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SEPT/OCT 2025
V40 | N5

Intelligent Care

How AI Is Driving Healthcare Transformation

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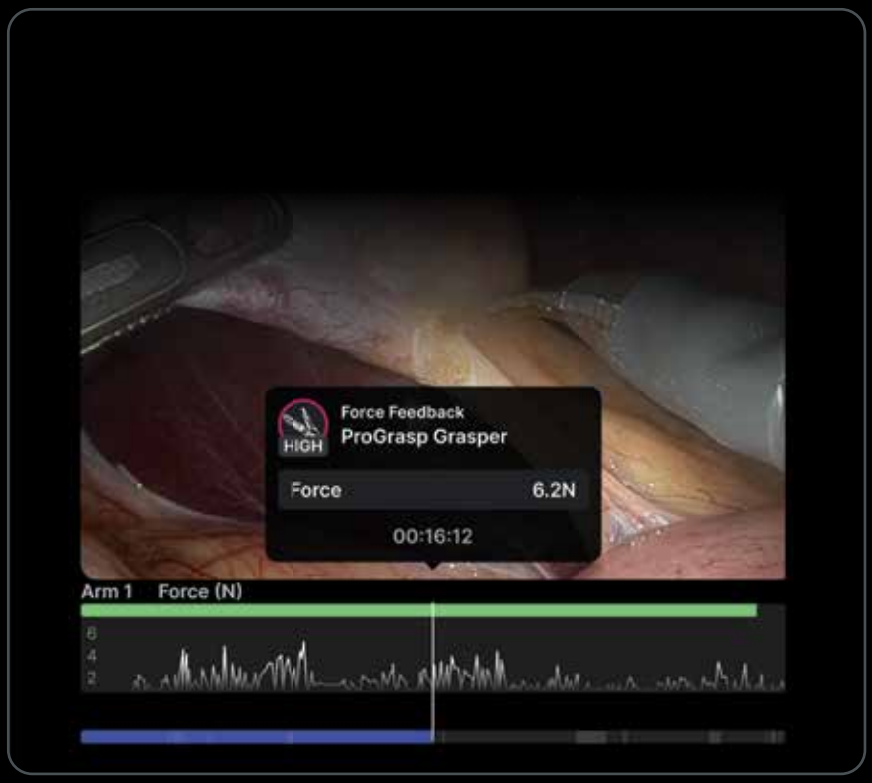

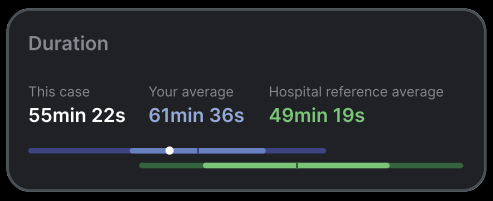

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Healthcare is well positioned to make the leap with AI.

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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

AI's Clinical Promise, Its Reality and Everything In-Between

Artificial intelligence is everywhere these days—all over the news, at our fingertips and seemingly being discussed by anyone talking about the future. The speed by which large learning models are debuting and evolving, and the rising rate of adoption, makes me wonder where we'll be a year from now.

Our cover story, "Intelligent Care: How AI Is Driving Healthcare Transformation" (Page 8), looks to the near future as well. Specifically, we dig into four clinical areas that AI might impact in ways that can revolutionize patient care and how it's delivered.

Additionally, experts and providers offer guidance that can help leaders succeed in adopting and deploying AI systems. From providing predictive analytics to delivering more accurate diagnostics to automating tasks for clinicians, the promise of AI might make care processes look a whole lot different not too long from now.

While AI's potential is undeniable, successful adoption may not be a particularly linear path. In a recent episode of the *Healthcare Executive* Podcast, Richard G. Greenhill, DHA, FACHE, and healthcare IT expert Edward O'Connor discuss some of the realities of AI adoption and strategy, and why it isn't always translating to value the way leaders may have hoped. You can access this episode—and many others—at **healthcareexecutive.org** or wherever you download podcasts.

Thanks as always for reading. If you have any feedback about this issue, the magazine in general or even the podcast, just send me a note at rliss@ache.org ▲

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Deborah J. Bowen, FACHE, CAE

Volunteers Matter More Than Ever

Touching lives propels us forward

"It is in giving that we receive."

—St. Francis of Assisi

As leaders, we are givers by nature. We are among the first to raise our hand, help a colleague or a friend. In fact, ACHE's own core values articulate our profession's commitment to lead through example while recognizing that caring must be a cornerstone of our interactions.

Roughly 76 million people formally volunteered their services in 2023, not counting the informal acts of service that happen every day, according to the U.S. Census Bureau and AmeriCorps.

We are fortunate to be the beneficiaries of this generosity, with the support of more than 3 million community volunteers at hospitals and healthcare organizations—who are the everyday heroes—helping at the grassroots level and making a positive impact. Research shows that the contributions of community health volunteers are linked to improved outcomes, care team productivity and reduced costs.

This demonstrates what we as leaders innately know: that volunteering is more than a generous act; it is a strategic imperative for organizations and individuals.

Volunteerism Builds Engagement

Volunteering can be a force for organization and team engagement. A study by Deloitte found that 89% of employees who volunteer through company-sponsored programs report greater job satisfaction, and 76% say it made them feel healthier.

Developing formal organizational constructs to support volunteerism, such as cross-functional task forces, project-based committees or skill-sharing initiatives, can cultivate leadership among employees and break down silos, all while supporting broader mission goals.

Such structure doesn't require a large budget, but it does necessitate intentional design and leadership support. By creating volunteer opportunities for people to lead from where they are, organizations foster teamwork and satisfaction while reinforcing a culture of service.

Personally Giving Back Elevates Everyone

In a field as dynamic as healthcare, no one can succeed alone, and I am consistently inspired by how many of you who volunteer your time, especially as mentors, coaches and sounding boards.

The rewards of such work are deeply personal, but they also translate into greater impact. Research from the National Mentoring Partnership reveals that mentored professionals are five times more likely to be promoted, and 89% of those who are mentored go on to mentor others.

Moreover, according to a study in the *Leadership & Organization Development Journal,* volunteering improves emotional intelligence, communication, and conflict management—all essential for healthcare leaders navigating today's complexities. By cementing a culture of giving back by personally setting the example and by fostering in others a desire to volunteer, everyone wins.

Strengthen Community Through Reciprocal Giving

Finally, at a time when many feel anxious and possibly disconnected, communities matter more than ever.

ACHE chapters across the country are vital hubs for connection, collaboration and shared purpose. They are powered almost entirely by volunteers who generously give their time to bring education, networking and fellowship to local members. Each of you and all of you have helped to make ACHE stronger than ever.

All of this is a reminder that volunteering is an avenue to create something greater than ourselves. Though we may face resource limitations, our capacity for generosity, leadership and connection is boundless. Volunteering helps to light a path forward.

I offer my sincerest gratitude for all you do in service to others and your countless acts of kindness. ▲

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




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How AI Is Driving Healthcare Transformation

By Ellen Lanser May

From financial services to manufacturing, today's economic sectors are increasingly seeing AI as an essential component of their business strategy.

According to a 2025 Bessemer Venture Partners survey—in partnership with Amazon Web Services and Bain & Company—of 400 senior healthcare leaders in the provider, payer and pharmaceutical sectors, AI adoption is accelerating. Although the healthcare field has not yet achieved at-scale implementation, 95% of respondents said generative AI will transform the industry, with 85% of provider and 83% of payer leaders saying that it will "reshape clinical decision-making within three to five years." Fifty-four percent of all respondents said they are already seeing a meaningful return on investment in their organization after their first year of generative AI adoption.

As the pace of development and implementation rapidly accelerates, where and how will AI alter healthcare frameworks as we currently know them? The following are four areas in which AI may revolutionize patient care and the way it is delivered.

Diagnostic Accuracy

Independent studies, such as one by John Hopkins Medicine in 2023, "Burden of serious harms from diagnostic error in the USA," have shown that misdiagnosed health conditions are a significant patient

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safety concern. Fortunately, diagnostic accuracy is one of AI's most transformative promises. By analyzing massive datasets, machine learning algorithms have the potential to reduce human error through rapid precision and ability to uncover hidden relationships, especially with rare diseases. "Every day, thousands of scientific papers are published, making it incredibly difficult for physicians to keep up with current advances," says John D. Halamka, MD, Dierks president of Mayo Clinic Platform, which is part of Mayo Clinic. Mayo Clinic Platform, formed in 2019, harnesses new technologies and connects multiple elements of the healthcare ecosystem to enhance how care is provided.

> "An AI model can reveal variations in what may seem like an obvious diagnosis. It's an essential tool—another set of eyes, really—to keep clinicians informed and provide a safety net to prevent harm."
>
> —John D. Halamka, MD
> Mayo Clinic

"But an AI model can reveal variations in what may seem like an obvious diagnosis," he says. "It's an essential tool—another set of eyes, really—to keep clinicians informed and provide a safety net to prevent harm."

In the realm of disease diagnosis, AI is becoming more than just a reference tool. Part of this shift is due to the unprecedented growth in healthcare data. According to a 2025 article published in *Informatics and Health*, between 2011 and 2018 medical image datasets grew by three to 10 times, with annual increases of 21% to 32%. "In the United States, we're seeing emerging AI breakthroughs in pathology," says Robert Havasy, senior director of informatics strategy for HIMSS.

"Pathology has always been based on a physical medium, but once slides and results are digitized, AI can be used to analyze the data, and massive inroads can be made."

For example, a 2024 study, "Foundation models for fast, label-free detection of glioma infiltration," led by UC San Francisco and University of Michigan researchers found that using an AI-powered diagnostic tool can help neurosurgeons identify invisible cancer cells *during surgery* that may have spread beyond a visible tumor. By using a dataset containing 11,000 specimens and 4 million microscopic views, the AI tool can tell the difference between tumors and healthy tissue within 10 seconds. This gives surgeons the power to remove dangerous cells at the same time they remove cancerous tumors.

Stanford University has also made critical advances in health diagnostics with powerful AI technology. Called CheXNet, this groundbreaking tool can analyze chest X-rays for 14 different pathologies in 90 seconds as opposed to the hours required by radiologists to do the same evaluation.

Although this progress opens a new frontier for diagnostics, it comes with caveats. For one, the datasets that power diagnostic tools are only as good as the data used to "train" the technology. Furthermore, even if the data is diversified geographically and demographically, it is impossible to know if diagnoses are accurate for all people. However, according to the experts interviewed for this article, when viewed in tandem with a physicians' work, AI will assist in developing more accurate diagnoses rather than producing final verdicts on its own.

