio Hospital Association serves its diverse 250 member hospitals and 15 health systems through its strategic priorities of advocacy, economic sustainability and health outcomes for patients and communities. Hospital leadership endorsement, oversight, encouragement, presence and acknowledgement have formed a strong foundation that's led to notable progress and a successful sepsis mortality reduction initiative. Following is a look at how leadership strategies across the continuum of care helped reduce sepsis mortality.

Executive Commitment

A highly engaged board of trustees comprising hospital CEOs and other C-suite leaders charged a clinical advisory committee with identifying top priorities requiring outcome improvement. Fully informed, the board prioritized the need for reducing sepsis mortality to decrease loss of lives, limbs and individual functionality within the communities they served. In addition, because sepsis is among the costliest of hospital diagnoses treated, cost to hospitals from treating sepsis was also factored in and identified as an opportunity to secure endorsement of the initiative from hospital leaders.

From that point forward, progress toward the intended outcome was routinely revisited in meeting agendas.

OHA designed and launched the statewide initiative in collaboration with member hospitals and endorsement from hospital CEOs. OHA appealed to member hospital leaders to participate. Each hospital committed to engage in at least one leadership tactic and one operational tactic to promote and support targeted sepsis mortality reduction efforts. Examples of leadership tactics included visible and vocal leadership endorsement, identification of a hospital metric using a scorecard or dashboard, and fostering a culture of learning, accountability and sustainability.

Operational tactics included resource allocation, incorporation of the initiative into performance evaluations and action plan development. Hospital leaders were unified in their articulation of intended sepsis mortality reduction efforts, and, in doing so, demonstrated their own passion for the initiative. Such executive commitment continuously reinforced the importance of the initiative and resulted in the largest clinically focused collaborative cohort the association has hosted.

Thoughtful leadership has provided passion, guidance and motivation to teams that have realized notable sepsis mortality reduction rates.

Collaborative Actions

Executive leadership facilitated and supported several collaborative actions, beginning with a gap analysis of participating hospitals. Data analysis and education became key components to addressing needs identified in the gap analysis. To prevent participation burden, data submission, analysis and monitoring were limited to pertinent metrics that leadership identified. For example, mortality was analyzed by

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"present" on admission rates as well as "non-present" on admission rates, reflecting evidence-based literature.

Relationship building with leaders from other states and national organizations was undertaken to create a network of partners, advisers, supporters and peers. Leaders launched monthly evidence-based continuing education programs on trending topics, with regional, state and national subject-matter experts serving as faculty. While program content might have appeared to be evident by program title alone, listing a suggested audience for each program helped drive attendance.

Establishing a safe learning culture among multidisciplinary team members required role modeling, collaboration and ongoing leadership support. One way leaders fostered a learning culture was by collaboratively developing a sepsis case review tool, designed to capture both effective practices and opportunities for improvement. Once the tool was applied to sepsis cases, teams could identify operational and educational needs and address them without stigma.

It became apparent from the initiative's inception that success would require engaging with multiple stakeholders, often referred to as a "village." Leaders from throughout the continuum of care were engaged to expand the "village," ranging from the pre-hospital, acute care and post-acute care settings. An alignment with stakeholders—including providers, patients, families, survivors, legislators and payers—led to collaboration and support, and the identification of common barriers and areas of opportunity.

One key alignment has been with Sepsis Alliance, a leading patient advocacy organization, and its multitude of valuable resources. An appreciation for the challenges, lessons learned and effective practices enhanced the collaboration among these levels of care and leveraged stakeholders' support. For instance, sepsis physician champions, sepsis coordinators, quality improvement experts and front-line staff considered handoff issues between long-term care and acute care, while at the same time developing a structured process for decreasing interruptions in time-sensitive care during transfer between the two levels of care. The leadership action of encouraging dialogue across the continuum of care created a platform for transparency, communication and progress.

Leadership Strategies Lead to Significant Improvements

Both rapid cycle and long-term improvements were noted throughout the statewide initiative. Leaders placed a strong emphasis on dissemination of effective practices by conducting site visits, active listening and toolkit development. For instance, when considering the multiple challenges to decreasing "non-present" on admission sepsis mortality, site visits with hospitals that sustained a decreased mortality rate were conducted using a standard interview tool. This work resulted in the development of a "non-present" on admission sepsis mortality reduction toolkit, located and publicly available on the Ohio Hospital Association's website at ohiohospitals.org/sepsis.

Incorporation of related leadership priorities, such as health equity, guided the collaborative actions to explore areas of opportunity for further improvement. Topics such as access to care and health literacy became part of the initiative agenda, accessing the advice of national content experts.

Hospital, health system and state hospital association leaders routinely acknowledged progress by celebrating achievements. Through visual displays, such as public dashboards, leaders have transparently addressed outcomes. In their leadership rounding, executive team members inquired about barriers to sepsis bundle compliance, listened to team members and pursued viable solutions. In addition, executive rounding has been used to recognize the notable efforts of teams in their passionate pursuit of sepsis mortality reduction. One health system initiated an annual recognition luncheon event, where team members from throughout its system entities are honored for their contributions to sepsis mortality reduction.

Leadership support has been a significant part of the initiative's success. When leaders could readily cite outcomes such as the estimated number of lives saved, a shared commitment to the sepsis mortality reduction efforts resulted.

Thoughtful leadership has provided passion, guidance and motivation to teams that have realized notable sepsis mortality reduction rates. Moreover, leadership has been the catalyst to focus on sustaining such notable improvements. ▲

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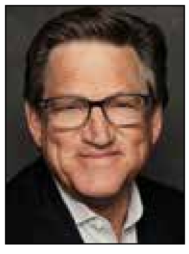
Paul H. Keckley, PhD

Tax-Exempt Status Reviewed at Nonprofits

Possible regulatory changes mean making community benefit a priority.

