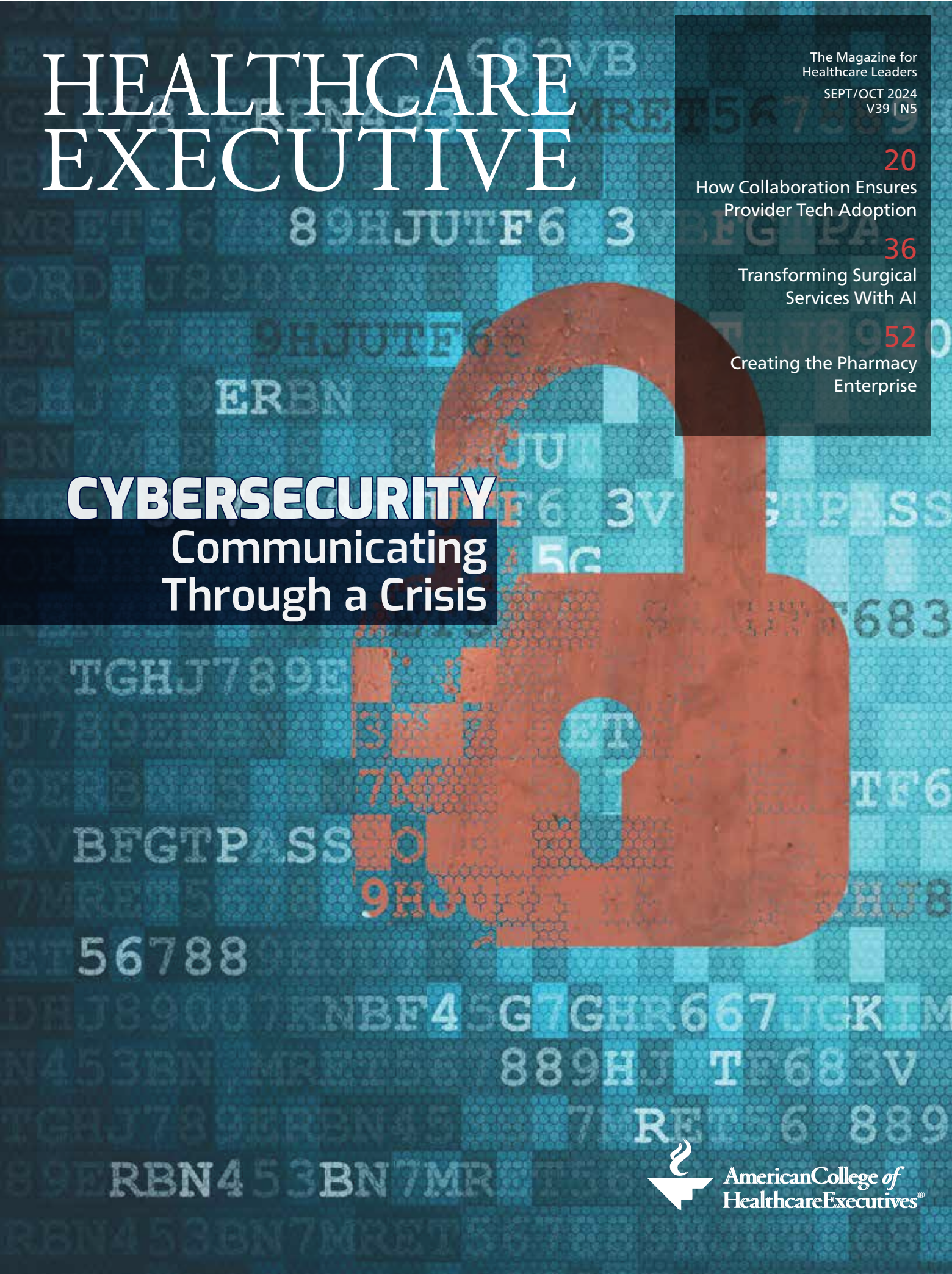
HEALTHCARE EXECUTIVE

The Magazine for Healthcare Leaders
SEPT/OCT 2024
V39 | N5

CYBERSECURITY
Communicating Through a Crisis



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Approximately 60 million adult Americans aged >45 years are currently **unscreened for colorectal cancer (CRC).**[1,2*]

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

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

References: 1. United States Census Bureau. Annual estimates of the resident population by single year of age and sex for the United States: April 1, 2020 to July 1, 2022 (NC-EST2022-AGESEX-RES). April 2023. Updated December 18, 2023. Accessed December 20, 2023. www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html **2.** American Cancer Society. Colorectal Cancer Facts & Figures 2023-2025. Atlanta: American Cancer Society; 2023. **3.** 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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Communicating effectively with stakeholders through a data breach is crucial to protecting a hospital's reputation and ensuring trust in the organization.

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Leaders are engaging providers in high-impact clinical technology decision-making processes. The results are promising.

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Inside ACHE

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10 KPIs to Ensure Your Healthcare Data Is Ready for the AI Revolution

To guide leaders on this crucial journey, we outline actionable steps for cultivating a data-driven, AI-ready culture of care, presenting 10 key performance indicators for extracting the value of health data.

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In "Innovations in Healthcare Delivery and Access to Care," **Myriam J. Curet, MD**, executive vice president/CMO, Intuitive, discusses enhancing patient care, including advances in healthcare equity.

In "The Most Important Job You Have as a Leader," **Warner Thomas, FACHE**, president/CEO, Sutter Health, delves into how culture is the backbone of any successful organization.

In "A Conversation With **Ashley R. Vertuno, FACHE**," the 2024 Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year recipient talks about her healthcare leadership background, the role mentors have played in her professional growth and advice for those who are beginning their healthcare management careers.

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Healthcare Executive (ISSN 0883-5381) is published bimonthly by the American College of Healthcare Executives, 300 S. Riverside Plaza, Suite 1900, Chicago, IL 60606-6698. The subscription cost is $130 per year (add $15 for postage outside the United States). *Healthcare Executive* is paid for by members of the American College of Healthcare Executives as part of their membership dues. Periodicals postage paid at Chicago, IL, and additional mailing offices. Printed in the USA. POSTMASTER: Send address changes to *Healthcare Executive*, 300 S. Riverside Plaza, Suite 1900, Chicago, IL 60606-6698.

To subscribe, make checks payable to the American College of Healthcare Executives and send to: Subscription Services, Health Administration Press/Foundation of the American College of Healthcare Executives, 300 S. Riverside Plaza, Suite 1900, Chicago, IL 60606-6698. Single copy is $36.00 plus shipping and handling.

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Randy F. Liss

When Strong Communication Means Everything

If it seems like we're hearing about cyberattacks and data breaches way more often these days, you're right. According to the Identity Theft Resource Center, a nonprofit organization that provides identity crime victim assistance and education, the number of data breaches in the first half of this year was 490% higher than in the first half of 2023. That, of course, includes cyberattacks on health systems.

Being prepared to not only address a data breach at your organization but also communicate throughout it is critically important, as experts and providers tell us in our cover story "Cybersecurity: Communicating Through a Crisis" (Page 8). What leaders say in the hours, days and weeks after a breach can mean the difference between maintaining the organization's reputation and eroding the trust it has with its employees, patients and the community. "The more transparency that you can demonstrate," one provider tells us, "the better off you're going to be."

Communication also comes into play when making big decisions about clinical technology. In this instance, it's about ensuring that IT professionals and providers are on the same page regarding their objectives and how to measure success. In our feature, "How Collaboration Ensures Provider Tech Adoption" (Page 20), three providers detail how they fostered collaboration between both the IT and clinical teams when instituting major projects.

Finally, healthcare lost a one-of-a-kind leader in late July with the passing of Charles D. "Chuck" Stokes, FACHE. A past Chair of ACHE and former president and CEO of Memorial Hermann Health, Houston, Chuck personified the term "servant leader" and repeatedly guided organizations toward excellence in patient care. Read more about his extraordinary career and the deep impact he made on Page 58.

As always, thank you for reading. If you'd like to share any feedback about this issue, just send me a note at rliss@ache.org. ▲

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Deborah J. Bowen, FACHE, CAE

Celebrating 20 Years of the ACHE-Chapter Partnership

Building on our collaboration will be key to future success.

In 2003, ACHE embarked on a vison to ensure that every member could benefit from having ACHE benefits close to home. By 2004, ACHE had brokered the first 60 independently chartered chapters. It was the beginning of what we now know to be a vibrant network of 76 chapters. The chapters are evidence that leadership, just like healthcare, is local. Chapters fill a vital role in our field by giving healthcare leaders local options to develop their skills, give back and inspire future leaders of our profession.

The strength and value of this network has grown exponentially in 20 years. In 2004, chapters hosted 311 total events, drawing about 12,000 attendees and covering roughly 34,000 attendee hours. In 2023, chapters offered nearly 1,500 events, with about 90,000 participants and covering 340,000 attendee hours—265,000 hours of which were education. During this time, the number of Members and Fellows has grown 44%. Chapters have also contributed to broadening the leadership ranks, increasing the multiple dimensions of the richness of our leadership community. Equally compelling are the countless relationships that are the product of chapter events and networking. Indeed, our local communities remind us of the passion, energy and commitment of ACHE.

What's also compelling is that chapters provide opportunities for everyone …

- For senior leaders, it's a chance to tell your personal story or showcase a promising innovation.
- For those new to our profession—whether clinical or nonclinical in practice—it's a time to learn about your local market.
- For early careerists, it's an opportunity to gain leadership experience by volunteering for an event or a committee.
- For students, it's a door that can open to a whole new career—a learning opportunity about the rewards of our profession.

Chapters also help members become stronger leaders, give back and support their own community through volunteering. For example, chapter officer and committee positions provide firsthand experience and recognition as a local leader. Serving as faculty for a chapter panel discussion provides an opportunity to help educate others while making new relationships. Raising your hand to help manage or coordinate a chapter-sponsored community service day offers the chance to contribute to a good cause wherever you are. The built-in networking these activities feature is yet another benefit, for senior leaders and emerging executives alike.

Perhaps the most rewarding component of the chapter evolution is the collaboration it represents. From the Board to the Regents to the local volunteers to the staff, together we have a partnership that fosters and strengthens this community. Nearly 1,900 chapter volunteers selflessly share their expertise, time and talent to help others learn, grow and connect at the local level—and we thank each of you.

Building on this collaboration will be key to our future success. For the Board's part, we are committed to ensuring this partnership strengthens and grows. While much is important, the following priorities will serve as our guide:

- To collaborate to provide meaningful membership experiences while advancing our mutual vision and goals to help leaders reach their highest potential to lead.
- To provide leading-edge content and support to chapters to help leaders grow and learn.
- To invest in best-in-class solutions to minimize risk, ensure compliance and address any identified administrative burdens for busy volunteers.

As we celebrate the success of chapters, we recognize there is more all of us can do. We look forward to our continued partnership with chapters, so that together we can leverage our strengths to realize the vison of adding value to the ambitions of every leader to advance themselves and their organizations.

We know many ACHE members have yet to discover the value of their local chapter. If you are not already involved in yours, I encourage you to find ways to take part. Doing so helps us advance as leaders and makes our ACHE community stronger. ▲

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

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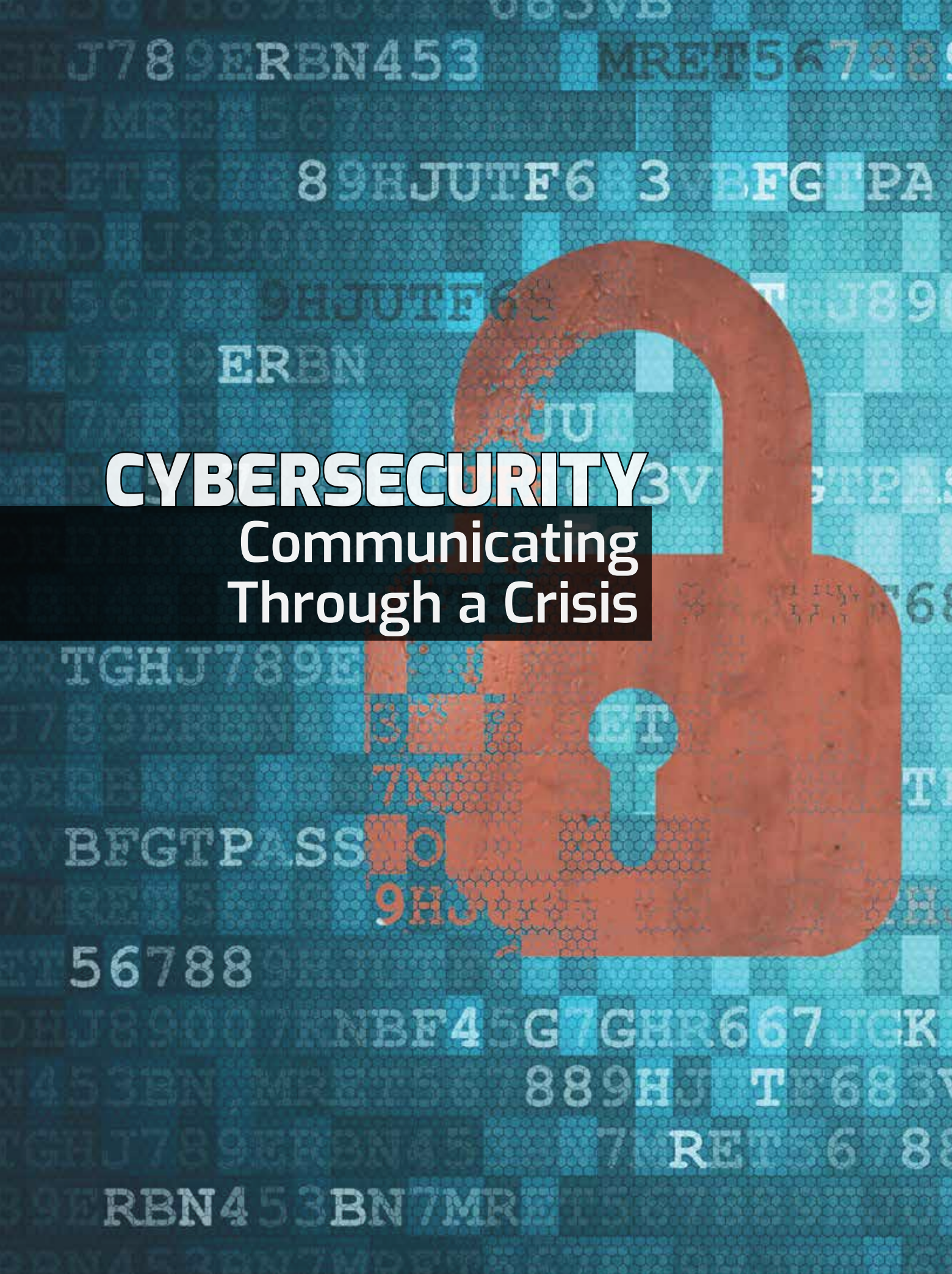

CYBERSECURITY

Communicating Through a Crisis

Frequent messaging before, during, after an event builds trust

Karen Wagner

Perhaps almost nothing strikes more fear in the heart of a hospital or health system CEO than protecting patient data from the threat of a cyberattack.