"AI and physicians together can get at something that neither can do alone," says Michael A. Pfeffer, MD,

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FACP, CIDO, associate dean for Stanford Health Care and Stanford University School of Medicine. "For example, peripheral artery disease has low diagnosis rates. To address that, we developed and are piloting an AI-based model to help detect peripheral artery disease before the clinical diagnosis. Then in real time, physicians can dig deeper into the patient's history and decide what kind of treatment will benefit that patient. The model by itself isn't good enough, but it is a valuable tool to augment physicians' work."

> "In the United States, we're seeing emerging AI breakthroughs in pathology."
>
> —Robert Havasy
> HIMSS

Predictive Analytics

Preventive care has long been a focus of clinicians as they work with patients to understand future risks. One of the most challenging aspects to preventive care is understanding what those risks are specific to an individual patient. But predictive AI models open a portal of precision by integrating comprehensive historical data with personal patient information, analyzing the data and then using that data to forecast specific future trends.

"Tracking all the variables of a disease and what they might mean is incredibly difficult," says Mayo Clinic Platform's Halamka. "There might be 80 different parameters: phenotype, genotype, where the patient lives, what the patient eats, lab results and so on. The challenge is integrating so many disparate datasets in order to predict a future disease state. It's not magic; it's math. But humans are simply limited in their ability to do that type of math."

Although the healthcare sector is not yet ready to scale with these tools, they do exist. For example, researchers from the Mass General Cancer Center and the Massachusetts Institute of Technology created an AI tool called Sybil. Using CT scans from patients in the United States and Taiwan, Sybil accurately predicted lung cancer risks for patients with or without a significant smoking history. With this information, providers can create targeted approaches that mitigate the chances of at-risk patients developing cancer. Similarly, researchers at the National Institutes of Health developed an AI tool that uses data from individual cells inside tumors to predict whether an patient's cancer will respond to a specific drug.

"Machine learning tools are exceptionally well positioned for predicting risks and helping us get out from under the disease management system that activates only once a patient is sick," says Anne Snowdon, PhD, FAAN, chief scientific research officer for HIMSS. "This allows providers to move to a proactive, data-driven mode. Of course, the data has to be vetted and tested. It all depends on the AI being trustworthy so that its predictions are reasonable."

Personalized Treatment Plans

The success of preventive care depends on patient engagement with lifestyle and treatment recommendations. Although AI has already emerged as a way to increase patient compliance, the power of those tools is growing because of greatly expanding data sources and robust mobile applications, cloud computing and wearable devices. New AI tools used in patient communication are agentic, meaning they can perform tasks and make autonomous decisions. In other words, they can help manage a patient's health journey.

"I think the personalized treatment plan is the holy grail of AI," says Stanford's Pfeffer. "The only way

to achieve that is to have access to large amounts of multimodal data that encompass everything from environmental factors to genomics to phenotypic information, both at the population level and specific to the patient in front of you. This is the practice of precision medicine: the ability to make personalized recommendations for a unique patient in real time at the point of care."

For example, continuous AI monitoring of physical activity, sleep patterns and stress levels, combined with glucose data, could produce and recommend real-time changes to medication or lifestyle for patients with Type 2 diabetes. As reported in a 2024 article in *Bioengineering,* "The Role of AI in Hospitals and Clinics: Transforming Healthcare in the 21st Century," mental health providers are using AI tools to monitor patients' speech patterns, behavior and social media use to make treatment recommendations and suggest interventions.

Although agentic AI cannot replace primary care physicians, it can provide consistent, repeated and predictive communication. "If you can only see your PCP every six months—because they're not only hard to schedule but difficult to find—how useful is that? What if you need to modify your daily medication regimen?" says Havasy. "An AI agent attuned to personalized patient parameters can interact with a patient on a daily basis with reminders or recommendations on what that individual needs to be doing to stay healthy."

The future for personalized treatment plans fueled by agentic AI is promising. But achieving its full potential depends on addressing issues like data protection, interoperability, access and regulatory compliance, to

Abdominal magnetic resonance imaging on screens using artificial intelligence applications. Photo credit: Mayo Clinic

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name a few. "Not everyone can see a physician in person, but AI can be anywhere," says Havasy. "Moving this forward requires organizations to be digitally enabled, knowledge-sharing focused and ready to help patients envision new roles for managing their care."

Healthcare Workforce

With the World Health Organization reporting a healthcare worker shortage of 11 million expected by 2030, generative AI has the potential to help bridge that gap. "The big advances with generative AI over the next few years will be in automation, whether its creating notes, summarizing discharge instructions or operating the revenue cycle," says Pfeffer. He notes that Stanford is piloting ambient AI scribe technology that listens to the interaction between patient and doctor and then documents the entire conversation. Thus, rather than taking notes, the physician is free to focus on what the patient is saying and can create a personal connection in the moment.

> "AI and physicians together can get at something that neither can do alone."
>
> —Michael A. Pfeffer, MD, FACP, CIDO
> Stanford Health Care, Stanford University School of Medicine

There is no denying that there is great value in how humans leverage AI, but by automating tasks, physicians and nurses are able to function at the height of their licensing scope instead of being mired in paperwork. Massachusetts, for example, has hundreds of unique youth summer camp forms that must be completed by a primary care physician for a child to be medically cleared for participation. "Working on these is a time-consuming exercise for physicians," says Halamka. "But if the forms could be sent to an agentic AI, physicians could spend that time on patient care instead. There are thousands of examples like this that arise in the daily work of providers." Given that healthcare organizations are having difficulty hiring and recruiting specialists and nurses for several reasons, including burnout, reducing practitioners' documentation and administrative burdens could could potentially improve their job satisfaction.

AI tools can also help fill gaps caused by healthcare workforce shortages. According to HIMSS' Snowdon, the number of clinicians working with less than three years' experience is steadily increasing. According to a 2023 *Heliyon* article, "Discrepancy rate and clinical impact of preliminary reports from radiology residents," this can become problematic in areas like radiology, where less experience has correlated with misinterpretations of results.

In the past, a senior physician working closely with a newer doctor would serve as the voice of experience. But with global workforce shortages, AI, with expert oversight by caregivers, is playing a fundamentally important role not only in improving diagnostic accuracy but also in addressing global workforce shortages.

"We are seeing AI play an interesting role in the radiology departments of Asia-Pacific countries," Snowdon says. "To overcome missed diagnoses, AI tools can flag the readings of early careerists and ask those providers, for example, if they double-checked a specific anatomical structure."

How Healthcare Leaders Can Succeed in AI Adoption

The technical barriers to implementing AI at scale are fairly clear, from creating interoperability with existing systems to ensuring data accuracy and integrity.

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Developing a strong IT team and collaborating with experts can help address data and implementation challenges. Successful AI deployment also depends on strategic, principled action by healthcare leaders in several key areas, including:

Developing data and AI governance. Data governance provides a framework to ensure that the information an organization uses is accurate, protected, legally compliant and used responsibly. Similarly, AI governance is composed of policies and procedures guiding the development and deployment of AI tools in a way that is responsible, ethical and safe. In other words, data governance applies to data assets, whereas AI governance applies to AI models and algorithms.

"Healthcare organizations have to have their digital houses in order, and governance provides the foundation for that," says Havasy. Without a framework governing use and performance, healthcare organizations risk implementing bad AI based on bad data, which can ultimately lead to patient harm.

Targeting the correct problem. Despite its revolutionary power, AI does not solve every challenge. Sepsis tools are a useful example of that. A sepsis model that predicts whether a patient will develop sepsis so that clinicians can administer antibiotics sooner isn't useful if hospital data shows that patients with sepsis are already receiving antibiotics when they should.

"Even if the AI model is accurate, it should demonstrate a benefit and actually solve a problem," says Stanford's Pfeffer. "A fundamental step in all of this is understanding what the AI model is telling us to do, what we are going to do with that information and if it's even possible to take that action. This kind of disciplined questioning is necessary as you roll out AI in the healthcare setting."

Once it has been determined that AI is the right solution for the problem, examining the accompanying workflow is critical for successful adoption. "The solution has to be embedded within the typical workflow that providers use every day," says Pfeffer. "If it's living outside of that workflow, it will be impossible to achieve the outcomes that the solution promises."

Learning from early adopters. To shorten the learning curve, healthcare leaders should examine what similar organizations have done. Early adopters are real-life test cases that provide practical do's and don'ts, as well as pitfalls, metrics and vendor insights. "Turn to organizations like Mayo Clinic that use scaled rollouts," says Halamka. "Working in stages helps us to do no harm to the patient and can also foster adoption among staff and clinicians."

Halamka notes that as AI solutions roll out, the workforce may feel apprehensive about AI, and communicating how it can augment patient care and reduce burnout is critical. This scale of change requires staff leaders who will understand the unique impact of each implementation. "Make sure to thoughtfully support your team throughout AI implementation with open, honest conversations that focus on the positive impact for both patients and care teams, while addressing any concerns that staff may have along the way," he says. "Encourage people to talk about how they got home earlier because they used a new AI tool or how AI picked up a nearly missed diagnosis. These kinds of wins help accelerate adoption so that you can scale across the organization."

Ultimately, the most important strategies for successful AI implementation are not much different than those used for EHR adoption. "The journey toward the goal of successful AI implementation is the same journey we have taken many times before," says HIMSS' Havasy. "We can't forget the lessons we have learned in the past. AI is the future and will continue to be the future. Not investing today is a strategic mistake."

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

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Harnessing Technology to Address Today's Real Estate Challenges

As healthcare organizations continue to seek innovative ways to offer the best patient care, they need help from all corners, especially given a challenging financial backdrop and an unpredictable regulatory environment.

Technology offers significant promise in solving the real estate problems that hinder today's healthcare leaders, including strategies for using capital more effectively.

Below are examples of how technology is helping healthcare organizations tackle today's operational and financial challenges. All aim to reduce costs and improve efficiencies so organizations can focus on what matters most—patient care.

AI-Driven Solutions

Healthcare leaders are tasked with making decisions daily and rapidly as new circumstances and challenges arise. For assistance, organizations can benefit from AI-driven solutions such as tools that allow them to manage their assets and facilities more efficiently.

These tools can provide quantitative and qualitative data that help an organization maximize the useful life of an asset, according to Cheryl Carron, COO, Americas Work Dynamics, and president, Healthcare Division, JLL, Chicago. "If you have 24-hour operations like most hospitals, you need to keep things going," she says. "Using technology for strategic maintenance planning to control when there's downtime for an asset allows you to provide uninterrupted patient care."

Being able to pivot from reactive to planned maintenance made a world of difference for one hospital system in Chicago. Using the cloud-based computerized maintenance management system tool Corrigo, the organization transformed its work order management, allowing maintenance staff to save valuable time and reducing costs substantially.