Tax exemptions for nonprofit hospitals are not a new topic inside healthcare, but they are drawing outside attention.

For at least the last half century, nonprofit hospitals have enjoyed tax-exempt status as a legacy of religious sponsorship. In recent years, critics have challenged the designation for some, based on media reports about their business practices—patient debt collection policies, executive CEO compensation, investment activity and others. Concurrently, consolidation of nonprofit hospitals into multi-hospital systems has reduced competition and increased hospital costs, according to industry studies.

Given that hospitals account for the largest share (30%) of all healthcare spending, and 58% of the 5,129 U.S. community hospitals are classified as nonprofit (24% are investor owned, 18% are state/local government owned hospitals), justification for tax exemption will be a critical issue for hospitals.

The Regulatory Framework for Hospital Tax Exemptions
Nonprofit hospitals are exempted from certain federal and state taxes by the IRS if they qualify under Section 501(c)(3):

- Earnings from operating margins and/or investments cannot inure to the benefit of private shareholders/individuals.
- Nonprofit hospitals may not use funds for partisan advocacy or for a political campaign in support of a candidate for office.

Eligibility is premised on two sets of activities that hospitals report to the IRS annually in their Form 990 filings: charity care and community benefit. *Charity care* is defined as hospital services provided to patients with no expectation of payment. *Community benefit*, per the IRS, includes a wide range of activities deemed necessary to a community's health, including but not limited to:

- Operating an emergency room open to all, regardless of ability to pay.
- Maintaining a board of directors drawn from the community.
- Maintaining an open medical staff policy.
- Providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare.
- Using surplus funds to improve facilities, equipment and patient care.
- Using surplus funds to advance medical training, education and research.

Notably, there are no federally mandated minimum thresholds for charity care or community benefits. And, in many states, additional requirements are used to authorize exemptions from state and/or property and income taxes.

The Current Debate
Attention to hospital tax exemptions heightened in 2024 as a result of studies that quantified the amount of tax exemptions and their relationship to charity care and community benefits provided. Specific examples include the following:

- In March 2024, Lown Institute published its Fair Share Hospital

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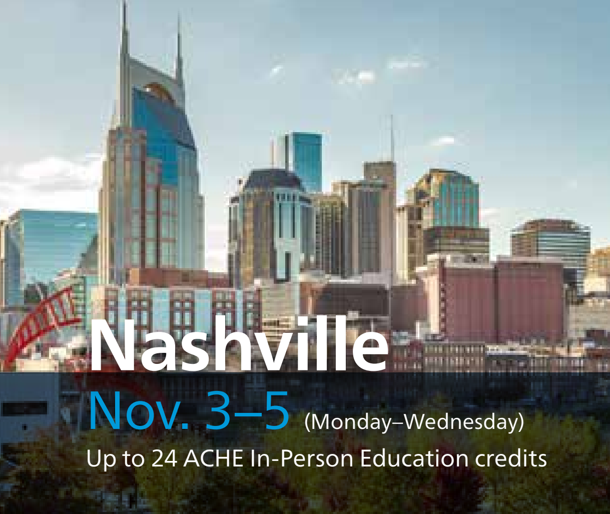

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Spending report covering 2021 and concluded that "of 2,425 nonprofit hospitals evaluated, 80% spent less on financial assistance and community investment than the estimated value of their tax breaks." The report estimated that the combined fair share deficit for all hospitals studied was $25.7 billion that year.

- A September 2024 study by Texas Christian University and Johns Hopkins researchers, published in *The Journal of the American Medical Association*, of 2,927 U.S. nonprofit hospitals concluded these facilities "received a $37.4 billion total tax benefit in 2021 with 7% of hospitals accounting for half of the total amount. Policy efforts to strengthen nonprofit hospitals' taxpayer accountability are likely to be more effective when pursued at the local level."

- The same week, the American Hospital Association released a study conducted by Ernst & Young finding "tax-exempt hospitals delivered $10 in benefits to their communities for every dollar of federal tax exemption in 2020."

- In November 2024, Johns Hopkins researchers reported that "on average, nonprofit hospitals allocated 8.8% (about $33 million) of their expenses to various community benefits … 24% of these hospitals received more in tax benefits than they spent on community benefits."

Hospital tax exemptions also drew coverage in ProPublica, *The Wall Street Journal, The New York Times*, NBC News and other news outlets. In their profiles of reputable nonprofit systems, revenues and "profit" were focus areas along with notable business practices like patient debt collection practices, executive compensation, investing activity in for-profit ventures and others.

In 2024, attention to tax exemptions for nonprofit hospitals and health systems peaked. Tax-exempt status is complicated and especially susceptible to misleading studies and misinformation. In 2025, given Republicans' control of the 119th Congress and their priorities of reduced federal spending and deficit reduction, unwarranted tax exemption likely will be a major focus.

Key Takeaways for Leaders

Hospital system boards and leaders in nonprofit settings must monitor this issue closely. Regulatory changes, including the possibility of minimum thresholds for specified community benefits that might result in reduced tax exemptions, are a significant possibility, and continued attention in media seems certain. To prepare, consideration should be given to three sets of activity:

1. ***Detailed, verifiable community benefits accounting***: Leaders must inventory and prioritize community benefit activities that correlate most directly with community health and well-being. Activities and programs of less demonstrated value to community health should be discarded. Though questions about charity care are fewer, ambiguity about community benefit is significant. And as regulators consider eliminating or reducing community benefit credit from Medicare and Medicare reimbursement shortfalls, budget adjustments must be anticipated.