During the past five years, there has been a 256% increase in large breaches reported to the Department of Health and Human Services Office for Civil Rights involving hacking and a 264% increase in ransomware, according to the federal office that enforces HIPAA security and breach notification rules, among other responsibilities. Ransomware and hacking are the primary cyberthreats in healthcare, according to the OCR.

What's the Plan?

What's at stake first and foremost is being able to deliver care, as healthcare leaders scramble to protect patients, sometimes having to divert care to other hospitals. After a data breach at an Ascension hospital in Detroit, for instance, the most severe heart attack patients were diverted to other hospitals, but stroke and trauma patients were still treated at the facility.

CYBERSECURITY

Communicating Through a Crisis

In addition to care delivery, revenues may also be threatened when a cyberattack occurs, as some functionality may come to a halt. According to the U.S. Committee on Energy and Commerce, the cyberattack at Change Healthcare that occurred in February knocked the subsidiary to UnitedHealth offline, creating a backlog of unpaid claims.

Mitigating the impact of such attacks and resuming normal operations are mission-critical first steps, according to experts.

But communicating effectively with stakeholders throughout the crisis—from initial messaging when an attack occurs to when the smoke clears and operations return to normal—is crucial to protecting a hospital's reputation and ensuring trust in the organization.

Knowing what questions will be asked and how to respond throughout the crisis is critical.

> "All the time, crisis or not, we want our organization to be a reliable source of information for our community."
>
> —Michael Mayo, DHA, FACHE
> **Baptist Health**

Do patients feel safe? Will community members trust the hospital? And, is the staff comfortable in using the facility's technology?

And, what is the correct course of action? Are there recommended practices for managing the public relations aspect of a cyberattack? What practices should be avoided?

"All the time, crisis or not, we want our organization to be a reliable source of information for our community," says Michael Mayo, DHA, FACHE, president and CEO of Baptist Health, Jacksonville, Fla. "During a crisis, frequent communication before, during and after the event about what is occurring, who is impacted and what we're doing is another way to help build trust with the people we serve."

These healthcare executives and a health information management expert offer their recommendations for effective communication throughout the crisis of a cyberattack.

Frequent Communications

With six hospitals and more than 14,000 team members, Baptist Health has a significant presence in northeast Florida, which makes the health system a major target for data breaches, according to Mayo.

Baptist Health has not experienced a data breach firsthand, but as a system located in a hurricane-prone area, preparing for disaster is commonplace, he says.

Mayo adds that what is of utmost importance in such disaster situations is communicating regularly and effectively with the workforce, patients and the community.

"Communications are extremely important in every aspect of what we do because the more transparency that you can demonstrate to your constituents, both your team members, your physicians and your patient population, the better off you're going to be," he says.

Regulatory bodies that investigate cyberattacks often institute restrictions on what information is communicated publicly, Mayo says, but beyond those restrictions, providing comprehensive information is critical.

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References:

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2. CMS.gov. Medicare part B drug average sales price. Updated April 2, 2024. Accessed June 12, 2024. https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price

ASP, average sales price; ASP+6 = reimbursement of 106% of the average sales price; NOPAIN Act, Non-Opioids Prevent Addiction in the Nation Act.

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CYBERSECURITY
Communicating Through a Crisis

Baptist Health has a plan in place to use various channels to communicate information in the event of a data breach—from desktop alerts for internal team members to the patient EHR, a call center hotline, and a mobile app to reach patients and the community, in addition to traditional methods such as email and telephone, Mayo says.

"So it really is a multichannel approach," Mayo says. "But most importantly, we want to be as upfront and as truthful and give as much information that we can, because that dispels a lot of concerns."

Mayo says an initial message at the beginning of a cybersecurity incident would provide essential information, such as, "We are experiencing an unplanned downtime; operations will continue as scheduled as IT teams work to resolve the issue. Our 'XYZ' system is currently offline. Please use downtime procedures. Regular updates will be provided via email, text, intranet and hotline. Thank you for maintaining continuity of care and service while our IT teams work to resolve this issue."

Lee Kim, senior principal, cybersecurity and privacy for HIMSS, says it's good practice to disseminate timely messaging about a data breach to individuals via a letter, website postings, or by sharing this information with the media and relaying what is known to date using the HIPAA breach notification rule and other applicable state and federal laws and regulations, along with advice from counsel, as guidance on what to do.

For example, Ascension Health's cyberattack occurred in early May and impacted its 140 hospitals. The health system set up a "Cybersecurity Event Update" on its website, and in mid-June posted a message announcing that EHR access had been restored throughout the system and that clinical workflow was functioning. The message also reported that the health system was still investigating the attack.

"Transparency and timely communications about what is going on is very much appreciated by everyone whose data may be impacted or people in the community who may be concerned," says Kim.

Kim adds that the messages should be in languages that represent the patient population and community at large—or they won't be effective. "I think that we owe it to our patients to ensure that any messages, whether individual notices, website postings or alerting media, be in different languages," she says. "Of course, be sure to work with your in-house counsel or retained

Large-Scale Breaches

up **256%** in the past 5 years and a

264% increase in ransomware.

Source: Department of Health and Human Services Office for Civil Rights

outside counsel to ensure that you are fully complying with the HIPAA breach notification rule and other state and federal breach notification requirements, as appropriate."

What to Communicate

Reaching stakeholders quickly and with the right information is imperative.

"One of the key things is not only having transparency, but making sure that you have a standard continued message that is the same to everyone," Mayo says. "So … talking points would be developed that can be used internally and externally, as well."

Patients primarily want to know what happened with their medical and financial data and whether it's been compromised, Kim says.

"I think the question is to what extent is that data out there? Did the cybercriminals, for example, publish it on the dark web?" says Kim, referring to internet sites accessible only through specialized browsers. "Is there any evidence of the information being exfiltrated? Was it actually stolen?

"Because it's one thing, of course, for the breach notification letter to state this happened," she continues. "But it's another thing to talk about the extent and what kind of data was at stake and where did it go."

Kim says people also want to know whether those who perpetrated the attack are truly removed from the system and what steps are being taken to prevent another breach, she says.

The message to the workforce may differ from communication to the general public, depending on the organization's communication culture and the specific roles of individuals within the organization, Kim says. "It is important to responsibly share information with people within the organization on a need-to-know basis, especially when there is a critical need, whether it is to do a job function or to make better informed decisions or for oversight purposes," she says.

CEO Communication Checklist

- Use different channels: Ensure all appropriate communication channels (telephone, individual letters, website, social media, mobile apps) are used.
- Keep stakeholders in mind: Ensure appropriate messaging for all stakeholders (governing board, workforce, patients, community members).
- Be transparent and responsive: Communicate what information is known, when it is known.
- Be inclusive: Make sure that messaging is in languages that represent all of your stakeholders.
- Share lessons learned: Assess what went wrong and how the cyberattack occurred and help other hospitals to avoid those errors.

CYBERSECURITY

Communicating Through a Crisis

During a crisis, Mayo says Baptist's front-line team members would convey information to patients, family and friends. The team would be provided with talking points to help guide these conversations.

"We want them to feel knowledgeable, equipped and confident so they can pass important information along to those they are serving," he says. "Ideally, we encourage them to point back to our public-facing channels for the latest information, like our website and social media channels, so all messaging is consistent."

Because a cyberattack involves sensitive organizational information that can damage the hospital's reputation, Kim says communication leaders should determine who the trusted circle is to be given more detailed information. This circle might include senior executives, the governing board or those with "boots on the ground" who are managing the information systems, she says.

> "Transparency and timely communications about what is going on is very much appreciated by everyone whose data may be impacted or people in the community that may be concerned."
>
> —Lee Kim
> HIMSS

Leadership Transparency

Because cyberattacks seem to be becoming everyday incidents, healthcare leaders should give special consideration to their communication.

Leaders should be extra vigilant in their messaging to those whose data has been breached, ensuring they appreciate the seriousness of the situation and act on it, he recommends.

Mayo says one of the very first communications once a cyberattack was detected would be to the hospital's governing board.

"I'm in frequent communication with our board chair, and I'm talking through matters all the time. If an event like this happened, we would bring the board in and have a full report out and disclosure" he says.

The source of the information would be the system's incident command team, which includes information security, operations and corporate communications teams, he says.

"We're locally owned, locally governed. We want our board members who are active in our community to be knowledgeable so that they are kept up-to-speed themselves and so they can answer questions they may receive from others."

Mayo says he would work with the public relations department to create talking points for the board and executive leadership team to ensure messaging is consistent. The leaders would also be asked to direct any inquiries to the public relations department.

After the event, Mayo says he would review the incident command team's findings on how the incident happened and ways to reduce risks or improve responses for potential future incidents.

Messaging to the community would be multilayered, consisting of the facts known to date, along with compassion for what people are going through and reassurance that the system is still providing high-quality care, Mayo says.

"During a cybersecurity incident, we want to communicate in a way that reassures our community that the

people entrusting us with their care are safe and in good hands," he says.

Sharing Lessons Learned

Perhaps the final piece of communication that should be shared when a cyberattack occurs is with other healthcare organizations.

Though healthcare organizations may be hesitant to talk about how a cyberattack or event occurred and its impacts, other healthcare stakeholders could benefit from hearing about those experiences and the lessons learned, especially in terms of how organizations choose to become more resilient, Kim says. "It's not just cyberattacks that can cause disruptions, but also IT events, natural disasters, insider threat activity and other things," she says.

For example, Baptist Health was not significantly impacted by the ransomware attack to Change Healthcare information systems earlier this year, Mayo says. But, the Baptist Health IT team was in communication with its counterparts at Change Healthcare to learn the details about the incident and how it happened.

"We learned a lot from our friends and colleagues and what they went through," he says.

One of the greatest lessons Mayo learned from the incident from organizations affected was that business continuity plans are imperative. "For example, we are exploring having a secondary claims processor," he says. "In addition, it's important to have language in vendor contracts and business associate agreements to address vendor responsibility in the event of a breach."

Mayo says when a nearby regional hospital system suffered a data breach, his IT staff also reached out to learn about the experience.

"When we talk about evidence-based medicine practices to perform at the highest level to get the best result, I would look at cybersecurity in the same way," he says. "What is the best practice in terms of preparation and response in the event that something happens?

Kim agrees that part of the communication in such a crisis is reaching out to other healthcare organizations.

"We need to responsibly share vetted information about our experiences and best practices within trusted circles," she says. "Because unless we keep learning, we'll be behind, and information superiority is ultimately what's going to win the cyber race in terms of these threats. We need more situational awareness."

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

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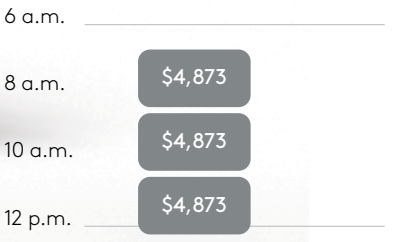

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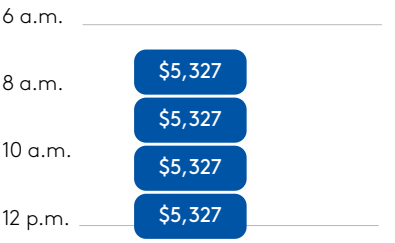

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* Scenarios utilize observed surgeon console time reduction based on a review of their da Vinci Xi system log data (n = 69) from 2023, and da Vinci 5 system log data (n = 13) from 4/1/2024-6/25/2024. **Cost inputs are estimated from actual customer data on file. †Contribution margin equals actual payment less total direct cost for closed encounters only.

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Building a Strong Robotic Service Line: Lessons From Sharp HealthCare

When Christopher Walker, RN, NP, NEA-BC, COO, Sharp Memorial Hospital, and an ACHE Member, assumed his current role in 2019, he embarked on a mission to strategically grow the organization's ORs.

During initial conversations with surgeons, however, Walker learned many of the robotically trained physicians weren't happy. Limited access to robots was preventing them from delivering equitable care to their community and serving patients in ways they believed would achieve superior patient outcomes.

Tony Guerra, FACHE, who was then the hospital's CFO, spoke with Walker about giving physicians more robotic access. Guerra quickly realized that he needed to reevaluate the organization's financial picture around robotic surgery. Understandably, previous executives had been wary of adding more robots, as, up until that time, capital purchasing was used exclusively to finance robotic assets. Guerra and his team decided to take a fresh look at alternative financing options.

"We realized there were advantages to the flexible acquisitions model," says Guerra, who is now chief finance/market growth officer for Sharp Metropolitan Campus. "You get protection when it comes to technology obsolescence, service and maintenance."

With a new approach to financing in 2020, Walker was given the go-ahead from system leadership to strategically grow the entire health system's robotic service line. Following are keys to success.

Purposeful Alignment

For Sharp HealthCare, its mission to become one of the strongest robotic programs in the country required a strategic alignment among executive, operational and clinical leaders. It also needed commitment from all three areas to grow the robotic program in support of the health system's vision: to be the best place to work, practice medicine and receive care.

This collaboration allows each area to better understand the others' needs and perspectives, says Kathleen Kracht, RN, CNS, CNOR, director, Surgical Services, Sharp Memorial Hospital and James S. Brown Pavilion, Sharp HealthCare.

"If your operational team just sees a robotic program as added costs, then they're not really aligned with the physicians to make sure that we are training appropriately. And if your executive team is just looking at straight dollars from a capital purchase perspective, then it is a giant barrier," she says. "When you have open communication about what the needs are for each area, then you quickly realize, 'wow, this could be beneficial for everybody.'"

The health system underscores this alignment via robotics committees at each hospital, where members discuss local performance issues and ideas regarding quality and efficiency. A systemwide executive steering committee, which incorporates executive, operations and clinical leaders from hospitals across the system, meets every other month.