Previously, staff could not effectively track when a work order was complete and would need to physically go to a site to check. Now, they can use Corrigo to analyze work orders for the day or week and determine which orders are a priority and how many staff members they require to perform the work. The team can also capture trends in data by season, time of year and patient volume. At a moment when organizations are short-staffed in all areas, the time savings has been invaluable.

"Now more than ever, it's critical we maximize maintenance staff's time due to the shortage of technical

trade workers in healthcare," Carron says. "AI is helping organizations plan out their maintenance schedules, showing them where there could be additional tools, parts or people needed."

AI and other emerging technologies are also helping healthcare organizations more effectively manage use of their physical spaces, which allows them to respond to changing patient demographics and needs, like a shift of care from inpatient to outpatient settings. Outpatient care needs are poised to grow as technology is expected to reduce inpatient volumes by 1.8 million over the next five years, according to JLL's *2025 Health Care Trends to Watch.*

Carron says AI is assisting organizations with capital planning thanks to its ability to analyze large swaths of geospatial and demographic data—rapidly—to identify where a patient population's greatest needs are. Health systems are also using AI to automate lease administration, reducing human error and speeding up occupancy planning.

"It helps health systems know the utilization of space across campuses exactly without occupancy planners having to look through reams of information or go out to the site and count rooms and desks being used," Carron says. "They can see how to better utilize the space or retrofit the space to meet a healthcare facility's growing and changing demands."

Energy Management Tools

The Chicago health system also implemented technology to manage its energy costs.

"We implemented 110 energy projects for the system and generated roughly $9 million of savings over five years, in addition to getting utility incentives to offset the startup costs of implementing some of the projects," Carron says.

She notes hospital systems are also saving on costs and improving efficiencies with technology in other areas like building automation, system optimization, LED retrofitting, steam system upgrades, and chiller and cooling tower upgrades and improvements.

"All of it drives toward getting more useful life out of your assets and improving overall staff efficiency," Carron says. "We know that employee dissatisfaction leads to reduced patient outcomes. When we have happy employees operating in spaces that are working and nothing is broken and they're not disrupted, they then can provide the absolute best patient experience."

Success Strategies

For organizations looking to take advantage of emerging healthcare real estate technologies, Carron has the following advice.

"You don't need to do it all at once," she says. "Start out with some individual problems you need to solve. Then try to see where technology can be leveraged efficiently and cost effectively to help you get the maximum value and return on that investment."

Focus on change management. When employees don't know the "why" behind a new technology or new processes, it can feel like just another thing to do or learn, which could make today's overwhelmed workers feel even more so, Carron says. She suggests getting feedback early from staff and bringing champions on board to promote the use of the tools. Conducting small pilot projects that demonstrate to employees how a tool can save time, reduce waste and improve patient care—the ultimate goal—may also be useful.

Partner up. "So many organizations that we see are so great at what they do, but not every organization is great at technology," Carron says. She advises seeking external partners that can provide insights into best practices and successes.

Make sure tech meets the mission. "The goal of technology utilization should be that healthcare organizations can focus on what their core mission is," Carron says. "The tool should enable you to become more efficient and effective and allow you to have clearer line of sight to where you and your team need to be spending their energy, time and effort to drive to your core mission—excellent patient outcomes and happy employees."

For more information, please contact Sara D'Onofrio, Healthcare Marketing Lead, JLL, at sara.donofrio@jll.com.

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Moral Distress in Leaders

This growing problem is often overlooked.

Jason Lesandrini, PhD, FACHE

Healthcare organizations are grappling with ethical challenges that go far beyond what happens at the bedside. Although considerable time has been spent studying how clinical ethics issues affect clinicians, the field has largely overlooked healthcare leaders' experiences.

This missed opportunity involves both the type of ethics issues experienced and the impact on leaders. The latter challenge—failing to examine the emotional impact on leaders—is significant, as they often face tough organizational decisions that affect everything from patient care to staff well-being.

Recent research paints a troubling picture: About one-third of healthcare leaders are experiencing burnout scores in the high range, according to an article in the September/October 2022 issue of *ACHE's Journal of Healthcare Management*. That's a substantial chunk of the leadership workforce, and it represents a real organizational challenge. When leaders are burned out, it ripples throughout their teams, affecting staff burnout, professional fulfillment and, ultimately, patient care.

Studies have pointed to sleep problems and low self-compassion as key predictors of leader burnout, but these factors alone don't seem to tell the whole story. There's a gap that needs to be addressed, and it appears part of this gap concerns the phenomenon known as moral distress.

Most of what ethicists know about moral distress comes from studying nurses and clinicians, with very little research looking at how it affects leaders who work outside of direct patient care. This oversight is noteworthy because these leaders face a unique set of ethical challenges that can deeply affect their well-being, their decision-making ability and their entire organization.

If moral distress is contributing to the documented burnout rates among healthcare leaders, then our current wellness approaches may not be enough. We might need to think bigger and consider implementing initiatives such as ethics-focused leadership support systems, moral distress consultation services and organizational culture changes that acknowledge the profound ethical burden healthcare leaders carry.

Understanding moral distress among healthcare leaders is a critical step toward addressing it. With healthcare systems facing unprecedented challenges and clear evidence that leader well-being affects organizational performance and staff outcomes, identifying and addressing moral distress in the leadership ranks has become essential.

Only by addressing moral distress at all levels can healthcare organizations create truly ethical and sustainable healthcare environments.

Background: What Is Moral Distress?

Researcher and ethicist Andrew Jameton, PhD, introduced the concept of moral distress in 1984, defining it as the psychological discomfort healthcare providers feel when they know the right thing to do but are prevented from doing it by organizational constraints. This definition has evolved over the years with recent definitions thinking more broadly about the impact of experiencing morally challenging events. In a May 2019 article in the journal *Nursing Ethics*, author Georgina Morley, PhD, RN, describes moral distress as having three components: experiencing a morally challenging event, feeling psychological distress

about it and having a direct link between the two.

What makes moral distress different from regular job stress is that it stems from specific ethical situations and can leave behind what researchers call "moral residue"—emotional baggage that builds up over time. When moral distress becomes severe and persistent, it can progress to moral injury, which represents deeper, longer lasting damage to someone's sense of moral integrity, according to a paper in the March 2025 issue of the *Journal of Radiology Nursing.*

What Causes Moral Distress in Healthcare Leaders?

Several key factors may contribute to moral distress among healthcare leaders, including three main ones: resource pressures, competing stakeholder demands and legal/regulatory constraints.

Resource Prioritization

Perhaps no area creates more moral distress for healthcare leaders than resource prioritization decisions. Leaders constantly face situations where organizational resources—financial, human and technological—are insufficient at meeting all identified needs. These decisions carry profound moral weight because they directly affect patient care quality, staff safety and community health outcomes.

Consider the CFO who must decide between investing in updated imaging equipment that would improve diagnostic accuracy and hiring additional nursing staff to reduce patient-to-nurse ratios. Both investments would enhance patient care, but budget constraints force an either/or decision. The leader experiences moral distress knowing that either choice means accepting suboptimal conditions in one critical area.

Competing Stakeholder Demands

Healthcare leaders must balance the often-conflicting needs and expectations of multiple stakeholder groups: patients and families seeking the highest-quality care, staff members requiring safe working conditions and fair compensation, board members focused on financial sustainability, regulatory bodies demanding compliance, and communities expecting accessible healthcare services.

A hospital CEO facing pressure from the board to reduce costs while simultaneously dealing with staff demands for better working conditions and community expectations for expanded services can experience moral distress when these competing demands cannot be simultaneously satisfied. The leader knows that prioritizing one group's needs may compromise another's well-being or satisfaction.

Regulatory and Legal Constraints

Healthcare leaders frequently encounter situations in which regulatory requirements, legal mandates or organizational policies conflict with their professional judgment about what would best serve patients or staff. These constraint-based scenarios represent classic moral distress situations in which leaders possess the knowledge and authority to make better decisions but are prevented from doing so by external forces beyond their control.

More Examples of Leadership Moral Distress

Staffing Decisions

During the COVID-19 pandemic (and even today), many healthcare leaders faced the moral distress of having to make staffing decisions that could compromise patient care quality.

CNOs, for instance, might know that reducing nursing staff ratios in certain units would negatively impact patient outcomes, but financial constraints and staffing shortages forced these decisions.

As a result, these leaders can experience moral distress, knowing that their administrative decision, while necessary for organizational survival, directly contradicts their professional commitment to patient welfare and safety.

The moral distress arises not from poor leadership or inadequate planning but from systemic constraints that made morally optimal decisions difficult.

Limited Beds

Consider a hospital administrator who must decide how to allocate limited ICU beds during a surge in critically ill patients.

The administrator knows that evidence-based guidelines suggest certain patients have a better prognosis, but implementing strict allocation protocols based solely on clinical criteria may conflict with the organization's commitment to equity and compassionate care.

The leader experiences moral distress when forced to make decisions that, while clinically sound, may appear to devalue certain patients' lives or limit families' ability to make autonomous decisions about their loved ones' care.

What Can We Do About Moral Distress in Leaders?

An important caveat must be acknowledged at the outset: The field lacks validated assessment methods specifically designed to measure moral distress in healthcare leaders. The existing tools, developed primarily for bedside clinicians, may not capture the unique ethical challenges and systemic pressures executives face. However, practical experience working with healthcare leaders suggests several critical interventions that organizations can implement until more rigorous research and validated instruments are available.

Recognition: The First Critical Step

A fundamental challenge in addressing moral distress among healthcare leaders is recognition. In working with hundreds of healthcare executives, most leaders view moral distress as simply part of the job—an inevitable burden of leadership that must be endured silently. This normalization of moral suffering represents a dangerous misconception that prevents leaders from seeking help and organizations from providing adequate support.

A course of action may include teaching healthcare leaders to recognize moral distress in themselves and their colleagues. This recognition training can focus on identifying the physical, emotional and behavioral symptoms of moral distress, including persistent feelings of guilt or regret after difficult

decisions, sleep disturbances following ethical dilemmas, cynicism about organizational values and withdrawal from decision-making processes.

Ethics Consultation for Leaders
Most healthcare organizations provide ethics consultation services for clinical dilemmas but neglect to offer similar resources for administrative ethical challenges. This gap represents a substantial missed opportunity for preventing moral distress among leaders. To fill this disparity, review how your ethics consultation services are addressing the needs of leadership-focused ethical dilemmas and seek consultation proactively—before making difficult decisions—rather than waiting until moral distress has already occurred. This preventive approach can help leaders navigate complex ethical terrain while minimizing psychological harm.

Moral Discussion Forums for Leadership Teams
One of the most effective interventions for tackling moral distress head-on is creating structured moral discussion forums, in which healthcare leaders can bring ethical issues they have experienced for group processing and problem-solving. The goal of these forums is to create safe spaces for leaders to discuss their moral challenges without fear of professional judgment or career consequences.