2. ***Communication***: Messaging about nonprofit status, and its quantifiable value to community health, should be ongoing and routinely updated. Two particular targets for these communication activities are local employers, who pay 1.6–2.5 times more than Medicare rates and provide the operating margins on which hospitals are dependent, and hospital employees, who are the primary source of information about hospitals in most communities.

3. ***Executive compensation***: Board committees should align hospital management compensation with specific charity care and community benefit targets. Transparency about and justification for executive compensation should be a priority for boards, especially in messaging to community leaders, hospital employees and regulators.

In 2025 and beyond, tax exemptions for hospitals will garner attention. Its sustainability cannot be taken for granted, nor can criticism be ignored. ▲

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

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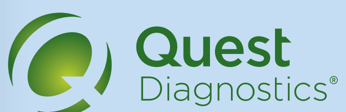

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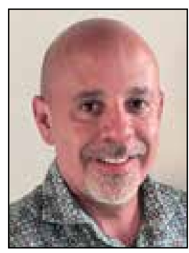

Dino Scanio, DHA, CO, LO

Overcoming Institutional Creatures of Habit

Advice for navigating staff resistance to change.

Healthcare organizations often grapple with resistance to change, particularly from people deeply entrenched in established routines. These institutional "creatures of habit" may view new practices or technologies as disruptive to their comfort zone. The adage, "if it ain't broke, don't fix it" often underlies this resistance, emphasizing the perceived value of consistency and the avoidance of unnecessary change. This resistance, however, can significantly impact clinical outcomes and operational efficiency.

The reluctance to change often stems from a fear of the unknown. When people are accustomed to a particular way of doing things, they may perceive deviations as risky or disruptive. This can manifest in various ways, from outright rejection of new initiatives to passive-aggressive behaviors that undermine change efforts. The challenge for healthcare leaders is to navigate this opposition while continuing to drive necessary improvements.

The healthcare landscape is in a constant state of flux, necessitating regular reevaluation of existing processes. New technologies, regulatory changes and shifting market trends can quickly render established methods outdated or inefficient. A process may appear functional on the surface, but underlying issues or inefficiencies can become apparent over time. Even when things seem to be working well, there is often room for improvement. Small changes can yield significant long-term benefits. Additionally, familiar processes can sometimes hinder organizations' ability to capitalize on new opportunities or advancements.

Overcoming institutional creatures of habit is a critical task for healthcare organizations.

Changing the Creatures of Habit Mentality

A successful approach to changing the mentality of institutional creatures of habit requires a delicate balance of empathy, firmness and effective communication. Strategies to overcome this resistance include:

- ***Practicing empathy and understanding***. Acknowledge the discomfort associated with change. Recognize that people may have valid concerns about the potential impact on their work. By empathizing with differing perspectives, leadership can build trust and foster a more receptive environment.
- ***Communicating clearly***. Articulate the reasons for change and the expected benefits. Use data and evidence to support the rationale, demonstrating that changes are not arbitrary but driven by a desire to improve patient care or organizational performance.
- ***Involving stakeholders***. Invite people to participate in the change process. Seek their input and address their concerns directly. By involving stakeholders early on, leadership can increase buy-in and reduce resistance.
- ***Adopting a phased implementation***. Introduce changes gradually to minimize disruption and allow people to adjust to the new practices. A phased approach can help alleviate fears and build staff's confidence in the changes.
- ***Providing training and support***. Offer comprehensive training and support to ensure employees have the skills and knowledge necessary to

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implement the new practices effectively. This will help mitigate any concerns about their ability to adapt.

- ***Celebrating successes***: Recognize and reward those who embrace change and contribute to its successful implementation. This positive reinforcement can encourage others to adopt a more open-minded attitude.

Healthcare leaders should also remember the importance of their own presence. No matter how busy they are, taking time to connect with their team members is nonnegotiable. A leader's support serves as a beacon, guiding teams through the stormy seas of change. By demonstrating a commitment to transformation, leaders inspire their teams to do the same. Personal engagement is not just a gesture; it is a catalyst that ignites passion, fuels determination and reinforces the belief that together, they can weather any storm.

The Psychology Behind Resistance to Change

Understanding the psychological factors that fuel resistance to change can help healthcare leaders develop more effective strategies to overcome it. Several psychological concepts are relevant in this context:

- ***Loss aversion***: People tend to be more sensitive to losses than to gains. When change is introduced, they may perceive the potential loss of familiar routines, comfort zones or social connections as more significant than the potential gains.
- ***Fear of the unknown***: Uncertainty about the future can trigger anxiety and resistance. People may fear the unknown consequences of change, such as job insecurity, increased workload or skill obsolescence.
- ***Status quo bias***: People often prefer the status quo, even if it is less than ideal. This bias stems from a desire to minimize effort and avoid risk.

With these psychological insights in mind, healthcare leaders can employ the following strategies to mitigate resistance and foster a culture of innovation:

- ***Frame change positively***. Emphasize the benefits of change, such as improved patient outcomes, increased efficiency or enhanced job satisfaction. Focus on the positive impact for people and the organization.
- ***Involve staff in the change process***. By involving stakeholders in decision-making and implementation, leaders can increase buy-in and reduce resistance. This approach also provides an opportunity to address concerns and alleviate fears.
- ***Provide transparent communication and support***. Open and honest communication is essential to dispel rumors and misinformation. Regularly update stakeholders on the progress of change initiatives and provide clear guidance and support to help them navigate the transition.
- ***Build trust and relationships***. Strong relationships between leaders and their teams are crucial for fostering a positive change culture. Leaders can develop strong relationships with their teams by fostering open and honest communication, actively listening to team members' ideas and concerns, showing empathy and understanding, and celebrating team successes.