One of the steering committee's goals was to become a Network of Excellence in Robotic Surgery, a designation the health system earned from the Surgical Review Corporation in 2023, making it the first health system in California to do so. Five of its hospitals are now designated as Centers of Excellence, and 30 of its surgeons have achieved the Surgeons of Excellence in Robotic Surgery designation.

A Commitment to Health Equity

The aligned leadership structure and increased robotic competence among surgeons has helped support Sharp HealthCare's organizationwide commitment to health equity.

"Because of the alignment with administration and with operations, we now have a 24/7 robotic program," says Pamela Lee, MD, FACS, FASCRS, chair, Department of Surgery, Sharp Memorial Hospital/Sharp Rees Stealy Medical Group. "If we want to do a case at 9 p.m. or at midnight, if it's an emergency, we have the staff to do it. Many organizations shut robots down at 4 p.m. because they haven't trained after-hours staff to support the cases."

To make 24/7 robotic access a reality, Sharp HealthCare leadership committed to making robotics a core competency for all staff, including nurses and techs, which provides flexibility for the team to cross-cover multiple areas, according to Walker. The organization can now serve more patients, including after hours and on weekends. This ensures patients have access to robotic surgery, whether it's an elective case or an emergent case and no matter what type of insurance they have, Kracht says.

A Culture of Positivity

Being able to provide robotic care 24/7 contributes to what the team at Sharp HealthCare emphasizes is a positive culture.

"Our doctors talk about it all the time," Walker says. "They feel better; they feel like they're delivering the same care to all patients without any discrimination."

Alignment among executive and clinical leadership and clinicians themselves has resulted in greater physician satisfaction, according to Lee.

"I've worked at other institutions where there is an adversarial relationship between clinical staff and the administration, and it's a recipe for clinician burnout," she says. Sharp's leadership, she says, "really cares about physician satisfaction" and makes clinicians feel heard.

The positive organizational culture and alignment combined with surgeon access to robots has also aided the organization's ability to recruit and retain surgeons. Lee says multiple physicians in the organization have started working at Sharp because of access. And, due to the robotic surgical systems' ergonomics, some senior-level physicians who haven't performed robotic surgery are beginning to train on it, extending their careers and allowing their knowledge and mentorship of early careerists to remain in the organization for longer, according to Walker.

Being able to provide robotic care 24/7 contributes to what the team at Sharp HealthCare emphasizes is a positive culture.

Data Drives It All Home

Data has been a key to growing and sustaining a strong robotic program at Sharp HealthCare, which now has 14 robotic assets, including the newest Da Vinci 5 model. Lee says she and the other surgeons benefit from data shared from Intuitive that reveals trends such as conversion rates from robotic to open surgery, which help drive performance improvement.

The data has also been beneficial in showing the robotic program's value overall. For example, reduced length of stay resulting from the use of robotic surgery versus open surgery has saved the health system $25 million over five years. Since 2019, there has been a 16% ICU admission rate following robotic thoracic lobectomies versus an 81% chance of ICU admission following open and laparoscopic thoracic lobectomies.

Guerra points to situations in which the robotic approach per case is costlier than the strictly laparoscopic approach, and some service lines don't necessarily perform as well financially on a per-case basis. "But when you look at the entire picture and take into account the reduced length of stay, complication and infection rates, patient post-operative pain and need for opiates for pain control, when you look at patient satisfaction and outcomes and surgeon and physician satisfaction, you truly can see the more value-based view of the entire program that we've created," he says.

Written and published by ACHE

How Collaboration Ensures Provider Tech Adoption

By Ed Finkel

At the Mayo Clinic, it was time to replace a quarter-century-old 3-D image viewing system. For both UChicago Medicine and Piedmont, the era of nose-in-keyboard provider stenography gave way to AI-generated appointment notes.

In all three cases, these health systems worked to engage providers in high-impact clinical technology decision-making processes, marrying their subject matter knowledge and experience as end users with the technical-heavy assessments and highly detailed systems requirements that information technology professionals are best equipped to handle.

"We find that our clinicians speak one language, medical-speak, and IT folks speak their technical language," says Kay Thiemann, FACHE, emeritus executive administrator for Mayo and executive director of the Brooks College of Health Leadership Institute at the University of North Florida. "They often don't cross, they don't connect. But it's important [that they do] because the technology we select for providers impacts them every day, for every patient."

Tripartite Structure at Mayo

Mayo Clinic aimed to replace its old 3-D image viewer with a new enterprise image viewer. It adds options and advanced functionality requirements, such as the ability to support additional image types, availability across multiple device types, and native capabilities for emerging standards and integrations.

The system's approximately 40,000 end users, who range from radiologists to pathologists to cardiologists, should see the new viewer go live in October. The path to bringing this new viewer online has required balancing several work cultures within a strong organizational structure.

To manage the diverse cultures, Mayo established an organizational structure with clinicians at the table driving decisions on which technology to use, and with IT present in a consulting

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role but free to speak up when they had information that could be impactful to the decision, Thiemann says.

"We asked ourselves, 'How do you translate technical information … in a way that the clinicians will understand, so they could make an informed decision?'" Thiemann says. "And then vice versa, 'How could clinicians talk about the functionality they needed in a way that our IT staff could understand, and interpret clinicians' needs, to help inform vendor selection?'"

To manage the work, the project created a "triad leadership model" with physician leader Eric Williamson, MD, associate chair for radiology informatics and manager of the radiology AI program, partnering with Thiemann and Allison Latham, IT program manager.

Mayo needed to ensure that a wide range of end users had input into the needed functionality and performance, Williamson says. "They're not a hive-mind," he says. "It's thousands of people in different locations with different practice patterns. We needed to come up with a product that met all of their needs and use cases."

Latham recalls that she was asked on numerous occasions throughout the process to "say that in plain English." She says, "It is really about delivering it to the folks making the decisions, providing the inputs in a way that is easily understandable." After presenting a lot of numbers and tables and scores initially, Latham and her team took more of a visual approach as the process went on.

Latham adds that Williamson, and two other physicians who served as leads on the project, helped to translate the technical requirements for their colleagues. "They took those concepts, features and requirements to the clinical team, in a way that was understandable. … It was the first time I've seen that deliberate step inserted into that process. It was transformative."

To ensure that clinicians were able to participate adequately without taking them out of their day-to-day work too much, the clinical selection committee met for 40 minutes, once per week over their lunch hour, Thiemann says. They were asked for a simple thumbs-up or thumbs-down on different aspects of the system "instead of getting into the minutiae of scoring," she says. "That helped the clinicians not get down into the weeds of the technology too far."

During these meetings, team members reviewed the responses to a request-for-information from an initial group of 15 vendors that contained a subset of nonnegotiable requirements considered foundational to the new viewer's capabilities, such as compliance with imaging standards, the ability to display certain image types and the provision of adequate security.

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The group of candidates was reduced to five, who were sent a more detailed request for proposal. Two vendors were selected to participate in on-site demonstrations, after which the practitioners voted for their preferred vendor using a QR code, Thiemann says. "That method of voting is a little different than what we've experienced before," she says. "Our clinicians were really happy with the level of engagement."

"If you're going to get healthcare provider—physician and nursing—input on a clinical tool, you have to get that tool in front of them, somehow," Williamson adds. "Their time is very valuable. Nobody wants physicians, nurses and other healthcare providers filling out surveys or answering questions; we want them seeing patients."

The demonstration process made sense and made it easy to participate. "If you talk techno-babble, they're not going to understand it, and they're going to find it frustrating and disengage," he says. "We engaged them by asking, 'Imagine you are using this tool in your clinical practice. What do you want it to do? If you're going to be able to access this type of image in this type of format, will that help you in your practice?'"

In addition to ensuring that IT did not drive the process, Latham says Mayo Clinic wanted to ensure that no one geographic location or practice area dominated that process. And enabling the end users to test out the potential systems was critical. "Come in and play with it. Come kick the tires," she says. "We got great turnout to the on-site demonstrations. We weren't sure anybody would show up. The enthusiasm from the attendees created a buzz that was really encouraging."

Among the successes were the culture of teamwork that developed between all the groups and the communication among different parts of the organization and leadership, Thiemann says.

In addition, "We are going to end up with a best-in-class viewer that is going to have more features and functionality designed specifically for a clinical practitioner than I think I've ever seen before," Williamson says.

Others considering such a tripartite structure should have a plan before they start engaging end users, but don't get married to it, Williamson says. "The scope and direction of this project changed throughout the project based on what we were hearing from the end users," he says. "We engaged the clinical practice, the people the viewer is designed for, and we did so openly and honestly: 'We're going to value your input. We're not going to ask you questions then disregard the answers because they don't match what we have planned.'"

Even when ideas were turned down, Latham says the technical team documented that those interactions had happened and why a certain feature would not be workable in a transparent manner. The overall team also made meeting materials available for those who missed a meeting because they were in clinic at the time. "Make sure to maintain transparency and accessibility, so there's not a sense that decisions are being made behind a curtain," she says. "We wanted to make sure they knew they were being heard and in the driver's seat."

Leveraging AI to Reduce Physician Burnout

Both UChicago Medicine Sciences and Piedmont in Atlanta have turned to generative artificial intelligence and large language models to move their clinical documentation platforms beyond the electronic health recordkeeping of the past 10 to 15 years, which forces physicians to face their computers and type as they talk to patients.

"The amount of time that's spent on documentation … is one of the big factors in clinician burnout," says Sachin Shah, MD, chief medical information officer and an associate professor of medicine and pediatrics at UChicago, which has partnered with an AI provider on a system that 200 providers began using in early summer. UChicago expects to ramp up the system to at least half of clinicians by the fall

and to adopt it systemwide—across more than 1,200 doctors and more than 1,000 residents and fellows—in the next year.

Physicians begin a patient encounter with an app on their device that starts recording the interaction as soon as they walk into the room, Shah explains. The clinician can directly engage the patient without splitting their cognitive bandwidth and eye contact with a screen. At the end of the encounter, they press "stop," and the system generates a physician's note within one minute that they can quickly glance over and correct as needed. "You can even highlight the text generated, and it plays the audio recording of that part to remind you of where in the conversation that detail came from," he says.

While the app generates a full transcript of the conversation, what's most notable is the way it distills the discrete elements into a complete progress note, Shah says. "It saves one to two hours of documentation time," he says. "It's a major game-changer from a quality-of-life standpoint. … There's that sense of focus on the patient, which is nice and very noticeable. That's a major paradigm shift."

At the outset of bringing its clinical documentation platforms into the 21st century, Shah gathered feedback from about a half-dozen physician informatics leaders who are front-line clinicians like himself and talked through what capabilities they needed from a clinician and patient standpoint, then researched potential solutions and providers, "not the other way around," he says.

Shah's team spent time with leaders of potential vendors to better understand their vision and road map of the different platforms, and the team chose a vendor that "wanted to have a partnership to do strategic development and a lot of collaborative research," he says. The current phase one trial with 200 providers across a diverse group of specialties will provide feedback over the next three months, and if all goes well, the system will transition to an enterprise-wide license, he says.

"We're doing due diligence, a detailed analysis, closely following the ROI and KPIs, rolling it out to a subset of providers and getting feedback," he says. His team is asking questions such as, 'What are the key problems? What are the key capabilities we want to develop? How does that map back to our strategic priorities?' We're trying to get as diverse a perspective as we can," he says.

In doing so, Shah says his team has closely collaborated with IT leadership to better understand the technical capabilities needed and the resources available. "As much as one group might like to make the decision, if it doesn't make clinical sense, it's not going to take off," he says. "If it doesn't make technical

Mayo Clinic's Lessons Learned

- Include people of influence at every level on the project's governance structure, communicating to senior leadership to ensure they are on board; take the same approach with the clinical selection committee from every practice.
- Manage expectations and balance priorities and risks between rapid versus more deliberative decision-making. "At certain points in the project, you get some pressure to do things quickly: 'Let's just get on with it.' We had to avoid that temptation and be thorough in how we vetted and analyzed things," Thiemann says.
- Stick with the teamwork aspect, and make sure everyone feels heard. "If they saw something that wasn't going to work, technically … we made it safe for them to raise their hands," Thiemann says of the IT team.

How Collaboration Ensures Provider Tech Adoption

sense, that's also not going to work."

Shah's informatics team is routinely involved in IT governance processes, including decision-making around prioritization and funding allocation based on institutional strategic priorities, clinical and operational needs, and return-on-investment across numerous potential domains.

"We meet regularly in governance and executive steering committee meetings with other key stakeholders, so that the decisions we make on what to prioritize, fund and implement are aligned across the health system," he says. "It's not perfect, but the conversations are continually happening in both formal and informal settings, which helps ensure we are all on the same page—and if not, that we can quickly reconcile."

The hope is that over time, the tool will help with nursing documentation burdens, as well, Shah says. "This is a fundamental thing that everybody does; everybody is writing notes across the health system," he says. "We're talking about changing everyone's daily workflow. We're talking about protecting health information. We're talking about following HIPAA regulations."

Settling on the right technology has been straightforward compared to coordinating the change management piece, Shah believes. "We're addressing all the obstacles to making something a 'new normal,'" he says. "Paradigms shift slowly in medicine. ... It's such a complex endeavor. We're talking about patients, clinicians, care team members, different sites in a bigger health system, different different physicians, APPs, medical students, residents and fellows."

Those diving into such a process need to realize that it will not all come together quickly, Shah says. "You have to be thoughtful, consider most of what you need to do and have the right people at the table," he says. "We're going to iterate on it. ... You have to succeed or fail fast—and learn from it."

With "buzzy" technology like generative AI, "You want to resist the temptation to do something for the sake of doing it," Shah adds. After settling on the use case, "engage the right stakeholders across the organization. You want to have your go-to people among all these stakeholders to say, 'Here's what we're trying to do. Here's why we want to do it. Here's the strategic priority we're trying to address.' If you have buy-in up front, everyone is going to be on the same page."

Piedmont has undertaken a similar process as UChicago for a similar clinical documentation system. This was based on hearing physicians' frustrations related to documentation and excitement around the potential to improve interactions with patients, says Lacy Knight, MD, chief health information officer and an ACHE Member.

After a small pilot with around 20 users, Knight and his team put together demonstrations around what the technology does and how it works. "We engaged 'super users' who understand the nuances of technology early on," he says. "Then we launched a formal program to get as many

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>
> —Sachin Shah, MD
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people enrolled as possible to use the software frequently."