The Critical Need for Measurement and Assessment
A key component for addressing moral distress among leaders is using systematic approaches to measure and monitor its presence. Healthcare organizations routinely measure clinical quality indicators, financial performance metrics, employee satisfaction or engagement, and well-being at work, but few systematically assess moral distress among their teams, especially leaders. This gap represents a major oversight that undermines efforts to create sustainable leadership cultures.

The path forward requires a comprehensive approach that acknowledges the distinct nature of leadership moral distress while integrating solutions into broader organizational ethics initiatives.

Regular assessment protocols can be implemented that specifically identify moral distress among healthcare leaders. While validated instruments for leadership moral distress are still in development, organizations can adapt existing tools and create interim assessment approaches. For example, a simple and easily implemented tool is the Moral Distress Thermometer by Lucia Wocial. While validated in clinicians, its application appears reasonable for leaders and can happen at more frequent intervals given the assessment's simplicity.
Although measurement is just the beginning of the work, what organizations do with the scores is likely to matter more to the leaders and future of healthcare organizations themselves.

What Ethics Programs Can Do
Ideas to expand the scope of ethics programs to address leaders' moral distress include:

Tailored Education and Training
Organizations should consider developing specialized resources for healthcare leaders that address their unique ethical challenges. This might include training on:

- Ethical decision-making frameworks
- Ethical leadership and the impact on organizational culture
- Recognizing and addressing personal moral distress

Given healthcare leaders' critical role in shaping organizational culture and making decisions that affect entire healthcare systems, addressing their moral distress is essential. The path forward requires a comprehensive approach, one that acknowledges the distinct nature of leadership moral distress while integrating solutions into broader organizational ethics initiatives through recognition and resources tailored to leaders' needs.

Only by addressing moral distress at all levels can healthcare organizations create truly ethical and sustainable healthcare environments that support providers and leaders in delivering compassionate, high-quality patient care. ▲

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Funding Challenges for Rural Hospitals

The struggle is real, and so are the solutions.

The range of complex and evolving challenges that hinder healthcare organizations' ability to achieve their mission and effectively serve their patient communities is well documented. But executives in rural community hospitals and public health institutions know their challenges are even more acute, as they operate on tight budgets.

This financial strain can make investing in attracting a workforce, staff development, medical equipment and technology, and innovative care models challenging, to say the least. Add all this to the ever-shifting public expectations of care and reimbursement models, and the struggle is not only real but also perplexing in how to face these challenges effectively.

Alternative Funding Sources and Partnerships Can Help

Rural healthcare leaders must prioritize seeking alternative funding sources and fostering partnerships that amplify impact without significantly increasing costs.

Whether you're an individual healthcare professional seeking guidance or a stakeholder for your organization, a simple and relatively affordable option to consider is associations and other groups that work for the interests of rural and community hospitals.

These organizations focus on areas such as policy, advocacy, education, research and technical assistance to support the unique needs of these hospitals and the communities they serve. At the national level, they include the National Rural Health Association, the National Organization of State Offices of Rural Health, the American Hospital Association (which includes its Hospital Community Collaborative and its Section for Rural Health Services) and many other groups.

Additionally, state-level organizations play an essential role in coordinating activities and providing support within their respective states that include not only your state hospital association but also the state's rural health association.

Of course, ACHE and its partner organizations focus on professional development in a wide range of areas, including help for rural institutions.

Don't discount tapping into these types of organizations for assistance, even though there are often costs involved. Leaders cannot stay current on regulations and gain that knowledge if they don't have access to training and education. It's crucial to not cut costs too much in these areas and remain strategic about spending money. Continued training helps us be informed and ensure hospital care services are as advanced as possible. Training options vary widely in format and focus, equipping current or aspiring leaders with the skills to manage complex healthcare challenges, trends and regulatory compliance.

Networking is also important, and at the C-suite level in rural hospitals, leadership team members can reach out to colleagues at comparable healthcare facilities to learn how they handle financial challenges and constraints, reporting requirements or regulatory issues. Rural hospitals often face similar challenges. Leaders at these facilities can be a beneficial resource for others navigating the increasing complexity of the rural healthcare environment.

Vendor partnerships are also essential. Rural hospitals often have difficulty attracting and retaining skilled staff at certain high-level positions in areas such as IT, revenue cycle management and finance. Vendors can provide access to critical resources, technology, expertise and cost-saving opportunities that would otherwise be difficult for small or under-resourced facilities to secure. Forward-thinking vendors can act as innovation partners, not just suppliers. Vendors can be an effective partner in helping rural hospitals adopt value-based care models, providing data analytics and quality improvement tools while offering

consulting services to optimize operations.

Vendor relationships provide a variety of benefits, including:

- ***Access to advanced technology***. Rural hospitals often struggle to afford or maintain cutting-edge medical equipment and IT systems. Vendors can provide leasing options, shared service models or cloud-based systems, such as EHRs and imaging, bringing urban-level care capabilities to rural areas without the capital investment.
- ***Cost savings through scale***. Small hospitals often lack the purchasing power of larger health systems. Vendor partnerships—primarily through group purchasing organizations—help rural hospitals negotiate better rates and reduce costs on supplies, pharmaceuticals and services. For example, partnering with a regional lab services provider can be cheaper than running an in-house lab.
- ***Help filling staffing gaps***. Rural areas face persistent healthcare workforce shortages. Vendors can provide contracted services such as telemedicine platforms, virtual specialty care, temporary physicians, revenue cycle management and billing support. These offerings can help to keep rural hospitals' services running despite staffing constraints.
- ***Improved patient access and outcomes***. Vendor relationships can expand service offerings and reduce the need for patient transfers. Teleradiology or tele-ICU partners help hospitals keep

patients local, and pharmacy vendors offer 340B program management, increasing medication access.

- ***Regulatory compliance and risk management***. Complying with billing, cybersecurity and data privacy regulations can be challenging. Vendors can offer HIPAA-compliant technology, auditing tools and staff training modules. These offerings can reduce legal risks and improve accreditation readiness.

Managing Organizational Change

The healthcare industry constantly evolves through policy reforms, new patient care standards and the adoption of technologies that today can include AI diagnostics. Change can be unsettling for both clinical and administrative staff. Leaders are essential in guiding their teams through transitions by communicating clearly, listening to concerns and fostering a shared sense of purpose centered on improving patient care.

For example, C-suite leaders can collaborate with their communication teams to develop effective strategies, such as a monthly email from the CEO that highlights current issues and stories, along with the latest services, like a new scanner. Consider sending an e-newsletter from HR leadership that promotes employee surveys and encourages staff to share their ideas and concerns through the hospital's intranet platform. Host quarterly town halls, where leaders address updates on operations, accounting, physician relations, human resources, marketing and communications, among other topics.

Workforce Among the Most Significant Challenges

High turnover, clinician burnout and difficulty recruiting qualified professionals are common, especially in under-resourced and high-stress environments. Healthcare leaders can tackle these challenges by fostering a culture of support, recognizing and rewarding contributions, and offering opportunities for professional growth and mental wellness.

Designate a human resources team member to focus on internal recognition tactics, such as a peer-to-peer recognition program, messages of gratitude, Healthcare Heroes and the Daisy Award, an international program that rewards and celebrates the extraordinary clinical skills and compassionate care provided by nurses. Focus on national recognition days, such as National Doctors' Day, Nurses Week and more. Create internal campaigns around American Heart Month (February), Breast Cancer Awareness Month (October) and Mental Health Month (May).

A productive and collaborative workforce begins with a positive culture, a supportive environment and the necessary resources to help people perform their jobs effectively. Leaders can work to provide an environment where people want to come and work by implementing these employee recognition programs and internal campaigns.

Assess the Communities Served

Additional advice to overcome challenges: perform a realistic community needs assessment to understand what your community genuinely requires. Conducting a health needs assessment for the area helps rural hospitals identify where and how to allocate their limited resources best.

It's important to recognize both what they need and what your organization can and cannot provide. If your maternal care services are lacking, consider partnering with a hospital that offers comprehensive maternal care services instead. Focus on strengths and allocate resources accordingly.

For a community needs assessment, various state associations—such as state hospital associations and state universities that offer rural health services—can be a valuable resource. The Rural Health Information Hub is also an online resource that offers step-by-step guides on how to approach a community health needs assessment.

Different communities may have younger or older populations, so it is essential to tailor services to meet those specific needs. Don't try to be everything to everyone. Stay focused on your mission and keep that goal in sight.

Ultimately, effective healthcare leaders are those who not only recognize these industry-specific challenges but also empower their teams to overcome them. By fostering resilience, embracing innovation and staying focused on internal operations and external healthcare trends, leaders can help their organizations deliver exceptional care and succeed—even in the face of adversity. ▲

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Transforming Patient Flow With Technology and Strong Operational Leadership

Cedars-Sinai Medical Center, Los Angeles, is one of the nation's largest nonprofit academic medical centers, and effective patient flow is a daily imperative. Heidi High, NE-BC, FACHE, executive director, Capacity Management, and her team in the Capacity Command Center are dedicated to ensuring every patient receives the right care, in the right place, at the right time—every single day.

Managing throughput and optimizing capacity at this scale is no easy task. Yet over the past few years Cedars-Sinai has achieved measurable improvements in discharge velocity and bed utilization, integrating advanced technology with strong operational leadership and cultural transformation.

Aligning Innovation With Communication

A cornerstone of Cedars-Sinai's patient throughput undertakings is its ability to align teams around a single, transparent source of data. "Because the data is centralized and objective, it allows us to have shared visibility and speak the same language," says High. "This common understanding enables more open and productive discussions about patient progression and operational priorities."

The process to achieve success for the health system began six years ago with the launch of structured, daily interdisciplinary bed huddles. During these brief but focused meetings, clinical and operational teams review real-time patient data, identify who is ready for discharge and collaborate on resolving barriers. A key enabler of this process is LeanTaaS' iQueue for Inpatient Flow, a capacity management platform that uses predictive AI algorithms to forecast admissions, discharges and overall bed demand.

Contrasting this approach with past practices, High says, "Years ago when there were 20 or more patients in the ED waiting for beds, a CNO would gather everyone in a conference room to discuss next steps. But the paper lists provided were already outdated. There was no consistent data source, leading to conflicting information and priorities. We'd leave those meetings with marching orders, but without alignment."

Now, empowered by shared data and predictive tools, the team can proactively manage discharges and optimize patient placement in near real time.

Enhancing Outcomes and Patient Experience

These operational and technological enhancements have led to improvements in key metrics. Cedars-Sinai has seen early reductions both in ED boarding times and in the number of patients leaving the ED without being seen—two metrics strongly correlated with clinical outcomes.