Overcoming institutional creatures of habit is a critical task for healthcare organizations. By cultivating a culture that values innovation, empathy and collaboration, leaders can create an environment where change is embraced as an opportunity for growth and improvement rather than a threat to the status quo.

The reluctance to change often stems from a fear of the unknown.

This positive shift will not only lead to better patient care and enhanced organizational performance, it will also foster a more fulfilling work environment for healthcare professionals. By empowering their teams, inspiring innovation and nurturing a sense of shared purpose, healthcare leaders can overcome resistance to change and drive sustainable improvements that benefit patients, staff and the organization overall. ▲

Dino Scanio, DHA, CO, LO, is director of clinics, Driscoll Children's Hospital, Corpus Christi, Texas, and an ACHE Member (Dino.Scanio@dchstx.org).

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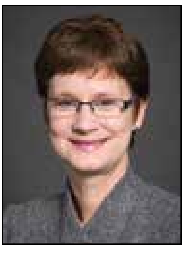

Kimberly A. Russel, LFACHE

The Art and Science of CEO Succession Planning

A deep understanding of governance is essential for a potential CEO successor.

One subject has appeared more frequently on board of directors' agendas in the past five years than in any previous decade: Talent. Necessarily, governing bodies have spent significant time, energy and organizational resources on talent acquisition, development and retention. Many organizations, with full board support, have adopted variations of a "grow your own" talent development strategy. This strategy extends to the C-suite, including identification and preparation of internal executives for possible promotion to the CEO position.

Andrew Chastain, president and CEO of WittKieffer says, "Our internal data indicate that among the largest health systems, 65% promote an internal candidate to the CEO position. Historically, community hospitals have had an even higher rate (83%) of internal promotions. However, over the past three years, we have seen a drop to 62% of community hospitals promoting internally to the CEO role."

Many boards, therefore, expect the incumbent CEO to mentor selected senior leader(s) to be a potential CEO successor in the future. Even for highly experienced executive leaders, there is much to learn about stepping into the CEO role. Preparing a potential CEO successor for the governance and board-related aspects of the CEO's responsibilities requires a robust training approach.

When an incumbent CEO is preparing a potential successor, general exposure to the board is often the first move.

Incumbent CEO as Mentor

From personal observation, most CEOs take seriously their responsibility to coach selected executive leaders to be as prepared as possible to assume a future CEO role. Often, organizations provide an array of leadership experiences for people on a potential CEO career trajectory, exposing them to quality, finance and strategy. Overseeing operations (clinical and support), fostering physician relationships and exploring leadership of different geographic sites are standard professional development elements for most future CEOs.

Incumbent CEO Checklist

- ☐ Preparing the organization's next CEO to be accountable to the board requires an understanding of governance principles and processes, as well as building relationships with current directors.
- ☐ Exposing high-potential senior leaders to governance is as important as providing professional development in strategy, finance, quality and operations.
- ☐ Developing governance and board knowledge should follow an intentional plan, led by the current CEO.
- ☐ Sharing insights and depth of knowledge about governance. This experience will be priceless to the next generation of CEOs.

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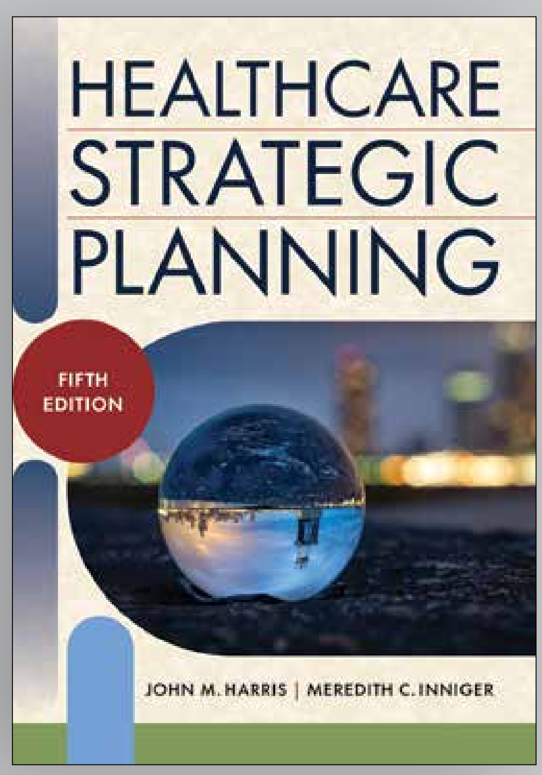

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Sometimes overlooked is the importance of developing a deep understanding of the governance function, including expanding boardroom skills, building board relationships and growing expertise in effective governance practices. Placing governance on the professional development list for high-potential senior leaders will benefit both the board and the future CEO, while also contributing to a smoother beginning for a new CEO.

First Steps

When an incumbent CEO is preparing a potential successor, general exposure to the board is often the first move. Attending board and board committee meetings, providing presentations to the board and organizing occasional social contact with board members are typical steps that an incumbent CEO may facilitate for his or her successor. This is where the governance preparation sometimes ends, which is unfortunate because additional opportunities can build governance knowledge and associated skills.