More than 300 physicians and advanced practice providers signed up for a 90-day evaluation period beginning in April. Teams went out to practices "to talk to doctors and providers about what the technology did, how it was going to work and to provide at-elbow training," Knight says, adding that he and his team have gathered feedback via a formal survey, direct outreach to certain providers, and unsolicited emails and other input.

"We have been looking at what the impact has been, among the people who have used it often compared to those who have used it less often," he says. "We completed assessments around specialties that seemed to take on technology faster than others and gave feedback to the vendor about enhancement requests."

Piedmont also surveyed several hundred patients about the impact on their interactions with physicians and providers, he adds, of whom 84% strongly agreed that providers seemed more focused on them, and 86% said the provider spent less time typing.

Doctors who participated in a parallel survey said they were spending less time on visits and found they could close their charts faster than before. Of those who responded, 65% said the system reduced their cognitive burden, nearly the same percentage said they had better interpersonal interactions with patients and 54% said they had a better work-life balance.

"We were able to take some time and show people how it would work, so they would go from skeptical to believers in the technology," he says. "We managed to enroll one-third of our outpatient physicians [out of 900] on this tool. And they save, on average, 15% of their time writing notes, is what we've seen in-house. And it's also worth noting that the patients we surveyed are happier with their interactions."

Knight urges those considering such an initiative to keep in mind that physicians are extremely busy and to carve planned time out of their schedule, even if it means seeing fewer patients, so they have adequate opportunity to understand the power of a new technology.

Systems will also need to overcome resistance to behavioral change. "If they don't have the confidence, it's not going to be worth it in the end; there's definitely a reluctance to adapt behavior to new technology," he says. "A specific example is that AI software can't record anything if you don't talk about it. You have to talk out loud: 'I want you to take this medication when you go home and follow up with this person.'"

In addition, when considering an AI-related project, some will have a mixed level of trust around how well it will work and how safe data will be. "There were some people who felt that they didn't want to be very early in learning how the technology would work," he says. "They wanted to let other people go first, work the kinks out, work the bugs out, without realizing that we were bringing a mature product into the system."

Ultimately, Knight advises those considering similar initiatives to be very clear on their objectives and how they plan to measure success. "Physicians are data-driven," he says. "So make sure you take the opportunity to provide enough data, in detail, upfront, to help them understand how it's going to work."

"If they don't have the confidence, it's not going to be worth it in the end; there's definitely a reluctance to adapt behavior to new technology."

—Lacy Knight, MD
Piedmont

Ed Finkel is a freelance writer based in Chicago.

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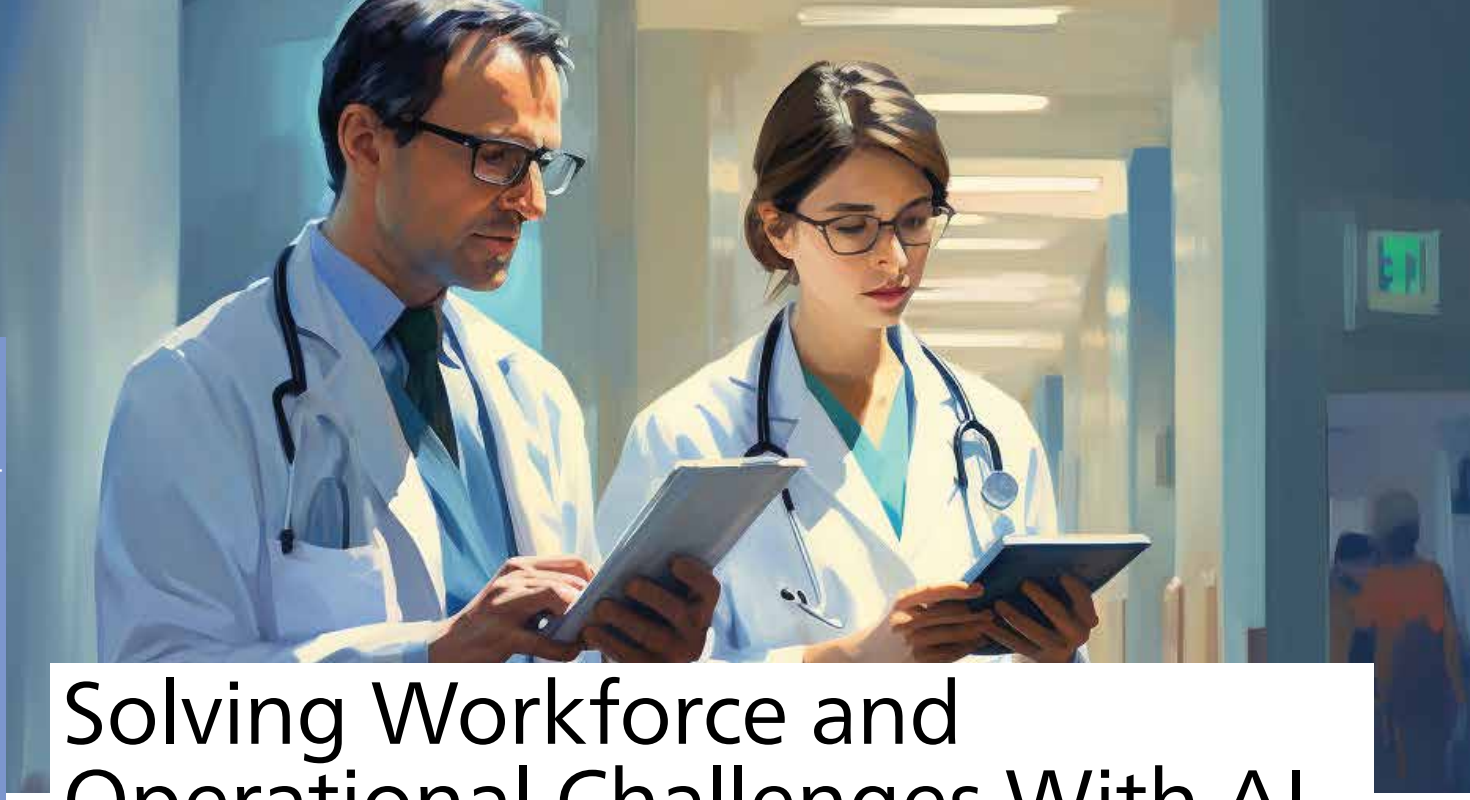

Solving Workforce and Operational Challenges With AI

Predicting demand can optimize capacity, improve patient flow and promote efficiencies.

Achieving operational efficiencies has become increasingly critical for today's healthcare organizations, as they continue to face staffing shortages that amplify capacity and other issues. Organizations can succeed in solving complex operational and workforce challenges with innovative tools that help enhance patient and workforce satisfaction, increase access to care in their communities, and achieve cost sustainability—all in a demanding financial climate.

Harnessing some of today's most transformative technological tools, including artificial intelligence and machine learning—with a dose of Lean principles—can enable healthcare provider organizations to achieve greater capacity and workforce-staffing efficiencies, according to Mohan Giridharadas, CEO, LeanTaaS.

"Today's organizations need tools to address the overwhelming complexity of the current healthcare field—tools that can help minimize rework and keep patient flow going," he says. Tools, ultimately, that will help healthcare organizations deliver on their missions to provide the best care to their patients and the communities they serve.

AI-based tools that use advanced mathematical principles proactively address the biggest challenges, according to Giridharadas, especially when it comes to streamlining administrative tasks, addressing scarce capacity, improving patient and workforce engagement, and reducing clinician burnout.

The Power of Prediction

One way to tackle patient flow and capacity and staffing challenges—and improve a patient's overall journey throughout the health system—is using powerful, "smart" algorithms that can predict demand, which have proven beneficial in the airline, package delivery and ride-hailing industries. In healthcare, these predictions can optimize capacity, improve patient flow and promote overall efficiency.

AI-powered solutions, such as LeanTaaS' iQueue suite, match supply with demand to dynamically manage capacity and improve utilization of constrained resources like operating rooms, infusion chairs and inpatient beds. They also predict the type of patients, volume and timing of patient demand across hours, days and weeks, allowing hospital leaders to better understand their staffing needs and more efficiently create schedules.

"Based on patterns, our algorithms predict where the demand is going to be," Giridharadas says. "For example, we

can predict that unit two, four hours from now, will be four beds short. If you know that, you can start to figure out, 'Do I have the right staff?' Or if you can predict what the demand's going to be three days from now, you can look at your nursing roster and say, 'I'm predicting the med-surg unit is going to be bursting at the seams with patients, and I don't have enough staff. Let me look to the float pools."

From there, Giridharadas says, hospitals can "layer on additional complexity" into the algorithm that fits their unique circumstances, such as considering what credentials or skill sets the team needs to fill upcoming shifts or which staff members have already taken overtime.

Reducing Burnout

In addition to streamlining scheduling, these tools can reduce workforce burnout and frustration on the job. This is particularly true among nurses, who are often weighed down by an abundance of nonclinical work and a scarcity of staff members.

"Nurses desire to take care of patients," says Giridharadas. With that in mind, there are tools in the iQueue suite designed to reduce nurses' "cognitive burden regarding things they don't need to worry about, so they can focus on engaging with patients and staff," he says. For example, the recommendations the tools make to nursing schedules and rosters, based on predicted patient volume and staffing requirements, augment the front-line staff's decisions, not overrule them, an important distinction, according to Giridharadas.

"We think of it as an amplifier—as augmenting, not replacing," he says. "It's making the recommendation, but the staff owns the last mile" when finalizing staff schedules and patient timeslots, based on their professional assessment of patients' medical histories and other factors that might influence urgency of certain cases.

A Force Multiplier

These AI-powered solutions, coupled with Lean principles, serve as what Giridharadas calls a "force multiplier." That is, they allow healthcare provider organizations to get more work done with fewer staff and with more efficient use of the assets and resources they already have. This is welcome news in an era of persistent workforce shortages and post-pandemic-related financial pressures that continue to reverberate throughout the field.

> Harnessing some of today's most transformative technological tools, including artificial intelligence and machine learning—with a dose of Lean principles—can enable healthcare provider organizations to achieve greater capacity and workforce-staffing efficiencies.

According to Giridharadas, there is substantial value that can be uncovered when hospitals can use technology's newest tools to achieve more efficient resource and asset utilization.

"Consider the impact on 5,000 hospitals, which have an average of $300 to $400 million in assets, such as ORs, inpatient units and imaging machines," he says. "This means $150 to $200 billion in value could be unlocked each year if we can get just 10 percentage points better at improving asset utilization within our health systems."

Giridharadas estimates that could be worth between $30 and $40 million per hospital, which could be a huge boost to their bottom line and ability to serve patients more effectively.

"Demand is up, nursing and physician shortages still exist, and reimbursements are down," Giridharadas says. "We have to learn to do more with greater efficiency while taking care of our most precious assets—our patients."

LeanTaaS

For more information, please contact Kate Soden, communications director, LeanTaaS, at kate.s@leantaas.com.

Jason Lesandrini, FACHE

Innovation in Healthcare

Ensuring equity and responsibility is vital.

As the healthcare field enters a new era of technological advancement, leaders are witnessing an exponential shift in how technology influences our lives, experiences and how we take care of patients, team members and our communities. This rapid progression brings both opportunities and challenges.

Innovation in any sector can result in ethical challenges; innovation in healthcare can be particularly challenging as leaders must try to ensure fair distribution of technologies while balancing their benefits and potential risks. To mitigate these ethical dilemmas, particular attention can be paid to how equity in innovation is achieved, with special emphasis on the following:

- Equal access to innovative healthcare solutions.
- Distribution of resources for implementing new healthcare technologies.
- Mitigation of potential biases in healthcare innovations.

Equal Access to Innovations
Groundbreaking medical technologies and treatments are best delivered when all patients have access. The ethical challenge lies in balancing the high costs often associated with cutting-edge innovations against the moral obligation to provide the best possible care, regardless of the patient's ability to pay or where they live.

We should consistently ask ourselves the essential question: How is this innovation doing what is best for patients, healthcare providers and the broader community?

Failing to ensure equal access can exacerbate existing health disparities, creating a two-tiered system where only the wealthy or well-connected benefit from medical advancements. Ultimately, the ethical implementation of healthcare innovations requires a commitment to dismantling barriers to access and recognizing that medical progress is often realized when it improves outcomes for all members of a community, rather than those with special economic status.

Distribution of Resources
As healthcare organizations allocate finite resources, navigating the tension between adopting cutting-edge technologies and ensuring care for those communities they serve is critical. Ethical tensions can arise when state-of-the-art innovations, often accompanied by high costs, compete for funding with essential services. Leaders should weigh the potential benefits of implementing advanced technologies in select locations against the broader impact of more widely distributed, albeit less sophisticated, interventions.

This raises questions about prioritization: Should resources be concentrated in centers of excellence that can push the boundaries of medical capabilities, or should they be spread out more evenly to elevate the standard of care across all communities? Furthermore, the implementation of new technologies often requires specialized training and infrastructure in addition to financial investment, potentially exacerbating existing disparities between well-resourced and underserved areas. Best practice for establishing and maintaining ethical resource distribution is to consider long-term sustainability, the potential for knowledge transfer and the scalability of innovations.

Mitigation of Potential Biases
This is a critical ethical imperative that demands vigilant attention throughout the innovation process. Biases can manifest in various forms, from the initial conception of an idea to its development, testing and implementation. Biases may stem from limited perspectives on clinical teams, skewed data sets or underlying assumptions that fail

to account for diverse patient populations.

The consequences of unchecked biases can be severe, leading to innovations that not only fail to address health disparities but also potentially exacerbate them. For instance, diagnostic tools developed using data predominantly from one demographic group might be less accurate for others. Ethical innovation requires a proactive approach to identifying and addressing these biases.

The future of healthcare innovation should not only be groundbreaking in its scientific achievements but also in its ability to narrow, rather than widen, the gaps in healthcare access and outcomes.

Values as a Guide

In the competitive, fast-paced world of healthcare, it's easy to get caught up in the excitement of emerging innovations. As leaders in the field, however, we need to remember that our professional, personal and organizational values should serve as the guideposts for decision-making. These values should inform every decision, shape every development and guide every project we undertake.

Most importantly, we should consistently ask ourselves the essential question: How is this innovation doing what is best for patients, healthcare providers and the broader community? And, when there is tension—for example, moving forward with an innovation that is best for patients but not for the clinical team—we need to acknowledge this and think through how to manage this ethical tension.