"Any time a patient is waiting unnecessarily in the ED, their risk of a poor outcome increases," says High. "We've seen progress in both of those areas."

One approach that solves patients waiting in the ED is routing them to a departure lounge. Some may assume this strategy could negatively impact the

patient experience. However, early findings suggest otherwise. In fact, preliminary reports indicate a slight improvement in satisfaction among patients who spend time in the lounge. The space offers a safe, comfortable environment for patients who have been medically cleared for discharge to wait for medications or transportation, helping to free up inpatient beds more efficiently.

Support services staff have also responded well. Key collaborators, such as pharmacy, imaging, dialysis, echo and therapy, now access the same patient discharge data as clinical teams, allowing them to better prioritize workflows and support timely discharges.

"Our focus is on improving discharge velocity," High explains. "The more stakeholders using the system and communicating through it, the faster we can move patients efficiently and safely."

Within just months of implementing LeanTaaS' platform and process enhancements, Cedars-Sinai recorded a nearly 200% increase in the average number of patients sent to the departure lounge. Over the past year, the time from discharge order to actual discharge has improved by 10%.

High reccomends focusing on four components for effective patient flow.

1. **The Role of Leadership and Culture**
   While technology has been a vital driver of change, High emphasizes that cultural transformation and leadership consistency are just as essential.

2. **Consistency and Accountability**
   To build a culture of accountability, High stresses the importance of consistent leadership communication and follow-through. "If leaders aren't aligned and consistent in their messaging and actions, staff won't know where to focus," she notes.

3. **Human-Centered Leadership**
   Technology may drive efficiency, but it's human connection that sustains engagement. High credits unit-based leadership for cultivating a positive, proactive culture. Leaders mentor staff, celebrate wins and make the work enjoyable.

   One creative example: A unit leader designed a poster with team members' photos, roles and responsibilities—styled like comic book superheroes. The playful tool helps build camaraderie around the hard work.

   Another unit created a "flow tree" poster. Each time a patient is sent to the departure lounge, a leaf is added. "When it's full, it's a beautiful tree," says High. "It's a fun, visible way to celebrate our progress."

   Even the AI model got a human touch. "We gave the algorithm a name—'Alex'—and now everyone refers to it that way. Humanizing AI helped build trust and familiarity," High explains.

4. **Peer Collaboration**
   High also underscores the importance of learning from others. "Connecting with peers through organizations like ACHE and the American Hospital Association's new Hospital Capacity Management Consortium has been incredibly valuable. Sharing ideas and problem-solving collectively helps us all tackle these complex challenges."

> Now, empowered by shared data and predictive tools, the team can proactively manage discharges and optimize patient placement in near real time.

Cedars-Sinai's success illustrates the power of aligning data, technology and people to deliver high-quality, efficient care. Through proactive planning, transparent communication and a strong operational culture, the organization is setting a standard for what modern patient flow management can achieve.

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

LeanTaaS

Paul H. Keckley, PhD

Eroding Institutional Trust Poses Risk

Why building and maintaining public trust matters.

Trust is foundational to how the U.S. healthcare system operates and the policies by which it is regulated. Trust in government entities tasked with public health directives (Centers for Disease Control and Prevention), drug approvals (U.S. Food and Drug Administration), clinical evidence recognition (National Institutes of Health) and health policies (Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services) enables policy-making around evidence-based care management, population health, patient quality and safety, and healthcare workforce satisfaction, among others.

Trust is foundational to how the U.S. healthcare system operates and the policies by which it is regulated.

Trust in America's institutions, including the health system, however, has eroded in the last two decades. The current political environment is further impacting healthcare, bringing unparalleled scrutiny to how the health system operates. For example, more attention is now given to vaccine efficacy and necessity. And alternative therapies for chronic conditions that might not have been accepted as "mainstream medicine" are now being touted as potential treatment options. How government directives are perceived and accepted or rejected by people is predicated on whom trust.

Distrust is significant and growing, according to a 2024 Gallup poll, with only 36% of U.S. adults saying they have "a great deal" or "quite a lot" of trust and confidence in the medical system—down from 51% in 2020. In addition to concerns about increasing costs, 73% of respondents say the healthcare system fails to meet their needs in some way, with 61% saying they seek healthcare only when they are sick, per a May 2025 Harris poll.

Trust in government health agencies like the CDC and FDA has fallen, with only 32% surveyed indicating that they "have confidence in them to act independently without interference," according to a May 2025 Kaiser Family Foundation poll.

Declining trust is problematic for the entire health system. Consider the importance of a trusting relationship between a physician and a patient, which increases the patient's adherence to a treatment recommendation and potential outcomes.

Particularly striking is the 69% of adults who agree that "hospitals in the U.S. are mostly focused on making money"—up 46% from 2021. Hospitals, especially large multi-hospital systems that pursue public recognition through branding and marketing activities, are considered "big business" that cater to their own financial priorities instead of the overall public good, according to the healthcare consulting firm Jarrard Inc.

These findings suggest that trust and confidence in the U.S. healthcare system is suspect, even for its doctors and hospitals who have generally enjoyed more trust than others.

Studies show the erosion in public trust is rooted in two sets of factors: 1) growing societal skepticism about the motives, performance and ethics of prominent institutions, including those in healthcare, and 2) a lack of public understanding about the health system and hospitals.

Growing societal skepticism

Fueled by social media and investigative journalism, public exposure

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to the business practices of high-profile organizations like hospitals and government health agencies is increasing. Studies show misinformation, political polarization, age and socioeconomic characteristics of certain underserved populations contribute to widening differences in levels of trust across populations and increased susceptibility to disinformation.

Restoring trust and confidence in the health system, particularly its hospitals, is vital to the health of the population.

Lack of public understanding

How the $5 trillion U.S. health system is regulated, structured and funded is relatively unknown to the vast majority of the population. Public understanding of hospital business practices is low. Pricing, clinical care management, supply chain procurement, quality controls, risk management and payer reimbursement are not widely understood.

What's "known" is based on individual, direct experiences with hospitals, physicians, insurers, pharmacies and prescriptions.

Media reporting about medical errors, executive compensation, aggressive debt collection practices, costs, inadequate price transparency and other topics lend to sensationalism in news reports and on social media. The public pays attention to these, filtering the headlines through a personal view about the trustworthiness of sources and their degree of trust in the hospital featured.

Considerations for Leaders

Restoring trust and confidence in the health system, particularly its hospitals, is vital to the health of the population. At a community level, the trust imperative must be addressed directly by hospitals, medical professionals and business leaders who influence the public response.

Many institutions do an inadequate job of gauging their trustworthiness and addressing gaps, so healthcare institutions should consider these actions:

- Systematically quantify levels of trust in key cohorts of the community and among suppliers and employees. Using standardized, peer-reviewed measures (such as the Wake Forest Physician Satisfaction Survey) that facilitate longitudinal trending and probe specific trust-building actions and attitudes is necessary.

- Appoint a board-level task force to examine trust objectively and prioritize rebuilding and maintenance.

- Provide educational resources useful to local employers, schools, faith-based groups and public health organizations that go beyond traditional marketing efforts, some of which can oversimplify operational complexity, blame others for costs, and lack outcome and price transparency data.

- Encourage state and national trade associations to prioritize both restoring trust through messaging and pursuit of the population's health over their finances and biases.

- Provide hard facts and data on business practices, pricing, profitability, user satisfaction, governance policies and other topics that provide verifiable evidence of stewardship.

- Seek coalition building for the greater good. Healthcare's future is dependent on partnerships and shared endeavors that accrue to the benefit of others. Engaging with alternative therapies, public health programs, faith-based organizations, ethicists and more is necessary to the health and well-being of households, communities and society. Hyper-protectionism lends to public distrust of the health system and its stakeholders, who play key roles not appropriately considered.

While U.S. institutions have seen an erosion of trust, overall confidence in the healthcare system remains strong—especially for doctors and hospitals. Healthcare has maintained its long-standing tradition of public trust even as others have faltered. Meanwhile, healthcare leaders would be wise to take every opportunity to promote and maintain the existing public trust in their communities. There's much work to be done. ▲

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When Silence Speaks

What great healthcare leaders hear first.

Jose R. Edwards, FACHE

In healthcare, performance is often judged by what can be measured—staffing ratios, safety scores, compliance reports and financial targets. Leaders track dashboards, resolve backlogs and report metrics with precision.

But some of the most critical organizational challenges never appear in a report. They live in subtler forms: missed feedback loops, unspoken misalignment or the quiet pause that follows a difficult question. These kinds of challenges don't trigger alarms; yet, over time, they cost more than the errors that leaders can easily quantify.

What distinguishes great healthcare leaders isn't just their ability to act—it's their ability to notice. And, more importantly, to listen when silence is trying to speak.

Clarity Gaps: The Silent Risk to High-Performing Teams

In every healthcare organization, there are what can be called clarity gaps: unspoken misalignments between strategy and behavior, policy and practice, or what is said and what is understood. These gaps form not through neglect but through the natural pressures faced in fast-paced environments.

The gaps are easy to miss, but over time, they compound. They often show up in three ways:

1. **Assumed Alignment**
   Different teams may believe they're aligned on priorities or timelines yet hold conflicting assumptions about success. Because output remains steady, these discrepancies go unexamined until progress stalls or finger-pointing begins.

2. **Operational Workarounds**
   Healthcare staff are adept at adapting. When a process becomes inefficient or unclear, they often create informal fixes to keep things moving. But when those workarounds go unreported, leaders lose visibility into system gaps and risk normalizing unsafe or unsustainable practices.

3. **Cultural Caution**
   In high-stakes environments, not everyone feels comfortable speaking up. A 2023 report from the Agency for Healthcare Research and Quality found that nearly half of healthcare workers observed a safety issue they chose not to report, often due to fear of negative consequences. Similarly, a 2022 Press Ganey study revealed that 41% of clinical staff hesitated to raise concerns because of fear of reprisal.

These aren't communication issues. They're leadership design issues. They reveal what the system teaches people about safety, permission and trust.

A Framework for Leadership: Notice. Invite. Reinforce.

Closing clarity gaps requires intentional leadership. One simple but powerful leadership approach can help executives at every level move from awareness to action: Notice. Invite. Reinforce. The following is an explanation of the framework and examples in each area.

Notice

Leadership presence is about being perceptive in addition to physicality. This means paying attention to what's not being said: who isn't speaking, what's being worked around and where silence masks hesitation.

Example:

A leader notices two teams exchanging short updates about a shared workflow during a morning safety huddle. No one raises an issue, but something about the energy signals disengagement. Instead of pushing through the agenda, the leader pauses and says, "It seems like something's off here—can we talk about it?" That moment, and the subsequent conversation, surfaces a miscommunication that had quietly been causing delays for weeks.