Consider any combination of these options for governance and board exposure. The potential CEO successor can:

- Join and fully participate in the board's governance committee.
- Attend and participate in all board committees on a rotational basis.
- Take the lead in working with the board (or the governance committee) to plan the board's education calendar for a year.
- Lead the onboarding and orientation for new directors.
- Participate in the review, analysis and communication of the board's annual self-evaluation.
- Plan the annual board retreat—in conjunction with the current CEO.
- Talk with the organization's governance support professional and/or chief legal officer about governance practices.
- Discuss the organization's conflict-of-interest process with the chief legal officer.
- Initiate self-study about governance, using resources provided by The Governance Institute, ACHE and others.
- Expand governance expertise by joining an outside board (either healthcare or non-healthcare) that offers meaningful boardroom experience.
- Gain a clear understanding of the distinction between the governance and CEO roles.

Incumbent CEO Perspectives

The incumbent CEO likely has significant experience with many boards—and a lot of wisdom to

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impart to a potential successor. Schedule regular conversations in which the incumbent CEO discusses his or her own experiences surrounding these responsibilities:

- Developing an effective partnership with the board chair.
- Deciding what to communicate to the board—including communication frequency and methods.
- Anticipating potential friction points among board members, including mitigation strategies.
- Working with board leadership to appropriately manage a conflicted director.
- Understanding the CEO's role in seeking new board talent.
- Keeping the board focused on governing and not managing.

For current CEOs who are thoughtfully preparing the next generation of CEO leaders, governance and board-related responsibilities should not be overlooked. When a newly appointed CEO has an unexpectedly short tenure, the underlying problem is often the board–CEO relationship. Providing robust exposure to the governance function and associated board relationships can mitigate the risk of an underperforming CEO in the future. ▲

Kimberly A. Russel, LFACHE, is CEO of Russel Advisors, a healthcare governance and CEO consulting firm, and an advisor with The Governance Institute (russelmha@yahoo.com).

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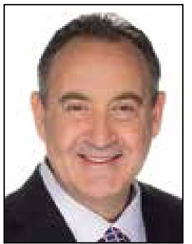
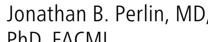
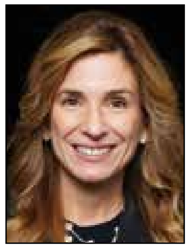




Jonathan B. Perlin, MD, PhD, FACMI



Alexandra Drane

Unpaid Caregivers in Today's Care Economy

They provide a critical role and deserve recognition and resources.

The "care economy" is booming. Today, nearly 1 in 2 people serve as unpaid caregivers. They show up for family members, friends and neighbors in whatever ways they can.

To honor, support and create upward mobility for this vital population, ARCHANGELS and The Joint Commission recently launched the Care Badge initiative.

Efforts to support family caregivers have historically focused primarily on parents of young children or elders. However, anyone who has experienced caregiving knows that care spans all ages and demographics. Caregivers support those with chronic or acute conditions, cancer, mental health impacts, disabilities, and more.

Every segment of the population feels the intensity of caregiving, but the "sandwich generation"—those caring for someone over and under 18 simultaneously—feels it the most. Nearly a quarter of adults across the country belong to this group.

To honor, support and create upward mobility for this vital population, ARCHANGELS and The Joint Commission recently launched the Care Badge initiative, leveraging ARCHANGELS' work with states, employers, health systems and local organizations to help unpaid caregivers and their communities, alongside The Joint Commission's focus on patient safety and quality of care across all settings.

Recognizing and Supporting Unpaid Caregivers

The Care Badge initiative is a free way for people to get recognition and timely access to resources and networks of support. It includes short training videos on topics central to care; links to quick, actionable tips; and free tools to ease the intensity of caregiving. It also provides organizations and communities an opportunity to rally around this population in ways that provide value for all.

As a healthcare leader, you can recognize and support the unpaid caregivers within your own organization. Showing you care is the best way to improve organizational culture and drive top- and bottom-line results. It also enhances an organization's reputation and increases productivity.

A cross-sector cohort of leading organizations participated in a pilot program for the Care Badge initiative. These organizations included the Alliance of Community Health Plans, the American Heart Association, the Association on Aging in NY, Blue Cross Blue Shield of Massachusetts, Blue Cross & Blue Shield of Rhode Island, Blue Star Families, Care.com, CaringBridge, Hilarity for Charity, the Massachusetts Caregiver Coalition, New York State Office for the Aging, and Northwell Health.

The pilot organizations demonstrated their care for employees. The initiative offered them a high-impact way to support those who are keeping our economy alive with their care. Through the pilot, the organizations encouraged their employees to obtain their Care Badge and access its free resources and support.

Within a month of its October 2024 launch, the Care Badge

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reached over 600,000 people on Facebook and Instagram, with nearly 10,000 connecting with the Care Badge page and posts on LinkedIn. Momentum continues to grow. The Care Badge connects people to support, with 50% of badge holders watching at least one video, 80% exploring resources and over a third sharing their badge on social media. These numbers do not reflect the countless ways the Care Badge has been shared family-to-family, neighbor-to-neighbor and friend-to-friend, creating a wave of support and recognition.

The Care Badge initiative is a free way for people to get recognition and timely access to resources and networks of support.

Within the pilot organizations, over 80% who got their badge also obtained their free Caregiver Intensity Score. Like any other job, unpaid caregiving can be intense—in both the best and hardest ways. ARCHANGELS' Caregiver Intensity Index engages all caregivers, especially those who do not see themselves in the role. It provides each caregiver with a "score" and a tailored list of what's most driving their intensity, as well as access to supportive resources at no cost.

Creating Opportunities in Healthcare

Front-line healthcare professionals form the foundation of our healthcare system. We rely on their expertise, dedication and compassion to protect and ensure the health and well-being of our communities. Unfortunately, the healthcare workforce faces unprecedented challenges.