Ethics Assessment: The Key to a Responsible Future

In the race to bring new products and features to market, we cannot ignore ethical issues, especially those related to equity. It is the responsibility of healthcare organizations and innovators to thoroughly consider the ethical risks and benefits of every project. The goal is not to restrict progress but to ensure that progress aligns with the organization's mission, vision and values.

Although the specific approach may vary depending on the nature of the innovation, there are key questions that should be asked in every ethics assessment:

- Who benefits from this innovation, and are there populations that might be excluded or disadvantaged?
- How might this innovation impact existing health disparities?
- Are there potential unintended consequences that could arise from implementing this technology?
- How might this innovation affect the patient-provider relationship?
- Are there potential biases in the algorithms or datasets used in this innovation?
- What is the environmental impact of this innovation, and how might it affect public health in the long term?
- What is the cost of implementing this innovation, and how might it affect healthcare affordability?
- Are there strategies to ensure equitable access to this innovation across different socioeconomic groups?
- How can the organization balance the adoption of cutting-edge technologies with the need to provide basic healthcare services to all?

Moving Forward

Innovation in healthcare holds immense promise for improving patient outcomes, increasing efficiency and advancing medical knowledge. However, this progress must be guided by organizational, professional and personal values with a focus on equity. By conducting thorough ethics assessments, considering the equitable implementation of innovations and continuously evaluating the impact of new technologies on diverse populations, healthcare leaders can help ensure that healthcare innovations serve the best interests of all members of society. The future of healthcare innovation should not only be groundbreaking in its scientific achievements but also in its ability to narrow, rather than widen, the gaps in healthcare access and outcomes. ▲

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Diane L. Dixon, EdD

Focusing the Equity Lens

Leadership and strategic change can make a positive impact.

Leading in today's complex healthcare ecosystem requires looking through multiple lenses. Because healthcare is driven by a mission to deliver safe quality care for all, the equity lens plays a significant role in achieving that mission.

Recently, I asked a group of healthcare executives what they see when looking through the equity lens. Many indicated they see people, fairness, inclusivity and diversity. This perspective is aligned with a common definition of equity: fair and just opportunity to attain the highest level of health for all and an inclusive workplace in which all people are valued and can succeed. The healthcare mission can only be achieved with both. This is why leadership through a lens of equity is a strategic priority.

Defining Study Focuses the Equity Lens

The National Academies of Sciences, Engineering, and Medicine published a report in June 2024, *Ending Unequal Treatment Strategies to Achieve Equitable Health Care and Optimal Health for All.* This report updates the 2003 Institute of Medicine's *Unequal Treatment* report and brings the equity lens into sharper focus. The results indicate that there has been uneven progress in achieving health equity in the past 20 years.

Specifically, the study describes a broken healthcare system that delivers different outcomes for different populations, with significant racial and ethnic inequities in life expectancy at birth, maternal and infant mortality, and many chronic diseases. These inequities cause excessive healthcare spending and reduced labor market productivity that make a significant economic impact. Further, the report states that "addressing inequities and improving the health of individuals in the nation's most disadvantaged communities improves the quality of care for everyone and advances population health." The study findings make a compelling case for leadership and strategic change through the equity lens.

Here are several considerations for moving forward.

Strengthen leadership and strategic change. This begins with being mindful of the equity lens by developing awareness and insight to notice how we view things and what influences our thinking. Mission-critical decisions in the business of health and healthcare require being equity-minded as complex challenges are addressed.

With decades of research on the need to improve health equity and diversity, equity and inclusion in the workplace, the problem is not a lack of evidence. Several critical questions to ask and act on include the following:

- Why do these problems persist?
- What are the root causes of these problems?
- What are the barriers that are blocking progress?
- What do we as leaders need to do and be to remove the barriers?

There are no easy answers to these questions. But with conscience and commitment to confront the equity challenges with dedicated action, measurable results can be achieved. In a November 2023 article, "The Compass for Health Equity Transformation: A Tool to Move from Compliance to Impact," Rishi Manchanda, MD, CEO, Health Begins, wrote that "to move beyond regulatory compliance and make a real impact for health equity, we need to translate a multilevel structural understanding of health equity into a portfolio of strategic action, not a patchwork."

Mission-critical decisions in the business of health and healthcare require being equity-minded as complex challenges are addressed.

This acknowledges that strategic change can only be achieved when leadership, strategy and culture are aligned in the effort to achieve equity in communities and populations served. Organizations in the healthcare ecosystem do this work. From an organizational perspective

this means equity, diversity and inclusion strategy are at the heart of the organizational strategy. And there is coherence and alignment of goals, priorities, key performance indicators, decisions, actions and culture.

Pay attention to organization culture. It is well documented that one of the key reasons organizational change fails is because of inattention to the culture. The organization culture model developed by business theorist and psychologist Edgar Schein, PhD, indicates that the ultimate source of values and actions come from underlying assumptions, those unconscious beliefs that determine how a group perceives, thinks and feels.

This suggests that to create a culture in which equity, diversity and inclusion are central to the mission, these assumptions must be surfaced. To look through the equity lens requires assessing the current culture and identifying the barriers to creating the desired culture in which equity and inclusion are not only valued but also live in the day-to-day work and interactions of people. Gustavo Razzetti's "Culture Design Canvas" framework may help with this analysis.

The board and executive leadership are the architects and role models of the culture shaping. Middle managers and front-line staff translate strategy and culture into action as they do their jobs, working collaboratively to provide service to patients, families and community members. Staff are more likely to work collaboratively toward achieving health equity and an inclusive workplace in a fair and just culture.

Cultivate an equity organizational mindset and cultures of growth. "Organizational mindset refers to the shared beliefs about intelligence, talent and ability that are held by a group of people in an organization," according to author Mary C. Murphy, PhD. In her book *Cultures of Growth*, she suggests that leaders need to be intentional about the mindset culture they are creating because it influences how people think of themselves, how they interact with others and organizational performance. Cultures of growth are focused on how all people can attain the highest growth opportunities in an environment that fosters learning, passion, creativity and resourcefulness to achieve results. Equity and inclusion are more likely to thrive in this type of culture.

Remove destructive friction. *The Friction Project: How Smart Leaders Make the Right Things Easier and the Wrong Things Harder* by Robert Sutton and Huggy Rao defines friction as "the forces that make it harder, slower, more complicated, or downright impossible to get things done in an organization."

A few examples include too many meetings with poorly defined agendas, inefficient policies and procedures, email overload, and unrealistic and excessive goals. To remove destructive friction, identify the bad friction that is impeding achieving strategic change. Then, work with leaders and staff collaboratively on all levels in the organization to determine what can be done to lessen the burden and develop positive paths forward.

Learn from pushback. Resistance to change occurs for a variety of reasons—uncertainty, fear related to perceived loss of control, status, relationships and fairness. Seek to understand different viewpoints and concerns about equity, diversity and inclusion through inquiry and active listening. Use data about disparities to educate and facilitate learning. An effective leader in this area creates an environment in which staff feel safe to engage in difficult conversations about equity gaps in the workplace and communities.

As Kedar Mate, MD, president and CEO, Institute for Healthcare Improvement, suggested in the article "Addressing Pushback on Health Equity" from the January/February 2022 issue of *Healthcare Executive*, "leaders can harness curiosity as antidote for fear and resistance" using these approaches with adequate coaching and support for changing practices.

Many leaders are doing good work focusing on the equity lens and making an impact in the organizations and communities they serve. This work takes individual and collaborative effort throughout the healthcare ecosystem. They should share their stories—both successes and failures. By working across boundaries to learn and solve problems together, achieving equitable healthcare and optimal health for all will be more than a possibility, but a reality that will benefit everyone. ▲

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Joseph S. Kascmar, FACHE

Transforming Surgical Services With AI

Algorithms put personalized medicine, improved patient care within reach.

Artificial intelligence is on the cusp of revolutionizing surgical practice, presenting significant opportunities to elevate patient outcomes and streamline healthcare delivery. There are two pivotal domains in which AI is demonstrating profound potential: preoperative planning and intraoperative navigation.

The incorporation of AI into preoperative planning signifies a significant transformation in surgical accuracy and patient treatment.

Enhancing Preoperative Planning

The incorporation of AI into preoperative planning signifies a significant transformation in surgical accuracy and patient treatment. For a long time, surgeons have relied heavily on static imaging techniques such as CT scans and MRIs. However, with the introduction of AI algorithms, surgeons now have the advantage of analyzing extensive imaging datasets in a dynamic manner. These algorithms employ machine learning to identify intricate anatomical features and identify abnormalities that may go unnoticed by human observation.

Artificial intelligence's capacity to analyze and comprehend intricate data improves the precision of surgical procedures by offering comprehensive anatomical knowledge before the operation. This proactive method not only diminishes the occurrence of complications during surgery but also tailors surgical strategies according to each patient's unique anatomy and medical background. This personalized planning maximizes results and expedites the recovery process, highlighting the transformative influence of AI on surgical care.

Recent developments emphasize the significance of AI in predictive analytics. By using past patient data, AI can predict surgical outcomes and improve treatment strategies. Through the analysis of vast datasets, AI enables surgeons to choose the most suitable approach for each individual, ultimately enhancing precision and patient satisfaction.

The implementation of AI in medical imaging enables prompt diagnostic assessments and improves surgical planning by identifying subtle anatomical details, according to the article "Artificial intelligence in perioperative management of major gastrointestinal surgeries" in the June 7, 2021, issue of *World Journal of Gastroenterology*.

Moreover, machine learning models play a crucial role in predicting surgical risks, leading to the optimization of patient selection and treatment results, according to the article "Artificial intelligence in surgery" in the May 13, 2024, issue of *Nature Medicine*.

Intraoperative Navigation Precision

AI-powered intraoperative navigation systems are a fundamental aspect of contemporary surgical procedures, revolutionizing the process

The Bottom Line

Keys to Successful Surgical AI Implementation

- Capital planning and investment.
- Stakeholder alignment.
- Regulatory and ethical considerations.
- Training and change management.

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of making real-time decisions in intricate operations. These advanced systems seamlessly combine with surgical instruments and imaging techniques to produce dynamic, three-dimensional representations of the surgical field.

Machine learning algorithms constantly update anatomical maps using real-time intraoperative data, allowing surgeons to navigate with unparalleled precision and safety.

Research in various fields, including neurosurgery and orthopedics, showcases the potential of AI to decrease surgical time, minimize tissue harm and enhance procedural outcomes by improving navigation accuracy.

Recent research has emphasized the capacity of AI-powered surgical navigation systems to optimize surgical processes and improve accuracy by providing live guidance, as seen in the article "Three ways AI can be used to transform surgical procedures" in the Aug. 4, 2022, issue of *AI Magazine*. (See sidebar.)

Additionally, AI has proven to notably decrease the duration of surgeries and enhance results in different surgical fields, according to the June 13, 2023, brief "AI is set to 'revolutionize' surgery" on the American College of Surgeons' website.

Artificial intelligence's capacity to analyze and comprehend intricate data improves the precision of surgical procedures by offering comprehensive anatomical knowledge before the operation.

Navigating Implementation Challenges in Healthcare Organizations

The successful implementation of AI in surgical services requires careful navigation of four key challenges to achieve optimal adoption and maximize organizational advantages.

1. **Capital planning and investment**. Thorough financial planning is essential for successful implementation, as it involves evaluating up-front expenses, continuous upkeep and possible profits.

   Working closely with finance teams and using financial modeling tools help in making well-informed choices.

2. **Stakeholder alignment**. Collaboration between healthcare leaders, IT professionals and surgical teams is of utmost importance for internal alignment.

   This collaborative effort guarantees the smooth integration of AI systems into the current infrastructure, effectively addressing cybersecurity issues and tailoring solutions to fit clinical workflows.

3. **Regulatory and ethical considerations**. Adherence to data privacy regulations and ethical guidelines is of utmost importance.

   Implementing strong governance structures and performing comprehensive risk evaluations support ethical principles and foster confidence in AI-powered healthcare innovations.

4. **Training and change management**. It is crucial to provide thorough training programs for healthcare professionals to ensure they have the required skills for implementing AI.

Three Ways AI Can Be Used to Transform Surgical Procedures

- **Connecting surgeons around the world with VR**. Using virtual reality projections of conjoined twins from CT and MRI scans, a team of surgeons was able to trial different surgical techniques for months in advance of an operation to separate the twins.
- **Using medical imaging analysis**. The development of computer vision has been transformative in making the use of visual datasets in predicting surgical risks and outcomes more efficient.
- **Assisting with surgical robots**. The digitalization of surgery goes hand-in-hand with efforts to improve robotic-assisted surgery.

Source: AI Magazine

> Encouraging a culture of ongoing learning helps reduce resistance to change and facilitates the successful incorporation of AI into surgical processes.

The incorporation of AI into surgical services represents a significant advancement toward personalized medicine and improved patient care.

By using AI's analytical capabilities in preoperative planning and intraoperative navigation, healthcare providers can effectively navigate surgical challenges with unparalleled precision and safety.

The key to successfully implementing AI lies in strategic collaboration with stakeholders. This collaboration is crucial in overcoming barriers and ensuring the successful adoption of AI.

It involves addressing financial considerations, aligning stakeholders' interests, navigating regulatory landscapes and investing in comprehensive training.

These steps are essential to maximize AI's potential to advance surgical care and redefine healthcare delivery.

Through strategic investment and collaborative innovation, AI holds the promise of revolutionizing surgical services. This will pave the way for a future where precision, efficiency and patient-centric care seamlessly converge. ▲

Joseph S. Kascmar, FACHE, was previously director of Surgical Services, Dartmouth Health, Lebanon, N.H.

Paul H. Keckley, PhD

Compliance With Widening Scope of Healthcare Policies

Navigating the complex regulatory framework.

Regulation of the U.S. healthcare system can be viewed as a complex web of laws that originate from federal, state and local legislators. Regular monitoring of regulations at all levels will keep healthcare organizations from the risks resulting from noncompliance.

Federal Level

At 17.6% of the GDP and the nation's largest industry employer, understandably, the healthcare system is heavily regulated by the federal government. Responsible for 33% of the industry's direct payments, the federal government has control over much of the $5 trillion system through four major initiatives:

Laws Passed by the U.S. Congress: Inflation Reduction Act (2023), Patient Protection and Affordable Care Act (2010) and Medicare Modernization Act (2003) are a few examples. Notably, 12 of the 20 U.S. Senate's and 13 of the House's 21 standing committees have specified responsibility over the system's performance and funding. And, the federal government has exclusive responsibility for two of the country's biggest programs: Medicare (66 million) and the Veterans Health Administration (9 million).