Invite

Even in inclusive cultures, many team members are reluctant to speak

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unless invited. A leader whose skill set includes curiosity will ask key questions. Useful questions include:

- What concerns are harder to raise in this setting?
- Where are we making assumptions?
- What seems misaligned, even if it looks successful on paper?

Example:
While rounding in a support area, a leader stops to speak with a team member waiting on a delayed handoff. Instead of asking, "Is everything okay?" they ask, "What slows you down that leadership might not see?" The team member explains that inconsistent communication between departments is creating routine delays. That insight leads to a small change in how handoff notifications are triggered, improving flow without adding complexity.

Reinforce
When someone brings forth a hard truth or questions a consensus, leadership's response is pivotal. If that moment is dismissed or ignored, others learn to withhold. But if it's recognized, followed up on and connected to outcomes, it becomes an organizational cue that candor is safe, valued and expected.

Example:
After a cross-functional meeting, a team member quietly approaches the manager to share that the new process being rolled out unintentionally bypasses a smaller team's capacity, something no one addressed in the meeting. It wasn't framed as a complaint, just an honest observation. The next day, the leader brings it to the broader team and initiates a refinement, framing it as a design improvement, not a mistake. That response sends a clear message: Thoughtful feedback won't just be heard—it will be acted on.

From Theory to Practice From the Top
Though the approach of Notice, Invite and Reinforce offers a strategic lens, its power lies in practical execution. These disciplines don't live on whiteboards; they show up in everyday interactions, meetings and decisions. To bring them to life, consider how they play out in the moments that most leaders encounter regularly.

Consider a cross-functional meeting where two departments discuss a systemwide initiative. Everyone nods in agreement, but post-meeting execution falters. One team assumed the other would lead. Deadlines slip. Frustration builds.

This scenario is not rare—it's routine. And it's rarely about competence; it's about clarity. If a leader had noticed the ambiguity, invited clarification during the meeting and reinforced shared ownership, that friction could have been avoided. These are not "soft skills": They're strategic corrections that improve throughput, reduce rework and preserve trust.

The healthcare environment is growing more complex, not less. Leaders have to navigate ambiguous expectations, cross-functional dependencies, financial pressures and evolving patient needs, all while maintaining safety, morale and quality.

In this reality, technical proficiency is expected. What differentiates high-trust leaders is their ability to cultivate visibility where others rely on control and to generate clarity where others lean on compliance.
A 2020 *Harvard Business Review* study titled "The Secrets of Great Teamwork" found that high-performing teams were not those with the most experience, but those with the most consistent trust and psychological safety. That starts at the top—and ripples outward.

For Every Leader at Every Level
The discipline of noticing is relevant to every healthcare role—not just those in the executive suite: a nurse manager who pays attention to workflow friction, a facilities leader who senses operational miscommunication and a system executive who listens past the first answer.

This practice works because it scales. Its impact increases as more leaders across the organization model it, building cultures that are alert, agile and aligned.

The greatest threats to leadership aren't found in urgent emails or broken processes. They're found in what goes unspoken: the question that didn't get asked, the idea someone hesitated to share or the concern that was silently rationalized. And while not everything needs to be said, more needs to be heard.

Because what goes unnoticed doesn't go away. It just waits—until it can't be ignored. ▲

Jose R. Edwards, FACHE, is assistant vice president of facilities at Cooper University Health Care, Camden, N.J. (Edwards-Jose@cooperhealth.edu).

Jeffrey Boord, MD

Natalie Martinez

Amy Weckman

Collecting Data on Workplace Violence

A standardized framework can include reporting, investigation, follow-up.

Workplace violence in healthcare is a persistent problem in the United States, weakening the safety and stability of the patient care environment. The Bureau of Labor Statistics reports that workers in healthcare are five times more likely to experience violence in the workplace than those in other private industry sectors.

5% INCREASE
in the number of assaults on nurses between 2022 (2.59%) and 2023 (2.71%).
Source: Press Ganey

Nurses are particularly vulnerable, with nearly half of all nurses reporting experiences of physical violence in the workplace. Two out of three ED physicians surveyed in 2022 reported verbal or physical assaults during the prior year, according to Press Ganey's "Safety in healthcare 2024." And workplace violence in healthcare is increasing. Press Ganey reported that the number of assaults on nurses grew by 5% between 2022 (2.59%) and 2023 (2.71%).

Many have pointed to the unique and extreme circumstances of the COVID-19 pandemic as the origin of this rise in violence, but the data tell a different story. Workplace violence in healthcare rose by more than 60 percent in the decade prior to the pandemic, according to the U.S. Bureau of Labor Statistics.

National regulatory agencies, such as the Occupational Safety and Health Administration, the Centers for Medicare & Medicaid Services, and The Joint Commission, are responding to this trend by developing resources and guidelines aimed at curbing the rise and prevalence of violence in healthcare. State-based agencies are also issuing requirements to health systems for prevention plans, risk assessments, training and reporting systems. Ensuring that these violence prevention programs and resources are effective and sustainable will require a broad, coordinated effort, as well as evidence-based standards for data collection of workplace violence incidents.

Standardized data frameworks and comprehensive data collection systems have helped improve patient safety for decades, across a wide range of outcomes. Yet the current state of measuring incidents and rates of workplace violence in healthcare is fragmented. What's required to truly understand and mitigate the risks of workplace violence is the adoption and implementation of standardized data reporting taxonomies, definitions and formats.

To help address this need, the Institute for Healthcare Improvement developed the Framework for Standardized Data Collection of Workplace Violence Incidents in Health Care, a standardized framework to allow for accurate classification, aggregation and analysis of violent incidents in healthcare. This approach enables organizations to learn from their data and use those insights to inform both specific process improvements and overall governance of violence prevention programs.

Standardized Data Collection Framework

To develop the framework, IHI combed the existing literature and conducted interviews with more than 30 industry experts from 19 organizations. This research was further refined by a workplace violence-focused expert panel, convened by the IHI Leadership Alliance, who provided strategic guidance and

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content expertise in developing the framework. Additional targeted interviews and expert reviews were conducted to gather, analyze and prioritize key data elements.

The framework includes three phases: reporting, investigation and follow-up. The recommendations are meant to provide a variety of key details while making data collection simple enough to encourage and facilitate immediate and accurate reporting of incidents.

1. **Reporting**
   This phase prompts the collection of basic facts of the incident to help inform immediate action. Data collected in this initial phase includes the date, time, location, type of visit and a brief description of the event. Additional critical elements to capture promptly after an incident include the type and severity of the workplace violence incident; if injuries were involved; and key details about the victim, aggressor and reporter.

2. **Investigation**
   This phase builds on the initial data collected in the reporting phase and dives into the specifics of the incident and who was involved. Data collected here helps to understand when, where and why the incident occurred to help better predict and prevent future events and inform workplace violence prevention strategies. Data includes detailed information on what occurred, who was involved, possible contributing factors, what resulted from the incident and what actions were taken in response.

3. **Follow-Up**
   The final phase centers on actions in response to the incident, ensuring that the victim, aggressor and front-line teams receive adequate support and resources. Data collected includes the types of physical and emotional support provided to all parties involved. If the aggressor was a patient, data should include what

types of action were taken to mitigate future events, such as adding alerts to the EHR or adjusting a clinical care plan. Data is also collected on organizational processes and responses, such as conducting a root cause analysis or providing staff education or training. Insights from this phase help assess the effectiveness of current processes, ensure support for those involved and inform future workplace violence strategies.

The effectiveness of this data-collection framework rests on establishing a common language that has clear and consistent definitions for workplace violence incidents and their details. The broader the adoption of this common language, the more improvement can be achieved.

The data itself can be used to conduct analyses and risk assessments, inform prevention programs, and generate shared learning across facilities, systems and the entire healthcare industry. Clear and compelling displays of the data, aggregated over time, help organizations identify actionable insights and assess the effectiveness of their efforts. The framework can support leaders by ensuring that their organizations comply with regulatory requirements, and by advancing research and innovation focused on reducing workplace violence across the healthcare industry.

Workplace violence incidents present a serious challenge to healthcare leaders who are responsible for preserving and improving the safety of their workforce. The standardized data collection framework is an invaluable tool that leaders can use to make real, measurable progress in improving worker safety and well-being, while helping to protect the organization's most valuable resource—its people.

To learn more, visit ihi.org/workplaceviolencedata. ▲

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You're the CEO—Now What?

5 steps that will serve you well.

Tauana McDonald, FACHE

Whether you're a newly appointed CEO or a seasoned executive, you likely feel the weight of your decisions, knowing that much is resting on your shoulders—patients, colleagues and communities count on you to lead with wisdom, integrity and heart. It's a responsibility many of us embrace every day.

Your role is to listen and seek creative, collaborative solutions.

Career goals evolve. They can be set, adjusted and reshaped repeatedly throughout a career. Yet for many of us, the core motivation remains the same: a deep-seated desire to add value, grow and learn with every opportunity. These aspirations—combined with experience, relationships, knowledge and leadership—pave the way to C-suite readiness.

Whether you are new to your role, striving to become a CEO or already have years of experience, these five steps will serve you well.

1. **Listen and Learn From Stakeholders**
   As tempting as it is to hit the ground running as a new CEO and make immediate changes, the following actions are important before undertaking any major adjustments.

   Start with your team. Listen to your team members to ensure they have everything they need to perform to their highest potential. Spend time with leaders, hear their perspectives, and understand what tools and resources will increase their efficiency and effectiveness.

   Whether it's a particular shift on the hospital floor with staffing issues, a technology upgrade that could enhance care, or a new regulation that must be implemented—your role is to listen and seek creative, collaborative solutions.

   Remember you were chosen for your strengths. However, it's just as important to recognize where you're still growing. For example, Mount Carmel Health System has a nursing college and a health plan, which were areas outside of my direct experience. I was fortunate to have great, strong leaders in those areas. That may not always be the case. I've learned that potential leaders exist throughout the organization. They may not be obvious at first glance; some may be hesitant to lead. But by nurturing skills, building confidence and creating space for every voice, I've discovered and elevated talent I might have otherwise missed.

   The CEO role naturally shifts internal and external relationships. A former peer may now report to you. A board member may now be your peer. Navigating these changes with humility and emotional intelligence is essential. Never assume you know everything—even in familiar territory.

   Great leaders keep an open mind and value the perspectives of others.