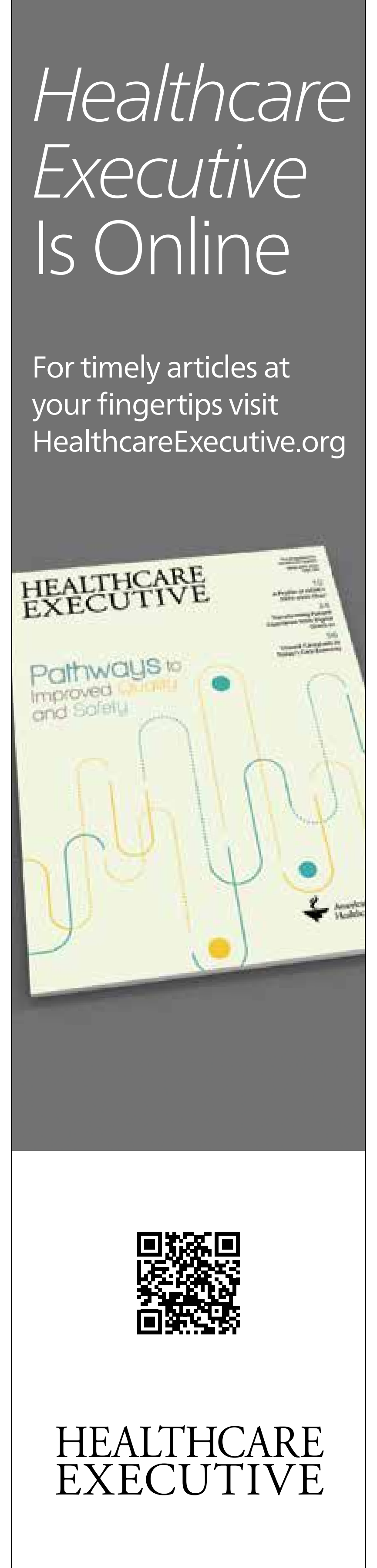
Healthcare urgently needs the skills that unpaid caregivers possess, such as hands-on care, medication management, and navigating finances and a complex healthcare system. Given unpaid caregivers' unique skill sets, there is a profound opportunity for them to apply their skills to the workforce.

We envision the Care Badge evolving to translate specific healthcare-related competencies into paid employment for caregivers. As your organization looks for qualified applicants, consider the many skills that unpaid caregivers possess.

Together, we are creating a movement. The Care Badge initiative not only provides a visual mark of the caregiving experience but also reframes caregiving as a strength-based asset invaluable in the workforce. Let's join forces to support this population that serves as the invisible backbone of our nation to achieve our vision that all people always experience the safest, highest quality and most compassionate care.

To learn more, visit www.thecarebadge.com. ▲

Jonathan B. Perlin, MD, PhD, FACMI, is president and CEO, The Joint Commission and Joint Commission International, Oakbrook Terrace, Ill. Alexandra Drane is co-founder and CEO, ARCHANGELS, Boston.



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ACHE MEMBER UPDATE

ACHE Policy Statements and Code of Ethics Updated

The ACHE Board of Governors approved at its December meeting changes to seven ACHE Policy Statements and the *Code of Ethics* suggested by subject-matter experts to the Board Policy Committee.

ACHE has nearly 30 Policy Statements that provide guidance and best practices to healthcare leaders on matters important to the profession. Policy Statements are reviewed and revised annually on a rolling basis to ensure they're relevant to leaders.

Along with the *Code of Ethics*, the following statements were revised:

- ACHE Statement on Diversity
- 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
- Strengthening Healthcare Employment Opportunities for Persons With Disabilities
- The Role of the Healthcare Executive of a Nonprofit Entity in a Change in Organizational Ownership or Control

Call for Candidates for ACHE's 2026 Leadership Slate

ACHE's 2025–2026 Nominating Committee is looking for experienced leaders to serve in ACHE's top leadership ranks for terms beginning in 2026. ACHE Fellows are eligible for the Chair-Elect and Governor vacancies, as well as 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 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.

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 more details on the candidate guidelines, visit **ache.org/CandidateGuidelines**. For more on call for candidates, visit **ache.org/CallforCandidates**.

In Memoriam

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

Casey Carlson
Santa Maria, Calif.

Margaret J. Ford, FACHE(R)
Ponte Vedra Beach, Fla.

Kevin L. Otto
Boiling Springs, Pa.

Joseph E. Roche, LFACHE
Charleston, S.C.

Candace S. Smith, PhD, RN
Punta Gorda, Fla.

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Remembering Don Avery, Former ACHE Governor, Regent

Donald Robert "Don" Avery, FACHE, president and CEO of Fairview Park Hospital, Dublin, Ga., passed away Jan. 23, 2025, at the age of 68. He was preceded in death by his daughter Meredith Fara Avery and is survived by his wife of 40 years, Fara Haney Avery; daughter and son-in-law, Amelia and Travis Cobb; and two grandchildren.

An Eagle Scout, Don showcased leadership early on. He graduated from the Air Force Academy in 1978 and served six years as a pilot, instructor pilot and operations officer, as well as two years in the Florida National Guard.

Don was a member of ACHE for 40 years. He served on ACHE's Board of Governors from 2008–2011, as a Regent for Georgia from 2003–2006, and on several committees. He received ACHE's Senior-Level Regent Award, the Service Award, the Distinguished Service Award and the Exemplary Service Award.

As a survivor of Hodgkins lymphoma in his early 20s, Don had a unique perspective on patient care and a fierce commitment to healthcare excellence. He earned two master's degrees from the University of Florida in business and health science and then worked in several hospital executive leadership positions before becoming president and CEO of Hughston Orthopedic Hospital, Columbus, Ga., in 2003. In 2008 Don was named to lead Fairview Park Hospital, where he immediately focused on creating a culture of excellence and a Fairview family.