White House Executive Orders: Executive Order on COVID-19 and Public Health Preparedness and Response (Biden 2024) and Hospital Price Transparency (Trump 2019) are recent examples. Frequently, EOs are challenged in courts or modified/rescinded by successor administrations. Notably, the Hospital Transparency Order was continued by the Biden administration, which subsequently increased its penalties for noncompliance.

Cabinet-Level Administrative Rules: Twelve of the 15 cabinet-level departments have jurisdiction over the U.S. health system on issues that address antitrust, competition, consumer rights, false advertising, workplace safety, workforce adequacy, drug efficacy, data protections, cybersecurity, disease surveillance, food safety and more. Most recently, consumer protections against consolidation among hospitals have been a focus of DOJ and FTC attention with tougher restrictions on merger activity implemented.

Court Decisions: The federal court system has three levels—district courts, which hear cases and render decisions; courts of appeals, which review district court decisions; and the Supreme Court, which has final authority. The country is divided into 94 judicial districts and 13 circuits for the district courts and the courts of appeals, respectively. Notably, the Supreme Court's decision overturning Roe v. Wade is among many healthcare rulings with implications that ripple across the industry. Lawsuits against hospitals, insurers, drug and device manufacturers are prominent on court dockets as well as challenges to regulations and laws by impacted parties. All lend to the industry's litigious spending on compliance and risk aversion.

Federal oversight will expand even more in coming years as pressure to lower healthcare costs and improve the effectiveness of the system grows. The use of AI in healthcare, implementation of interoperability, cost-effectiveness of specialty drugs, data protections, restrictions on insurer prior authorization business practices and vertical consolidation top the list of issues for which federal action is likely in 2024–2025.

State and Local Level

States are responsible for delegated functions per the 10th Amendment to the U.S. Constitution and subsequent referrals from federal agencies. Paralleling the federal government, states use gubernatorial executive orders, legislative approval of new/modified laws, results from referenda/ballot initiatives and court actions to direct their efforts. The scope and complexity of the issues now handled by states has expanded exponentially in recent years. Among major areas of current attention are these:

- Medicaid oversight, i.e., eligibility, benefits, funding (in tandem with the federal government).

- Retail health, i.e., efficacy of services, truth in advertising, consumer safety.
- Delegated responsibilities from the Affordable Care Act: health insurance marketplaces and insurer compliance with basic benefits.
- Medical malpractice and consumer protections.
- Health insurer oversight, including licensing, liquidity, network adequacy and benefits design.
- Abortion rights.
- Behavioral health (including substance abuse and addiction), workforce adequacy, licensure, scope of practice.
- Certificate of need programs.
- And others.

Adding to these, some states are considering regulations protecting consumers against harm from industry consolidation, exploring staffing requirements for healthcare facilities, and mandating requirements for integration of public health programs in delivery systems, among others. In many respects, state regulation is often the precursor to federal policies that follow.

Local government plays a leading role in regulations of public school clinics, workplace health ordinances, provider tax abatements, public health programs (safety net hospitals, food banks, ambulance services) and others. In most cases, regulations by local government originate from authority granted under federal/state laws.

Key takeaways for health leaders: Every organization in the healthcare system operates under an increasingly complex government regulatory framework. Monitoring and managing regulatory compliance are mission critical for every healthcare organization. The realities for leaders are these:

1. Regulatory compliance for hospitals, health systems and provider organizations is difficult, requiring dedicated resources for policy research, performance measurement, advocacy and, in some circumstances, legal defense. Laws, rules and regulations are changing, and risks of noncompliance including financial penalties and reputation damage are significant. Monitoring policy changes at the federal, state and local levels is a critical competency for boards and leaders. Practical starting points include:

   - Development of a list of pending regulatory changes that require discussion and monitoring.
   - Creation of a compliance risk dashboard to facilitate organizational awareness of compliance risk vulnerabilities.
   - Periodic stress testing of the organization's compliance risk.

2. Engaging directly with policymakers and elected officials to understand proposed rules and regulatory changes is essential. While comment letters on pending regulatory changes and white papers that provide context to a rule or potential policy shift are useful, there is no substitute for personal relationships with policymakers through formal outreach programs (regularly scheduled meetings) and informal outreach (through community-based activities and impromptu discussion at trade or professional meetings.

3. Most importantly, boards and leaders must understand the broader context in which health system compliance risks are acute and regulatory changes likely. "Regulatory environment update" should be an agenda item in every board and senior management meeting. Compliance risks must be systematically identified and systematically addressed. Conflict of interest disclosure and competency evaluations of senior leaders and directors must be regularly conducted. And leaders must demonstrate knowledge on issues of highest consequence to compliance risks, i.e., the use of artificial intelligence in diagnosing medical problems, workforce compensation and incentives, clinical documentation, business office operations, and many more.

Oversight of the U.S. healthcare system ensures it operates effectively for the public good. The complexities of the system, however, ensure regulations will continue at all levels of government. Thus, continual monitoring of regulations at federal, state and local levels will keep healthcare organizations from the risks resulting from noncompliance. ▲

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

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Ije Akunyili, MD

Cultivating Your Career for Success

A CMO's tips, strategies for women leaders (guidance for all) and personal insights.

From social media tools to professional associations and social clubs, there are so many resources these days for women to advance their careers.

Yet, although women have made inroads into leadership positions in healthcare in the past decade, several career advancement challenges remain. (See sidebar on Page 45 for relevant statistics from ACHE's 2019 gender survey, the most recent available, and when the next one will be released.)

It can be difficult, for example, for a woman to envision herself as a leader when there are too few female role models with similar career goals and life experiences. That was definitely a challenge for me during my journey to becoming a physician leader.

For many women, one of the greatest tools at their disposal can also be the most difficult to use—their own voice.

Advocating for yourself takes courage and ambition, and this can be tough for some women, who might be more reluctant to brag about their accomplishments to avoid the perception of being too aggressive, a trait that still seems to go against cultural norms for women. But moving up the career ladder requires first finding your voice and then speaking up for change while seeking support from those who inspire you and those you would like to emulate.

It is especially critical at the beginning of a career journey to reach out and connect with those in higher positions for advice and to learn from their experiences. During my first week in medical school, for instance, an ED physician agreed to let me shadow him, though I didn't even know how to use a stethoscope.

This physician became a great role model, mentor and someone to emulate. Because of my experience working with him, I fell in love with emergency medicine.

Reaching out to others is a mainstay along the career journey. Women should be sure to use all the networks available to them—not just those in healthcare. Professional networks include people who share your goals, who understand your vision and value, and who recognize your ability to grow. It is also important to connect with professional networks and associations that are empowering and will help to champion your growth.

The key to cultivating your career is being intentional about it. When I was in business school in Philadelphia, for example, I reached out to numerous alumni, including presidents of large hospital systems, requesting a chance to talk and learn about their professional experience. My diligence paid off, as one medical director took a train to Philadelphia to meet with me. I asked him why he would go to that length, and he said it was because I took the initiative—I reached out to him.

No one ever counsels you about this, but self-advocacy requires persistence, and a lot of it. Reaching out to 10 people may result in nine rejections, but that's part of the calculus of building a professional network. It does take courage, but that will build over time. Believe it or not, people want to be approached. There are always people who are willing to help.

Finding mentors also requires joining all kinds of networks and groups, from alumni associations to church groups, even those that focus on hobbies. Volunteering is another way to meet people who share interests and values and might provide an avenue into a new role. Reunions—high school, college and even family—also represent opportunities to network.

Social media tools are great resources for developing a brand, keeping a network updated on achievements, and simply staying connected to others. LinkedIn is a powerful tool to announce career moves or put out feelers for advancement.

Overall, building a professional community is extremely important and bidirectional; think of it as a network made up of not only peers or mentors but also those at the beginning of their career. This community can be referred to as a circle of "adopted mentees" who you regularly check in on. For example, if an early careerist recently attained a nursing degree, you can ask, "Okay, what's next?" Or, if someone earns an MBA, you can touch base with him or her and ask, "How can I help?" One way is to think about who that person's advocate can be. It's all part of the network circle—what goes around comes around and everyone moves forward.

I've also been honored to participate in professional groups within the organization where I work such as the Women's Leadership Alliance and Black Executive Alliance. These networks can become sounding boards for your work, another vehicle for networking with colleagues and provide an avenue for mentoring others.

Finally, listening to mentors and acting promptly on their advice is critical. For instance, data shows that women often wait too long to seek career advancement; they instead want to make sure they've checked all the boxes before making a move. Before I became a CMO, that's what I was doing, and I didn't even realize it. My mentor knew I was ready for a CMO position before I did. He told me I had the experience and the credentials and provided the name of an executive recruiter.

But when I called the recruiter, he told me I was too young and that I needed another 20 years of experience. He said my goal had "delusions of advancement." That only served as motivation. If I was unsure of my confidence before that call, I was sure after I hung up. My mentor knew my experience, he knew me, and he knew that I was well prepared to serve and lead an entire team of physicians at one of New Jersey's leading medical facilities.

Despite all the challenges I've faced as a woman in my quest to build my career, I also have to say that I feel immensely blessed to have had so many opportunities and privileges to have the platform to influence and use my voice to make positive change.

Reaching this point in my career was made possible through reaching out to others for support, advocating for myself, and being open to joining various groups and organizations for networking opportunities—all the essentials that should be part of every woman's toolbox for career advancement. ▲

Ije Akunyili, MD, is CMO of Jersey City (N.J.) Medical Center, an RWJBarnabas Health facility, and an ACHE Member.

The Equity Gap

How do executives feel about gender equity in healthcare workplaces? The answer depends on whether you ask women or men. The groups of women and men who responded to ACHE's 2019 *Gender and Careers in Healthcare* survey on average gave quite different answers. Perhaps not surprisingly, women saw the lack of equality in the workplace as a larger issue than men. For example:

- Eighty-eight percent of men, but only 64 percent of women, agreed with the statement: "All in all I think there is gender equity in my organization."
- Eighty-six percent of women, but only 62 percent of men, felt that an effort should be made to increase the percentage of women in senior healthcare management positions.
- Sixty-nine percent of men, but only 38 percent of women, felt that based on their own experiences, healthcare workplaces are better at providing fair opportunities to women executives than they were five years ago.
- The next ACHE *Gender and Careers in Healthcare* survey will be conducted this year and released sometime in 2025.

Source: ACHE white paper Addressing Gender Equity in Healthcare Organizations.

Leadership-Listening Arc

Developing genuine partnerships between leaders and staff to improve care.

Nana A.Y. Twum-Danso, MD, FACPM

John P. Kotter in his 2014 book *Accelerate* notes that "[Leadership is] not about mobilizing a group to act the same way they have always acted. It has to do with changing people and their organizations so they can leap into a different and better future, no matter the threats or barriers or shifting circumstances." These twin responsibilities—establishing a vision to inspire staff to bring their best talents and expertise to the work and providing the enabling environment for that vision to be realized—are essential for every leader.

So, how do leaders both inspire and enable transformational change to improve patient care and experience in partnership with those who are responsible for operationalizing and managing changes to operational and clinical processes? How can leaders identify and prioritize the adaptations that might be needed for specific contexts? The answer lies with "active listening," which is a total focus on the other speaker that allows no mental space to parallel process a response or prepare one's thoughts to start talking. When done well, it encourages even more feedback. Active listening enables leaders to develop and learn from genuine partnerships with staff, gain the knowledge needed to co-design solutions, relieve bottlenecks and build momentum where progress already exists.

Active listening … is a total focus on the other speaker that allows no mental space to parallel process a response or prepare one's thoughts to start talking.

Interpreting body language and subtext is an important aspect of active listening. Nonverbal communication conveys volumes about sentiments and concerns. Active listening also means refraining from interruptions, which influence the perception of your receptivity to the feedback and might therefore influence the feedback itself. Given the power dynamics in organizational hierarchies, leaders must be genuinely open and receptive to feedback, both positive and negative, to gain a system-level understanding of what is and is not working, as well as a granular understanding of what's happening at the front lines of delivering care to patients and their families and caregivers.

This practice can be described in five phases, loosely referred to as the leadership-listening arc: **Curiosity, Learning, Alignment, Negotiation and Creativity**. Each phase can help leaders achieve the dual goals of inspiring and enabling change in true partnership with clinicians and operational staff in service of providing high-quality patient care.

1. **Curiosity**
   Don Berwick, MD, the founding CEO of the Institute for Healthcare Improvement, emphasizes that without genuine curiosity there can be no genuine learning. Curiosity generates questions in the listener and focuses attention on the ongoing conversation while avoiding assumptions about what the other person(s) might be thinking. Real curiosity requires recognizing that we will never know the full breadth and depth of another person's thoughts and feelings, no matter how well we know them. It also requires being humble about the limits of one's own expertise and experience. This humility sharpens curiosity about how the change initiative may be affecting different groups and processes within the organization.

2. **Learning**
   Staying genuinely curious and truly working to understand what the other person(s) says often leads

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to learning something new. It might be a major insight that upends our thinking, an important nuance not yet fully appreciated or even new evidence confirming something we already knew. Regardless of the outcome, when we try to learn as much as possible from our colleagues, we honor their time, experience and expertise. We also demonstrate a willingness to listen and learn about what *is* and what *could be* instead of merely what *should be*.

3. **Alignment**
Sometimes, resistance to organizational change stems from misalignment or a misunderstanding of the changes needed. The leader may be thinking of a change conceptually, while those providing feedback are thinking about the challenges of practically applying the change in their contexts. It is essential to align these two different levels of thinking to include both considerations. Understanding the relevant change conceptually (i.e., as a general notion or approach to change) may help staff develop new ideas that align with the ultimate transformation desired. Considering the impact of the change at the practical level reinforces the leader's commitment to co-designing with staff and relieving bottlenecks. Combining and aligning perspectives will reduce hurdles in the change management process and increase the likelihood of greater impact.

4. **Negotiation**
In the event of genuine disagreement about the expected benefits and risks associated with a proposed process change or system redesign process, leaders need to shift the benefit/risk ratio in favor of benefits to make a more convincing case. They can also negotiate on timelines, milestones and resources needed, for example, adding more staff to the team responsible for implementing the change, or pausing other initiatives to create more time and space for the current change effort. Delaying launch by a few weeks or months may give staff the time needed to be more creative and deliver a reliable product or service. Leaders could also use a phased approach to

implementing the change—with agreed-upon pauses for reflection and learning—to create opportunities for productive negotiation and ultimate alignment.