   Extend that mindset beyond your leadership circle. Conduct a "listening tour," a series of meetings and gatherings with internal and external stakeholders. These conversations will give you insights into experiences, needs and aspirations across the organization. This process was invaluable for me in shaping a holistic

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Organizational psychologist, Wharton's top-rated professor and five-time #1 *New York Times* bestselling author, Adam Grant will set the stage for ACHE's 2026 Congress on Healthcare Leadership as the Opening Session Keynote. Don't miss this thought-provoking talk as Adam explores how we can find motivation and meaning, challenge assumptions and lead more generous, creative lives. Prepare to be inspired by one of the world's 10 most influential management thinkers and a *Fortune* 40 Under 40 awardee!

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understanding of what patients, colleagues, physicians and community leaders wanted and expected from Mount Carmel.

2. **Create and Share a Positive, Future-Focused Vision**
A shared vision begins with understanding how each entity within the organization fits together to serve the patients and the community. As leaders, it's our job to communicate that vision, earn buy-in and remove roadblocks to achieve it.

In April, Mount Carmel opened our newest hospital and medical campus in Dublin to serve patients in the northwest region of Central Ohio. The 35-acre campus offers a full-service 24-hour emergency department, primary and specialty care, surgical services, and outpatient lab and radiology services. Our team continues to listen to the voice of the community as we deliver health and well-being programs to keep people well.

Ultimately, our mission brings us back to patients and caregivers. Serving people at their most vulnerable is a sacred calling. That responsibility drives us. It also inspires us to keep improving care and cultivating a supportive environment for our colleagues.

We strive to be a "transforming, healing presence." Our mission lives in every project and every decision.

3. **Empower Yourself and Others to Execute the Vision**
Execution and excellence means turning vision into action—and results. It demands clear planning, communication and leadership.

Leaders must provide clarity around vision, strategy, goals and timelines. But it's equally important to empower others. Allow your team to break down big strategies into achievable milestones. Build in accountability—but also trust and flexibility.

Proactively identifying obstacles, engaging stakeholders, and removing roadblocks early will smooth the path to success. High-performing teams thrive when they understand the "why," have ownership of the "how" and feel supported throughout the journey.

4. **Have Confidence in Your Experience, Skills and Abilities**
Many system CEOs, myself included, move from hospital leadership to system leadership. It's an exciting promotion—and a challenging one.

Guiding Your Leadership

1. Listen and Learn
Before making big changes, take time to listen. Start with your team. Learn what they need to do their best work. Build trust and stay curious.

2. Lead With Vision
Your job is to shape and share a positive, forward-looking vision. At Mount Carmel, the new medical campus reflects the organization's commitment to delivering accessible, community-centered care.

3. Empower Your Team
Execution turns vision into results. Provide clarity around strategy and goals but also give your team the autonomy to act. Break goals into manageable milestones and anticipate roadblocks.

4. Trust Your Experience
Stepping into the CEO role—often from hospital leadership—can be daunting. But everything you've done has prepared you. Even early-career roles, especially outside the traditional healthcare setting, shape the leader you've become. Own your experience. You've earned this.

5. Prioritize Yourself
Leadership is demanding. To be your best, you need to recharge. Delegate. Say no when needed. Block time for rest—and protect it. Even a short break can restore your energy and clarity.

That's why it's vital to have confidence in your leadership. Trust in the knowledge and experience you've accumulated throughout your career. More than likely, you've been preparing for this moment in ways you didn't even realize.

Don't discount earlier career experiences, even those outside the healthcare setting. Those lessons can be surprisingly applicable in a larger leadership context. Every step of the journey contributes to who you are as a leader.

5. **Find Time for Yourself**
Finding personal time is one of the greatest challenges for a CEO. The work is hard, the responsibilities immense, and the stakes are high.

But to lead well, you must protect your own well-being.

There's no single formula for self-care, but a few strategies can help:

- Delegate effectively. Empower others so you don't carry everything alone.
- Say no to nonessential obligations. Focus your energy where it matters most.
- Plan for rest. Schedule downtime and protect it with boundaries.
- Take mini breaks. Even an hour during the day to reset can work wonders.

You carry a lot—but you don't have to do it all alone. Taking care of yourself ensures you have the clarity, energy and resilience to lead others with excellence.

Let these five steps guide your journey and remind you: You were chosen for this role for a reason.

Lean into the challenge, trust your leadership and stay connected to your purpose. ▲

Tauana McDonald, FACHE, is president and CEO, Mount Carmel Health System, Columbus, Ohio (Tauana.McDonald@mchs.com).

Harpreet Pall, MD, CPE

Laura Geron, DNP, RN

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Creating a Path for Clinical Leadership

Transitioning into leadership roles offers insights that enhance healthcare delivery.

In today's complex and rapidly evolving healthcare ecosystem, the need for strong collaboration between clinical and administrative leadership is critical for achieving financial stability and competitive advantage. Without alignment, conflicting goals between these groups can hinder operational performance, drive up costs through duplicated efforts and create communication gaps that weaken strategic execution.

In recent years, more physicians, nurses and clinicians have pursued MBA degrees to acquire managerial and organizational leadership skills. Even with this advanced academic preparation, many clinicians still face challenges in transitioning to administrative leadership roles.

Clinical leaders transitioning into leadership roles offer essential insights that enhance healthcare delivery. By addressing skill gaps, facilitating cultural integration and removing systemic barriers, healthcare organizations can create a pathway and environment where clinician leaders thrive and drive meaningful transformation.

Why Clinical Leadership?

The separation between clinical and administrative leadership stems from differing priorities and traditional reimbursement structures. The rise of value-based care models and integrated delivery systems have amplified the need for leaders who can seamlessly navigate both clinical and administrative domains. Experienced clinicians with leadership foresight bring unique value by bridging the gap between executive leadership and front-line patient care with clinical credibility and strategic insight, providing a well-rounded perspective that prioritizes health outcomes while ensuring financial sustainability.

Experienced clinicians with leadership foresight bring unique value by bridging the gap between executive leadership and front-line patient care with clinical credibility and strategic insight.

Additionally, for the past 22 years, Gallup polls have rated physicians and nurses as the most trusted professionals, due to their compassionate care, medical expertise, ethical standards and ability to build strong personal relationships with patients. Studies have shown that healthcare organizations led by executives with clinical backgrounds achieve better patient satisfaction, improved quality outcomes and greater cost efficiency due to their deep understanding of care delivery and stronger alignment with front-line staff. By integrating clinical perspectives into executive roles, organizations can create more holistic and innovative strategies necessary to balance patient care with organizational strategic vision.

ACHE's Impact on Supporting Physician Leadership

The American College of Healthcare Executives supports a strong interprofessional relationship between healthcare executives and clinicians, offering educational programs and publishing books and journals on the topic such as *Healthcare Executive.*

As more and more clinicians actively seek administrative leadership roles, ACHE created the Physician Executives Community—a LinkedIn group exclusive to

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physicians in leadership roles or seeking leadership positions. ACHE chapters across the country have also started establishing clinical leadership committees.

ACHE–New Jersey, for example, pioneered its Clinical Leadership Committee in 2023. Since its inception, the committee has experienced steady growth, with projections indicating continued expansion. It serves as a vital forum for clinicians to share leadership aspirations, challenges and successful transitions. Insights from the committee are now incorporated into ACHE-NJ's annual strategic planning. This model is a call to action for other chapters to engage clinicians interested in leadership.

The Transformative Potential of Clinical Experience

Clinical leaders bring unique strengths to administrative leadership roles. Their first-hand experience with patient care equips them with the empathy and insight needed to align organizational strategies with front-line realities. This perspective can be invaluable in:

- ***Quality improvement initiatives***: Clinicians can identify inefficiencies in care delivery and propose evidence-based solutions.
- ***Policy development***: Clinicians' understanding of the practical implications of policies ensures they are realistic and effective.
- ***Staff engagement***: Clinicians' ability to relate to their front-line peers fosters trust and improves communication, which is essential for driving organizational change.

Navigating Experiential and Knowledge Gaps

Transitioning from clinical practice to administrative leadership often reveals a lack of experience and knowledge in specific domains. Addressing gaps in financial acumen, strategic planning and systems thinking is critical. Clinical leaders should position themselves for success by:

- Taking on operational responsibilities in their current roles.
- Leading interdisciplinary projects to showcase strategic thinking.
- Joining relevant professional organizations such as ACHE.
- Pursuing formal education or certifications in healthcare administration. This is a pre-requisite but not sufficient by itself.

Actionable Strategies for a Seamless Transition

To create a successful pathway for clinicians into administrative leadership, healthcare organizations can consider the following five steps:

1. ***Invest in leadership development***: Provide training programs focused on essential administrative skills such as finance, operations and strategic planning. Partnering with academic institutions or professional organizations can enhance these efforts.
2. ***Foster mentorship***: Pair aspiring clinical leaders with experienced administrative mentors to provide guidance and support during the transition.
3. ***Encourage cross-disciplinary collaboration***: Create opportunities for clinicians and administrators to work together on projects, fostering mutual understanding and trust.
4. ***Promote a unified culture***: Emphasize shared goals and values, such as improving patient outcomes and operational efficiency to bridge cultural divides.
5. ***Leverage data and technology***: Equip clinical leaders with tools to analyze data and make informed decisions. Familiarity with healthcare analytics can enhance their ability to drive organizational success.

In today's healthcare landscape of rapid change and focus on value, integrating clinical leaders into administrative roles is not optional—it is essential. Breaking down silos and empowering clinicians with the right skills and support can unlock innovation and improve care.

Now is the time to invest in and empower clinical leaders to shape the future of healthcare. ▲

Harpreet Pall, MD, CPE, is CMO, Hackensack Meridian (N.J.) Jersey Shore University Medical Center and K. Hovnanian Children's Hospital, and academic chair and professor, Department of Pediatrics, Hackensack Meridian School of Medicine, Neptune City. Laura Geron, DNP, RN, is nurse researcher and innovator, Atlantic Health System, Morristown, N.J. Sophia Brown, PhD, RN, FACHE, is associate director, Memorial Sloan Kettering Cancer Center, New York.

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PEOPLE

ACHE Board Appoints Bly Interim District 6 Governor

ACHE's Board of Governors recently appointed a new member per the ACHE Bylaws. CDR Richard J. Bly, FACHE, U.S. Navy Medicine Readiness and Training Unit, Sasebo, Japan, will serve as interim Governor from July 1, 2025, until the Council of Regents meeting Feb. 28, 2026. The ACHE Bylaws state that the Council of Regents will elect a Governor to fulfill the remainder of the Governor term from Feb. 28, 2026, to March 20, 2027.

Bly most recently served as Regent for the U.S. Navy since 2023. An interim Navy Regent will be appointed to fulfill the remainder of his three-year term.

Bly fills the District 6 Governor vacancy due to the recent retirement of Alfred A. Montoya Jr., FACHE, from Veterans Affairs. The Board of Governors is tremendously grateful for Montoya's service.