The hospital earned numerous accolades under his leadership, including being named a Top 100 Rural Hospital, a CMS 5-star rated facility and the No. 1 medium-sized hospital by *Georgia Trend*. Don recently announced his intent to retire in July 2025. "For 17 years, Don led our hospital with passion and a personality that was bigger than life," Fairview Park said in a statement.

ACHE Author, Ethics Expert Frankie Perry Passes Away

Frankie Perry, RN, FACHE, passed away this past January. She was 90. Frankie was a champion of ethics in healthcare management, mentoring emerging leaders and supporting lifelong learning for all healthcare professionals.

She began her career as a registered nurse, taking on various nursing supervisory positions, including head nurse of the operating room at Hurley Medical Center, where she also worked to establish a dialysis center. She became the assistant medical center director in 1982. At Hurley, she created a biomedical ethics committee, an institutional review board and a patient advocacy program. In addition to her nursing diploma from Nazareth College, she received a master's degree with a concentration in sociology of medicine and a bachelor's degree from the University of Michigan.

In 1986, Frankie accepted the position of director, Communications and Marketing, at the American College of Healthcare Executives. She was promoted to vice president, Membership, and then to executive vice president. She helped develop ACHE's Ethical Policy Statements and wrote the first regular ethics column in *Healthcare Executive*.

Even after retirement, she continued to encourage advancement in ACHE and achievement of the FACHE credential. She supported New Mexico's Regents, served on their Advisory Councils, wrote the Regent's newsletter and helped secure funding for the annual ACHE breakfast. She authored many healthcare-focused articles and books, including *The Tracks We Leave: Ethics in Healthcare Management* and *Management Mistakes in Healthcare: Identification, Correction and Prevention*, in addition to teaching at the University of New Mexico and conducting ACHE online seminars.

In 2011, Frankie was the first female recipient to receive the ACHE Lifetime Service and Achievement Award. She also received an ACHE Regent's Award for Significant Contributions to Healthcare Management Excellence and the Edgar C. Hayhow Award for Article of the Year.

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Transitioning From Military to Civilian Employment

Results by ACHE's Executive Office, Research

In December 2023, ACHE conducted a survey of members who had transitioned from military to civilian healthcare employment. The survey collected information about their experiences and helpful resources in their job searches. It was sent to 304 individuals who had changed from military to civilian employment in the last three years. Ninety-three responded, for an overall response rate of 31%. Eleven respondents were still actively serving in the military and were eliminated from the analysis, leaving a final sample size of 82.

Length of Job Search

Table 1 shows the length of time that survey respondents spent searching for their first post-military healthcare positions, both before and after leaving the military. Most respondents began their search up to one year before leaving military service.

First Position After Leaving the Military

Table 2 shows the variety of levels of the first civilian positions respondents took after leaving the military. A little more than half (about 55%) took positions as department head/director or above.

Useful Techniques for Finding Civilian Positions

Survey respondents were asked to rate the helpfulness of different job search techniques for finding their first post-military healthcare positions on a scale of 1 to 5, where 1 was "not at all helpful" and 5 was "extremely helpful." The four highest-rated techniques were: "networking with civilians you already knew" with an average helpfulness score of 3.64, "networking with former military personnel you already knew" (3.45), "job postings on individual employers' websites" (3.30) and "answering ads or responding to job listings on general job sites such as LinkedIn, Indeed.com, Monster.com, etc." (3.27).

Challenges Faced in the Job Search

Survey respondents identified several challenges in securing their first post-military healthcare positions. A major hurdle is effectively translating their military experience to appeal to civilian employers, ensuring that employers can accurately recognize the skills and experience they offer. Additionally, respondents emphasized the importance of patience and maintaining a positive attitude throughout the job search process, as transitions can take time. By actively seeking to hire military veterans, CEOs can tap into a dedicated and resilient talent pool that is well-equipped to meet the demands of the healthcare sector. Embracing this unique expertise not only enriches your workforce but also demonstrates a commitment to supporting those who have served.

ACHE wishes to thank collaborators, Gigi Simko, FACHE, and Stephanie J. Underwood.

Table 1. Percent of respondents who searched for jobs before and after leaving the military by length of job search.

	Percent of Respondents Who Conducted a Job Search for This Length of Time	
Length of Job Search	Before Leaving the Military	After Leaving the Military
1 to 2 months	17%	25%
3 to 6 months	39%	22%
7 to 12 months	23%	7%
13+ months	7%	8%
Did not search during this time	15%	38%
Total	100%	100%
(N)	(75)	(76)

Table 2. Percent of respondents whose first post-military healthcare position was at each position level.

Position Level	Percent of Respondents Whose First Post-Military Position Was at This Level
C-Suite or Senior VP	18%
VP	8%
Department Head/Director	29%
Manager	14%
Consultant	11%
Other	20%
Total	100%
(N)	76

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

Hena Bajaj received the Early Careerist Award from the Regent for New Jersey—Northern.

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

Erik L. Carlton, DrPH, FACHE, received the Outstanding Chapter Leadership Award from the Regent for West Virginia & Western Virginia.

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

Lynda M. Christel received the Volunteerism Award from the Regent for Florida—Northern and Western.

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

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

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

Mary Egan, PhD, received the Mid-Careerist Award from the Regent for New Jersey—Northern.

Aparna Gupta, DNP, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for District of Columbia & Northern Virginia.