5. **Creativity**
If the proposed change proves to be inoperable within existing systems and processes, too expensive, too labor-intensive or not as good a fit for patients as initially envisioned, new ideas will be needed. When leaders create enough psychological safety, and have proven to be genuine partners to front-line staff and middle managers, the feedback conversations can produce these new ideas and adaptations. Challenging the status quo and diverging from mainstream problem-solving paths prompt creativity, help avoid mental ruts and foster transformational improvement ideas. In his 1992 book, *Serious Creativity*, Edward de Bono, an authority on creative thinking, describes this as, "exploring multiple possibilities and approaches instead of pursuing a single approach." Engaging staff in a creative exercise has multiple benefits. The obvious one is generating new ideas that weren't considered before. Another is that such exercises demonstrate a distributed leadership philosophy that empowers staff at all levels and creates a sense of shared ownership in the change and, ideally, in the long-term success of the organization.

These five phases can be pursued in sequence or in parallel, depending on the flow of the conversation and what leaders learn along the way. The time frame for the phases of the leadership listening arc can be as long or as short as needed based on the leader's context. The key is the effective practice of active listening in all phases. As with all practices, repetition and discipline lead to improvement over time. A leader who wants to achieve the vision they have set out by effectively partnering with staff needs to become an expert active listener. ▲

Nana A.Y. Twum-Danso, MD, FACPM, is senior vice president, Institute for Healthcare Improvement (ntwumdanso@ihi.org).

Britt Berrett, PhD, LFACHE

Creating a Total Leadership Development Plan

Build one that is comprehensive, detailed, forward-thinking and innovative.

Few will argue the importance of the U.S. healthcare system. With over 22 million workers and some of the most complex processes and systems, healthcare leaders are expected to lead effectively. However, W. Edwards Deming, the father of the quality movement, stated, "the health care system is the most complex, chaotic, and inefficient production system in existence." This complexity is expected to increase as it is estimated that by 2032, healthcare spending will exceed $7.7 trillion and represent 20% of the gross domestic product.

Admittedly, the delivery of healthcare services has emerged from a foundation of public health, community services and faith-based care into a multitrillion-dollar economic engine. In response, professionals have shifted from reactionary to proactive leadership. As such, leadership is obligated to develop many plans: strategic, business, staffing, capital, marketing, revenue enhancement and cost reduction. But is there a leadership development plan?

Jacob Kupietzky, president, HealthCare Transformation, Chicago, states in a March 22, 2023, *Forbes* article, "Strong leadership is critical in the healthcare industry, as we find ourselves moving through this constantly changing landscape."

Like any other plan, a leadership development plan is a purposeful and structured effort to achieve an outcome. Historically, leadership development has been a cursory assessment of traits and behaviors. Sprinkle in an annual assessment or a succession plan and healthcare professionals felt comfortable that their leadership development plan was adequate.

Today's healthcare professionals require a leadership development plan that is comprehensive, detailed, forward-thinking and innovative. In considering a plan, include the following:

- Implement internal and external scans.
- Create your personal mission, vision and values.
- Study your craft.

Internal and External Scan

No plan exists in a vacuum, so taking the time and effort to scan internally and externally becomes critical. An internal and external scan requires deep research into the organization's cultural DNA. Asking questions and being curious is imperative. Whether it is a startup biotech or an integrated healthcare delivery system, each organization carries historical context that helps leaders understand the terrain and their leadership obligations.

Leadership is obligated to develop many plans: strategic, business, staffing, capital, marketing, revenue enhancement and cost reduction. But is there a leadership development plan?

David Clark, area CEO, Sutter Health, Oakland, Calif., and an ACHE Member, with experiences in prominent integrated systems across the country, shares the following, "Each organization is different and unique. It requires tremendous effort to understand the dynamics that are organizational, generational, cultural, geographic, etc. I have become a student of cultures!"

Your Personal Mission, Vision and Values

Business schools preach the importance of understanding an organization's foundation—why it was created. An organizational mission statement is a declaration, and a personal mission statement is

just as important. Why are you in healthcare?

Consider this: The executive team in a Midwest healthcare system was having a difficult time understanding the CFO. His demands for fiscal accountability were assumed to be typical CFO behavior. But during an executive leadership retreat, he revealed that he was raised in the community. His grandfather was a local pig farmer, and his son was in desperate need of specialized care. If their organization stumbled, then the community he loved and the son he cared for would be impacted. The CFO was in healthcare for a meaning and purpose.

Today's healthcare leaders need to define their personal mission.

A leadership development plan includes a personal mission statement as well as a vision statement. Much like an organizational vision statement, a personal vision statement is a declaration of one's eventual scale and impact. A personal vision statement should be motivating and inspiring and convey an individual's hopes. Healthcare is becoming more complicated as economic interests can cloud one's purpose and meaning. Clarity on a personal vision statement allows healthcare professionals to envision the future and the role that they will play.

One healthcare leader transitioning from industry into academics was able to seamlessly transform executive skills into the classroom by declaring, "my vision is to prepare the next generation of healthcare leaders."

Along the journey, values become important pillars in navigating the ambiguities and changes in healthcare. Revealed in the internal and external scan part of the leadership development plan, it becomes apparent what the organization values. Profits? Harmony? Innovation? Healthcare organizations are famous for acronyms that convey meaning: Collaboration. Accountability. Respect. Excellence, or CARE. Can the same be said for leaders? What are the values that are the pillars of a personal mission and vision.

The power of declaring a personal mission, vision and values is experienced by healthcare leaders. Tim Pehrson, president and CEO, INTEGRIS Health, Oklahoma City, for example, carries a list of his personal and professional priorities and aspirations. As a daily ritual, he affirms his priorities and aligns his activities. His personal commitment translates into his professional responsibilities as INTEGRIS introduces its new mission, vision and values.

Study of Your Craft

A deep study of leadership is imperative for healthcare professionals, no matter the area of expertise.

Leadership theory is expansive and addresses the contemporary issues experienced by professionals. Patrick Lencioni, author and founder/CEO of The Table Group, Lafayette, Calif., discusses the dynamics of leadership in his groundbreaking work, *The Five Dysfunctions of a Team*. The Arbinger Institute advances the idea of mindsets and changes in outcomes. The *Harvard Business Review* is filled with leadership theory and concepts. The literature on transaction versus transformational leadership from outside the industry is another good place to start.

In addition, consider how a leadership principle experienced in other industries is applicable in healthcare, and become a student of leadership and invite robust conversations on the topic.

The American College of Healthcare Executives also recognizes the same and has developed a valuable list of key leadership competencies and educational modules. They include the *ACHE Healthcare Executive 2024 Competencies Assessment Tool*, Global Consortium for Healthcare Management Professionalization and *Inclusive Leadership Competencies Assessment Tool*.

Considering the growing complexity of healthcare, there is great value in developing a leadership development plan. A purposeful and thorough internal and external scan will reveal organizational dynamics that will impact and influence leadership behaviors. A declaration of one's mission, vision and values will provide a road map toward an expected outcome. And lastly, studying leadership invites consideration of experiences in other industries that can be applied to healthcare. ▲

Britt Berrett, PhD, LFACHE, is managing director and teaching professor, Healthcare Industry Collaborative, Brigham Young University (britt.berrett@byu.edu).

Editor's note: To access the list of ACHE competencies, visit **ache.org/LeadershipCompetencies**.

Robert M. Fink,
PharmD, FACHE

Creating the Pharmacy Enterprise

It requires a culture of accountability, effective communications and leadership presence.

Often, integrated delivery networks or health systems do not create a pharmacy enterprise to take advantage of their scale but operate pharmacies within various facilities as stand-alone departments. To create the pharmacy enterprise, the chief pharmacy officer must standardize and centralize systems, functions and processes to achieve improved efficiencies, cost savings and improve patient safety.

The fundamental requirement to establish an effective pharmacy enterprise is to set the culture for the organization.

Standard Systems

Standardized systems include the EHR—this may require incremental steps should standardization be desired across inpatient, outpatient, retail and specialty pharmacy operation—and dispensing technologies such as automated dispensing cabinets, inventory management carousels and automated high-speed medication repackaging devices.

When standardized across the enterprise, these systems can leverage the capital investment and improve safety by eliminating variation. This also includes standardization of the pharmacy group purchasing organization, distribution channels (e.g., drug wholesalers and distributors), and service vendors (e.g., reverse distribution, pharmaceutical waste).

Additional technologies include IV pumps to set limits on drug administration, electronic drug information systems, clinical documentation systems, IV workload management, employee scheduling, data analytics platforms and kit/tray replenishment and tracking systems, among many others.

Standard Functions

Standard functions that can be centralized include regulatory compliance, medication safety, controlled substance accountability/surveillance reporting, antimicrobial stewardship, opioid stewardship, research, procurement, inventory control, chargemaster, pharmacy benefit management, drug policy and formulary, informatics support, human resources functions, revenue cycle auditing, denials management, residency program/student training programs, and consolidated services center operations.

Consolidated services operations can add incremental value with each service provided, including kit/tray replenishment, sterile product preparation, total parenteral nutrition solution compounding, low unit of measure distribution, repackaging products from bulk containers for unit-dose dispensing, direct-to-manufacturer contracting, large quantity purchases to take advantage of greater discounts, spot purchases of short-dated products, drug shortage management, forward purchases to avoid potential price increases, with proper inventory transactions and cost allocation between various cost centers within multiple 340B covered entities.

Centralized Processes

Centralized processes include policy development, after-hours or remote medication order verification using a common order queue for all locations (this can be achieved for both inpatient and outpatient operations—as well as, depending upon state law, can be supported by remote staff), and billing/coding of pharmacist services to third-party or commercial payers and pharmacy financial reporting. These processes

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support standardized operating units for both inpatient and outpatient (retail, specialty, infusion and clinic) services. Furthermore, office functions, such as regulatory compliance, 340B program auditing, revenue cycle management, and certain informatics team duties, can be performed by remote staff, serving to improve efficiencies, reduce the need for on-site office space, and eliminate the need for outsourced services.

Set the Culture

The fundamental requirement to establish an effective pharmacy enterprise is to set the culture for the organization to include accountability, effective communications and leadership presence, including ownership of the operation. It is the role of chief pharmacy officers to establish the culture of their pharmacy organization, and they must establish the expectations for the department to serve the needs of the enterprise versus those of an individual facility. This involves the establishment of a leadership team whose contributions benefit the pharmacy enterprise.

In this culture, the chief pharmacy officer sets clear expectations and deadlines while holding leaders and staff accountable for their responsibilities. Furthermore, the pharmacy leadership team presents and demonstrates ownership of their individual teams, organizations and operations.

The CPO can accomplish this by completing a skills inventory of all team members and identifying the talents and passion that each person contributes to the team. From this, efficiencies can be gained by leveraging skills, talent and experience to serve the greater need of the enterprise to create enterprise-level positions where labor costs can be allocated across the system facilities versus being concentrated at a single location.

This also creates advancement opportunities, improves team member job satisfaction by allowing them to focus on the tasks they enjoy and possibly reduces those tasks that provide lower reward. This organizational structure helps improve employee retention and reduces duplication of roles and redundancy of work.

Overcoming the Challenges

Establishing the pharmacy enterprise has many challenges, the two main ones being the complexities of financial reporting and transitioning away from a primarily inpatient cost center-based operation and toward a predominately outpatient-centric operation that is a net revenue generator for the system.

Financial reporting is probably the most complex challenge, as it must incorporate the 340B program benefit, infusion services, impact of pharmacist billing for physician practice operations and various hospital-based outpatient departments that drive 340B program benefit. In addition, retail pharmacy, which can include multiple locations, specialty pharmacy, 340B contract pharmacy revenue and patient or employee prescription assistance programs, also poses challenges. An effective solution to this challenge is to embed an accountant or member of the financial services team within the pharmacy department or create a role for a financial manager to oversee the financial operations of the department and develop enterprisewide financial statements for all pharmacy operations.

A challenge regarding inpatient pharmacy operation, where cost containment is paramount, is changing the organizational approach to that of an enterprise mindset where pharmacy expense drives revenue in the outpatient setting.

The cost-savings drivers on the inpatient side include inventory reduction, as expensive products can be shared, capital equipment can be leveraged (eliminating duplication across multiple locations), and purchased service expenses can possibly be eliminated (for example 24/7 operations can provide coverage for non-24/7 locations).

By establishing an effective pharmacy enterprise, a health system can achieve synergies, economies of scale, and efficiencies that serve to improve the quality of services, improve patient safety, realize cost savings, drive outpatient revenue and improve margins. ▲

Robert M. Fink, PharmD, FACHE, is system vice president/chief pharmacy executive, University of Louisville (Ky.) Health.

PEOPLE

AHA Recognizes Member-Led Organizations During Leadership Summit

Four organizations led by Fellows of the American College of Healthcare Executives were among those recognized during the American Hospital Association's July 2024 Leadership Summit in San Diego. Recipients were recognized with the following prizes and awards:

Equity of Care Award

The AHA's Institute for Diversity and Health Equity awarded the 2024 Carolyn Boone Lewis Equity of Care Award to the following ACHE member-led organizations:

Main Line Health, Radnor, Pa., led by president/CEO **John J. "Jack" Lynch III, FACHE**, was selected as the 2024 Equity of Care Award, Transforming Winner. This award recognizes a hospital that is implementing strategies to influence equity in the surrounding community ecosystem.

August Health, Fishersville, Va., led by president/CEO **Mary N. Mannix, FACHE**, was selected as the 2024 Equity of Care, Emerging Winner. This award recognizes a hospital that is leveraging the Health Equity Roadmap resources to dismantle structural barriers in its care delivery system and the communities it serves.

AnMed, Anderson, S.C., led by president/CEO, **William Kenley, FACHE**, was selected as the 2024 Equity of Care, Small/Rural Hospital Excellence Award Winner. This award recognizes a hospital or health system that has demonstrated excellence in advancing health equity in rural or small communities.

The Carolyn Boone Lewis Equity of Care Award annually recognizes outstanding efforts among hospitals and health systems to advance equity of care to all patients and to spread lessons learned and progress toward diversity, inclusion and health equity.

Fellow Named AHA Board Chair-Elect Designate

The American Hospital Association Board of Trustees elected **Marc L. Boom, MD, FACHE**, president/CEO, Houston Methodist, Texas, as its Chair-Elect Designate. Boom will be Chair-Elect in 2025 and become the 2026 Chair of the AHA. Currently a member of the AHA Board of Trustees, Boom serves on AHA's Health Systems Committee. Boom has been a member of ACHE since 1997, earning a Senior-Level Regent Award in 2016.

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IN MEMORIAM

Remembering Chuck Stokes, Former ACHE Chair 1953–2024

When Charles D. "Chuck" Stokes, FACHE, became Chair of ACHE in 2017, he told *Healthcare Executive* that what attracted him to the healthcare profession came during his first job in the field as an orderly at the local hospital in Yazoo City, Miss.

"Our small community hospital offered me the opportunity to spend time in the operating room, and I became very interested in the field of anesthesia," he said.

After discussing his interest with the family physician and an RN, Stokes applied to nursing school to pursue a career as a CRNA. "I worked my way through nursing school as a surgical technician and critical care technician."

Stokes, who passed away July 23, is remembered as a relentless servant leader and a beloved colleague and friend to many.

"He was authentic and transparent," said Deborah J. Bowen, FACHE, CAE, president/CEO, ACHE.

"In practice and focus, he believed that making a meaningful contribution is the best reward of all. He never gave up on anyone or anything."

David L. Callender, MD, president and CEO, Memorial Hermann Health, Houston, where Stokes retired in 2019 as its president and CEO, said Stokes was a vital part of the health system, working "tirelessly to establish a culture of high reliability, innovation and transformation."

Under Stokes' leadership, Memorial Hermann earned regional and national accolades in patient safety, high-quality care and operational excellence, including the prestigious Malcom Baldrige National Quality Award, the nation's highest presidential honor for performance excellence, which was awarded to Memorial Hermann Sugar Land Hospital in 2016.

In addition, North Mississippi Medical Center also received the Baldrige award in 2006 while he was president.

"I knew and admired Chuck long before I came to Memorial Hermann, and he has been a good friend to me in the years since he left the system," said Callender in a statement. "He … had style, warmth and wit."

In addition to serving as Chair-Elect and Immediate Past Chair with ACHE, Stokes was also a Governor from 2014–2016. He was selected as ACHE's Gold Medal Award winner in 2020-2021, the highest honor bestowed by ACHE on outstanding leaders who have made significant contributions to the healthcare profession.

The nomination packet recommending Stokes for the Gold Medal Award read in part that he "contributed to the advancement of the profession through the example he has set in servant leadership, his focus on exemplary care delivery and his outstanding performance in the promotion of health services. He has succeeded in inspiring creativity, engendering support, and fostering an environment that values out-of-the box thinking and dedication to professional development. He has repeatedly guided organizations toward patient care excellence, and he has an unwavering commitment to create a healthier Houston."

Stokes began his affiliation with ACHE in 1981 as a Student Associate when he was in graduate school. He became a Member and then earned his FACHE® in 1999.

Stokes, who was a longtime COO for Memorial Hermann before becoming its president and CEO, taught the COO Boot Camp at the Congress on Healthcare Leadership for 10 years, and he was one of the founding faculty members of the Senior Executive and Executive Programs.

In his Chair profile in the March/April 2017 issue of *Healthcare Executive*, Stokes said, "One of the most important lessons I learned as a nurse is the patient is the center of the healthcare universe. I also learned that if you take great care of your employees, treat your medical staff with respect, and provide patients with high-quality and safe care and an exceptional patient experience, the financials usually take care of themselves, and you will have the resources to continue to grow your organization."

Stokes was most recently executive in residence at the University of Alabama, Birmingham. He resided in Huntsville, Ala., and is survived by his wife, Judy, and three sons.

In Memoriam

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

Patricia M. Morris
Queens Village, N.Y.

Carol L. Paul, LFACHE
Maplewood, N.J.

Timothy H. Reanick
Jacksonville, Fla.

Philip S. Rice
Lake Worth Beach, Fla.

Vanda L. Scott, EdD, FACHE
Knoxville, Tenn.

LEADERS IN ACTION

To promote the many benefits of membership, the following ACHE leaders spoke recently at these in-person and virtual events:

Michele K. Sutton, FACHE
Chair-Elect
2024 THEF (Triangle Healthcare Executives' Forum of North Carolina) Summer Soirée
(June 2024)

William P. Santulli, FACHE
Chair
Hawaii Pacific Chapter Annual Meeting
Honolulu, Hawaii
(July 2024)

ACHE STAFF NEWS

Following are new hire announcements.

Dean Golemis welcomed as editor, Department of Professional Development.

Dave Hagan welcomed as assistant director, infrastructure, Business Excellence.

Kimberli House welcomed as customer service representative, Customer Service Center, Department of Executive Engagement.

Mary Kelly welcomed as senior manager, content acquisitions, Department of Professional Development.

Jennifer Seebock welcomed as senior copywriter, Communications and Marketing.

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

Michael R. Canady, MD, FACHE, recently retired CEO of Holzer Health System, Gallipolis, Ohio, received the Career Achievement Award from the Regent for Ohio.

Victoria A. Clarke, program manager, Cleveland Clinic, received the Outstanding Service Award from the Regent for Ohio.

Alison Flynn Gaffney, FACHE, division president, JLL Healthcare Solutions, Salt Lake City, received the Senior-Level Regent Award from the Regent for New York—Metropolitan New York.

Gail Games, FACHE, vice president/chief learning/development officer, Holzer Health System, Gallipolis, Ohio, received the Senior-Level Regent Award from the Regent for Ohio.

Peter Mallow, PhD, chair, Health Services Administration Department/director, Master of Health Services Administration Program, Xavier University, Cincinnati, received the Healthcare Leadership Award from the Regent for Ohio.

Scott Roberts, director, Nursing, OSU Wexner Medical Center/James Cancer Hospital, Columbus, Ohio, received the Early Careerist Regent Award from the Regent for Ohio.

Amanda Todorovich, executive director, Digital Marketing, Cleveland Clinic, received the Healthcare Leadership Award from the Regent for Ohio.

Jeena Velzen, PhD, associate director, Memorial Sloan Kettering Cancer Center, New York, received the Early Careerist Regent Award from the Regent for New York—Metropolitan New York.

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ACHE of Upstate New York
Earlier this year, Upstate New York's Rochester's Local Program Council kicked off Women's History Month by teaming up with Healthcare Financial Management Association—Rochester Regional Chapter for the Women in Leadership Conference in Rochester, N.Y. In its first year as a co-sponsor of this annual event, ACHE of Upstate New York proudly celebrated the opportunity to reaffirm its commitment to advancing opportunities for women and girls—not only in healthcare leadership roles.

The event was a true beacon of inspiration and empowerment for women in healthcare. Elizabeth Bostock, MD, system executive/medical director, women's health, Rochester Regional Health, and an ACHE member, delivered an enlightening keynote address. Bostock's speech was a riveting journey through the history of feminism, a narrative that underscored the importance of mutual upliftment. She urged the audience to embrace their individuality, encapsulating her message in the powerful phrase, "Be you, everyone else is taken." Her words sparked a flurry of questions and comments, transforming the conference into a dynamic learning environment. She emphasized viewing negative experiences as opportunities for growth, a perspective that resonated deeply with the attendees.

The theme for the 2024 conference was "Empowering Leadership: Navigating Change, Fostering Diversity, and Building Confidence," and it was brought to life in a vibrant panel discussion moderated by Meghan Finneran, FACHE, ACHE Regent and interim vice president, women's health, Rochester Regional Health. The panel included Twylla Dillion, PhD, president/CEO, HealthConnect One; Destiney Fraguada, DHA, professor, Roberts Wesleyan College, and administrator II, University of Rochester Medical Center; and Erin Lemke-Berno, chief administrative officer/vice president, Clinical Network Integration, Rochester Regional Health.

The discussion delved into complex topics like imposter syndrome and the intersection of generational diversity and gender influence. These discussions sparked challenging yet meaningful conversations, providing attendees with fresh insights and perspectives. Several quotes from the discussion stood out:

- "It's not a direct path, it's a zigzag."
- "Be courageously vulnerable."
- "Everyone is already enough."
- "Take care of yourself. It's hard to be divine if you're tired."

The sold-out and waitlisted event was attended by 65 senior and emerging leaders in healthcare, representing a diverse range of organizations from across upstate and central New York.

The conference served as a platform for empowering women in healthcare, fostering a spirit of leadership, diversity and confidence that left an indelible mark on its attendees, inspiring them to navigate their unique paths with courage and conviction.

Missouri Chapter of the American College of Healthcare Executives
The Missouri Chapter of ACHE held its annual strategic planning retreat in November 2023 with a sharp focus on updating and standardizing the chapter's foundation and operations. The chapter board updated and approved its Chapter Leader Handbook, which contains detailed descriptions of all functions of the chapter board members and all forms needed for chapter operations. The chapter also revised its mission, vision and objectives to

align with ACHE's. Additionally, the chapter aligned its chapter objective metrics with ACHE's metrics.

The annual goals were then assigned to board committees, with a plan for the goals to be reviewed quarterly at the board meetings. Committee updates are submitted prior to the board meeting for all members to review and be prepared to discuss. The chapter renewed its focus on member value offerings and assigned each value offering to chapter committees accountable to their success. To ensure chapter operations are maintained during board officer transitions, the chapter instituted an annual policy to update the approved chapter financial account holders and registered agent with the State of Missouri. Additionally, the chapter has also begun to leverage its LinkedIn presence to provide value for both current and prospective chapter members.

Another focus of the chapter is strategic partnerships with other ACHE chapters and healthcare organizations on networking and educational events. In March, the chapter and the Kansas Association of Healthcare Executives held a networking event in North Kansas City, Mo. This event was co-hosted by local chapters of the Medical Group Management Association, the National Association of Health Services Executives, Healthcare Financial Management Association and the American Organization for Nursing Leadership. Student members of the organizations were also in attendance. The event had over 40 attendees, and the Missouri Chapter of ACHE intends to replicate co-hosted events in other parts of Missouri with other healthcare organizations.

West Virginia Chapter of the American College of Healthcare Executives

West Virginia Chapter of the American College of Healthcare Executives has been hard at work elevating health administration across the Mountain State by engaging with higher education in preparing the next generation of healthcare leaders, increasing frequency and accessibility of chapter events, and enhancing preparation for the Board of Governors Exam.

Engaging Higher Education

The chapter is engaging collegiate healthcare management programs throughout the state, including West Virginia University, Marshall University, Fairmont State University and American Public University. In addition to regular visits, the chapter hosted a special education and networking event just for students, faculty and early careerists. The chapter board also established a student representative board position.

Enhancing Board of Governors Exam Preparation

One of the more enduring initiatives of the chapter is enhancing members' readiness for the ACHE Board of Governors Exam. Chapter leaders have made this a focus, and in recent years it has held informational sessions, as well as individual and group coaching sessions to help with preparation. These efforts are bearing fruit as more and more members are advancing to Fellow. The chapter board also established an Advancement Committee and engaged current Fellows and former chapter leaders and Regents to develop and provide a series of preparation sessions. With a third of the current membership eligible to apply or already approved to take the Exam, it expects to greatly increase the number of Fellows in the state over the next three years.

Increasing Frequency and Accessibility of Chapter Events

The chapter is transforming how it delivers events and is working to reduce the cost of its annual meeting by bringing in high-quality local and regional speakers and leveraging ACHE's educational templates for in-person education. This has doubled meeting attendance over the past two years. Additionally, given the rural and mountainous Appalachian geography, it has increased the number of virtual events. One way is through a collaboration with WVU's Master of Health Administration program, which offers quarterly "Administrative Grand Rounds" that address a variety of critical current topics in healthcare management. These are offered virtually and provide qualifying education through ACHE. Finally, the chapter established a partnership with the Center for Rural Health Development to co-sponsor the annual Appalachian Health Leadership Forum. This event brings together a variety of health professionals from across the state and Appalachia, and the partnership expands the frequency and accessibility of chapter events. ▲

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


Bailey


Kharbat


Lynch


Maki


Michaels


Soderberg

Josie Abboud, FACHE, to executive vice president, Methodist Health System, from president/CEO, Methodist Hospital and Methodist Women's Hospital.

Kathy C. Bailey, FACHE, to retirement from CEO, UNC Health Blue Ridge, Morganton, N.C.

Wesley Bamburg, FACHE, to COO, HCA Houston Healthcare North Cypress, from COO/ethics and compliance officer, HCA Houston Healthcare Medical Center.

James F. "Jim" Bennett, FACHE, to market CEO, Emerus Holdings, San Antonio, Texas, from senior vice president/COO, St. Joseph Medical Center, Penn State Health, Reading, Pa.

Ahmed Farag, DDS, FACHE, to dental director, Oregon Health Authority, Salem, from system executive medical director, Rochester (N.Y.) Regional Health.

Duane Gill, FACHE, to executive director, Montana VA Healthcare System, Helena, from interim executive director.

Mohammad "Mo" Kharbat, RPh, FACHE, to senior vice president/chief pharmacy officer, Clearway Health, Boston, from vice president, industry affairs.

Donnamarie Lynch, PhD, to president/CEO, Broadway House for Continuing Care, Newark, N..J., from COO.

Jerrold A. Maki, LFACHE, to retirement from healthcare consultancy practice. ACHE would like to thank Jerrold for his many years of service to the healthcare profession.

Carol Noel Michaels, FACHE, to chief transformation officer, Valley Health Partners Community Health Center, Allentown, Pa., from administrator, care coordination, Populytics Inc. and Lehigh Valley Health Network, Allentown, Pa.

Gary William Paxson, FACHE, to president/CEO, UNC Health Blue Ridge, Morganton, N.C., from president/CEO, White River Health System, Batesville, Ark.

Brett Richmond, FACHE, to executive vice president, Methodist Hospital and Methodist Women's Hospital, Omaha, Neb., from president/CEO, Methodist Fremont (Neb.) Health.

Tory Shepherd to market COO, Sovah Health, Danville, Va., from CEO, Rutherford (N.C.) Regional Health System.

Michael Sher, JD, to vice president, facilities and real estate, Nemours Children's Health, Jacksonville, Fla.

Gregory Soderberg, FACHE, to principal, Enterprise Customers-Central Midwest, from comprehensive services executive, GE HealthCare, Minneapolis.

Thomas Snyder, RN, FACHE, to principal, AddPrana LLC, Phoenix, from director, quality, Banner Casa Grande, Banner Ironwood and Banner Goldfield Medical Centers, Phoenix.

Want to submit?

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

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