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

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

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

Derrick J. Hutton received the Senior Careerist Award from the Regent for New Jersey—Northern.

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

Asjad Javed received the Emerging Leader Award from the Regent for Florida—Northern and Western.

Paul Killion received the Collaborator Award from the Regent for New Jersey—Northern.

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

Donald Lighter, MD, FACHE(R), received the Outstanding Faculty Member Award from the Regent for Tennessee.

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

Ashleigh Nabers received the Early Careerist Award from the Regent for District of Columbia & Northern Virginia.

Lana L. Palmquist, RN, received the Volunteerism & Healthcare Leadership Choice Award from the Regent for Florida—Northern and Western.

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

Jonathan Puncochar, FACHE, received the Exceptional Service Award from the Regent for Tennessee.

Frances L. Revere, PhD, FACHE, received the Senior Faculty Leadership Award from the Regent for Florida—Northern and Western.

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Matthew C. Rivera received the Student Associate Award from the Regent for New Jersey—Northern.

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

Kenneth Sturtz, FACHE, received the Senior Executive Award from the Regent for Florida—Northern and Western.

LCDR Raben B. Talvo, FACHE, received the Early Careerist Award from the Regent for District of Columbia & Northern Virginia.

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

Leticia W. Towns, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Tennessee.

MAJ Tiara Walz, PhD, FACHE, received the Early Career Healthcare Executive Award from the Regent for Texas—Central & South.

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

Victor D. Weeden, DHA, FACHE, received the Academic Leader Award from the Regent for Florida—Northern and Western.

Derick B. Ziegler, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Tennessee.

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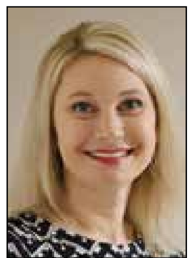
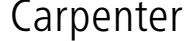
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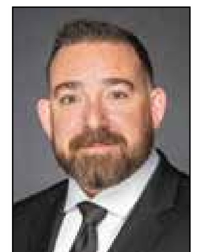
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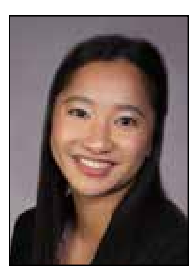
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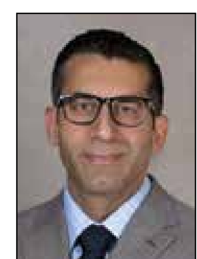
Thakkar

Thomas Aloia, MD, FACHE, FACS, to executive vice president/chief clinical officer, Ascension, Houston, from senior vice president/CMO.

Judy Bruno, RN, FACHE, to president and CEO, WVU Medicine Barnesville (Ohio) Hospital and WVU Medicine Harrison Community Hospital, Cadiz, Ohio, from president, Vidant Roanoke Chowan Hospital, Ahoskie, N.C.

Lynn Carpenter, FACHE, to president/COO, Lima (Ohio) Memorial Health System, from vice president/COO.

Matthew Chandler, PharmD, to COO, Casa Colina Hospital and Centers for Healthcare, Pomona, Calif., from executive director, operations, Providence Little Company of Mary, San Pedro, Calif.

Cory Edmondson, FACHE, to CEO, United Regional, Wichita Falls, Kan., from president/CEO, Peterson Health, Kerrville, Texas.

Flynn Gaffney, FACHE, to CEO, Banner–University Medical Center Tucson and Banner–University Medical Center South, from president, healthcare division, JLL, Chicago.

Kim Hale, DNP, NEA-BC, FACHE, to CNO, Providence St. Joseph Hospital, Orange, Calif., from executive director, surgical and cardiovascular services.

Jeffrey Harrison to CEO, Florida Rehabilitation Hospital at Tampa (Fla.), from market CEO for three specialty hospitals in the Tampa Bay area.

Vincent A. Kucich, MD, FACHE, FACS, to vice president/CMO, Heart of Mary and Sacred Heart Medical Centers OSF Healthcare Urbana and Danville (Ill.), from director of physician practices.

Maria Megdal to executive vice president and chief administrative officer, St. Jude Children's Research Hospital, Memphis, Tenn., from senior vice president/chief administrative officer, Dana-Farber Cancer Institute, Boston.

Kim-Quyen Nguyen to administrative fellow, Seattle Children's, from MHA student, Texas A&M University, College Station, Texas.

Sue Roberts, DO, FACHE, FACP, to CMO, VA Southeast Network-VISN 7, from deputy executive director, Veterans Health Administration.

Michael Stern, FACHE, to president/CEO, Tower Health, West Reading, Pa., from president/COO.

Jigar Thakkar, PharmD, FACHE, to CEO, LongitudeRX, from chief administrative officer and chief pharmacy officer, OU Health, Oklahoma City, Okla.

John R. Tucker, FACHE, to president, Heart of the Rockies Regional Medical Center, Salida, Colo., from CEO, Mt. San Rafael Hospital, Trinidad, Colo.

Jason Willliams, FACHE, to chief strategy officer, Cigna Healthcare, Birmingham, Ala., from vice president, Individual Family Plan Market.

Want to submit?

Send your "On the Move" submission to he-editor@ache.org. Due to production lead times, entries must be received by April 1 to be considered for the July/August issue.

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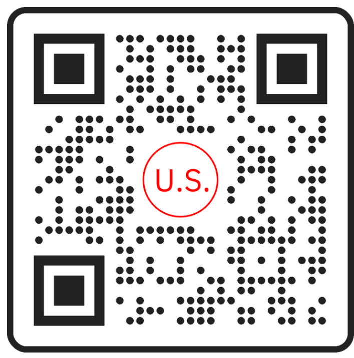

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