Prior to his current role, CDR Bly served the Department of Defense at the Office of the Chief of Naval Operations and the Office of the Joint Staff Surgeon at The Pentagon in Washington, D.C., from 2021 to 2025. He also served as deputy fleet surgeon and fleet medical planner for the U.S. Seventh Fleet from 2017 to 2020, surgical company commander, 1st Medical Battalion, from 2015 to 2017, and officer in charge of medical logistics in Southern Afghanistan from 2012 to 2013. CDR Bly also serves as an adjunct professor at the Uniformed Services University of the Health Sciences.

CDR Bly has held several leadership positions, including serving as chair of the speaker committee for the Lewis E. Angelo Professional Symposium in 2022 and co-founding the ACHE Navy Fellow Accelerator Program in 2020. He also served as the ACHE Regent for Navy from 2023 to 2025 and on various ACHE committees.

CDR Bly received the Service Award through ACHE's Recognition Program in 2025. He was the Office of the Chairman of the Joint Chiefs of Staff Action Officer of the Year in 2023.

CDR Bly earned Master of Health Administration and Master of Business Administration degrees from Baylor University. He also earned a Master of Arts degree from the U.S. Naval War College, a graduate diploma from Expeditionary Warfare School at the U.S. Marine Corps University and a Bachelor of Science degree from The George Washington University.

AHA Recognizes One Fellow and One Member-Led Organization During Leadership Summit

Two organizations led by members of ACHE were among those recognized during the American Hospital Association's July 2025 Leadership Summit in Nashville, Tenn. Recipients were recognized with the following prize and award:

AHA Quest for Quality Prize

AHA honored an exemplary health system led by an ACHE member for its dedication and commitment to quality. Hartford HealthCare in Hartford, Conn., led by president/CEO **Jeffrey A. Flaks**, is the 2025 recipient of the AHA Quest for Quality Prize. The award is presented annually to recognize exceptional healthcare leadership and innovation in improving quality and advancing health in America's communities.

AHA Dick Davidson NOVA Award

AHA also honored a health system led by an ACHE member for its hospital-led collaborative efforts to improve community health. MedStar Health, in Columbia, Md., led by president/CEO **Kenneth A. Samet, FACHE,** is one of the winners of the 2025 AHA Dick Davidson NOVA Award. The award recognizes hospitals and health systems for their collaborative efforts toward improving community health status, whether through healthcare, economic or social initiatives. Honorees participate in joint efforts among healthcare systems or hospitals, or among hospitals and other community leaders and organizations.

LEADERS IN ACTION

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

Michele K. Sutton, FACHE
Chair
California Association of Healthcare Leaders
CAHL Annual Meeting & Awards
Aug. 21

American College of Healthcare Executives of Kansas
ACHE of Kansas Fall Learning Session: The Patient Experience
Sept. 3

ACHE of Nebraska and Western Iowa
Inside ACHE: A Strategic Update from National Leadership
Sept. 10

ACHE STAFF NEWS

Following are new hire announcements:

Candice Holden welcomed as director, Business Development and Organizational Sales, Learning.

Annika Rae welcomed as publications production specialist, Learning.

In Memoriam

ACHE regretfully reports the deaths of the following ACHE members:

James D. Drury, LFACHE
Evanston, Ill.

Nicholas N. Manning, FACHE
Caldwell, Idaho

Addressing Medical Technician Shortages in Hospitals

Results by ACHE's Executive Office, Research

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

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

The primary reasons for the shortage of medical technicians are: 78% cited insufficient graduates, 69% mentioned competition from other hospitals and 44% noted the undesirability of the hospital's location. Additional factors include competition from agencies (39%), nonhospital providers (30%) and nonhealthcare employers (8%), staff retirement/leaving (29%), burnout (18%), and other reasons (4%).

Hospital CEOs address the shortage of medical technologists through various strategies: 86% focus on staff recruitment, 76% on staff retention and 71% on using contract agency staff who are travelers. Additional approaches include using per diem contract staff (29%), altering care models (22%) and reducing services (8%).

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

Table 1. Reason for staff shortage of medical technicians.

Reason for shortage	Percentages or numbers of CEOs citing reason for shortage
Insufficient number of staff graduating from schools	78%
Competition from other hospitals	69%
Hospital location makes it hard to attract staff	44%
Competition from agencies	39%
Competition from other non-hospital providers	30%
Staff retirement/leaving	29%
Staff burnout	18%
Competition from non-healthcare employers	8%
Other	4%

Table 2. Strategies to address the shortage of medical technologists

Strategies to address shortage of medical technologists	Percentages or numbers indicated by CEOs
Focusing on staff recruitment	86%
Focusing on staff retention	76%
Filling in with contract (agency) staff who are travelers	71%
Filling in with contract (agency) staff who work on a per diem basis	29%
Altering care models to reduce need for the position	22%
Reducing services that require this position	8%
Other	13%

Thank You to Our Premier Corporate Partners

ACHE is fortunate to have some of the field's leading companies share in our mission of advancing healthcare leadership excellence. Our Premier Corporate Partners play an important role in strengthening the healthcare leadership profession and in building healthy communities.

By partnering with us, these companies demonstrate a real commitment to career development and lifelong learning. Please join me in expressing thanks to our Premier Corporate Partners for all they do in support of our mission.

Deborah J. Bowen, FACHE, CAE
President/CEO
American College of Healthcare Executives

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

Zachary J. Almer, FACHE, received the Early Careerist Award from the Regent for New York—Metropolitan New York.

Kailani Amine received the Early Careerist Award from the Regent for Hawaii/Pacific.

Victoria Baez received the Student Award from the Regent for Connecticut.

Kate Cartwright received the DEI Award from the Regent for New Mexico & Southwest Texas.

Kristen L. Croom, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Hawaii/Pacific.

Amy DeAngelo received the Early Careerist Award from the Regent for New York—Northern and Western.

Michael J. Gatto received the Senior-Level Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Tristan Diane Greer received the Early Careerist Award from the Regent for New York—Northern and Western.

Lauren Hayden, FACHE, received the Regent's Award for Excellence from the Regent for Kentucky.

Halim Kaygisiz received the Early Careerist Award from the Regent for New York—Metropolitan New York.

Jeanine Loewen received the Early Careerist Award from the Regent for New Mexico & Southwest Texas.

Kevin B. Mahoney received the Healthcare Leadership Excellence Award from the Regent for Pennsylvania—Southeast & Southern New Jersey.

Andrew McCart, PhD, FACHE, received the Regent's Award for Excellence from the Regent for Kentucky.

Hary Moisidis received the Senior-Level Healthcare Executive Award from the Regent for New York—Northern and Western.

Joe Moscola received the Senior-Level Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Alexandria Ofer, FACHE, received the Early Careerist Award from the Regent for Connecticut.

Beth Oliver received the Senior-Level Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Susan A. Sales, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Ezela Tagliente received the Early Careerist Award from the Regent for New York—Northern and Western.

James Tompkins, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Delaware.

Donna M. Walsh, PharmD, FACHE, received the Early Careerist Award from the Regent for Pennsylvania—Southeast & Southern New Jersey.

Allison P. Wilson-Maher, FACHE, received the Senior-Level Healthcare Executive Award from the Regent for Pennsylvania—Southeast & Southern New Jersey.

Maurice T. Winkfield Sr. received the Early Careerist Award from the Regent for Delaware.

Leslie A. Zucker, LFACHE, received the Senior-Level Healthcare Executive Award from the Regent for Connecticut.

$1 MILLION Campaign for Healthcare Leaders of Tomorrow

WE DID IT

We would like to extend our deepest gratitude to the individuals and organizations who generously contributed a Major Gift during our $1M Campaign for Healthcare Leaders of Tomorrow, which concluded in March 2025.

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	Jennifer Alderfer, FACHE, CPPS, and Troy Alderfer
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	John Botsko Jr., FACHE (BrightStar Care – Naples, FL)
	Deborah J. Bowen, FACHE, CAE, and R. Norris Orms, FACHE(R), CAE
	John J. Buckley Jr., FACHE, and Sarah Buckley
	Noel J. Cardenas, FACHE, and Cristi R. Cardenas
	Cochran Foundation (Kenneth J. Cochran, DSc, FACHE)
	Delvecchio S. Finley, FACHE, and Kelly Finley
	Kaiser Permanente Northern California (Carrie Owen Plietz, FACHE)
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	Thomas M. Priselac
	MG(Ret) David Rubenstein, FACHE, and Pat Rubenstein
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Jim Allard, DNP, RN, FACHE, to vice president/CNO, Advocate Christ Medical Center, Oak Lawn, Ill., from vice president/CNO, Medical City Arlington (Texas) Hospital.

Reba Celsor, FACHE, to CEO, Murray-Calloway County (Ky.) Hospital Board of Trustees, from CEO, Spring View Hospital, Lebanon, Ky.

Kendra Crawford, FACHE, to CNO, Providence Santa Rosa (Calif.) Memorial Hospital, from associate CNO, Brigham and Women's Hospital, Boston.

Laurie Shanderson Evans, PhD, FACHE, to president/CEO, The Knoxville (Tenn.) Area Urban League. Shanderson Evans is founder/CEO, Accreditation Insights, Nashville, Tenn.

Sherie C. Hickman, LFACHE, to retirement from CEO, Sutter Delta Medical Center, Antioch, Calif. We thank Ms. Hickman for her many years of service to the healthcare field.

Robert Mach, FACHE, ARRT, to CEO, Schoolcraft Memorial Hospital, Manistique, Mich., from CEO, Arbor Health, Morton, Wash.

Wes Marsh, FACHE, to executive in residence, College of Public Health & Health Professions, University of Florida, Gainesville, Fla., from administrator, Department of Neurosurgery, University of Florida Health Jacksonville (Fla.).

David J. Masterson, FACHE, to president, Sentara Halifax Regional Hospital, South Boston, Va., from president, Sentara Obici Hospital and Sentara BellHarbour, Suffolk, Va.

Hilary Nierenberg, RN, ANP, FACHE, to senior vice president, Heart and Vascular Service Line, RWJBarnabas Health, West Orange, N.J., from director, Cardiovascular Care Transformation, Hackensack Meridian Health, Paramus, N.J.

Bob Sarkar, FACHE, to interim market vice president, Population Health and Physician Alignment, CommonSpirit Health, Chicago. He will continue as president/CEO, Arkansas Health Network, Little Rock, Ark.

David Smith to administrator, Mercy Hospital Pittsburg (Kan.), from CEO, Hammond Henry Hospital, Geneseo, Ill.

Russ Smith, FACHE, to COO, University of Toledo (Ohio) Medical Center, from senior hospital administrator.

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

Darin Szilagyi, FACHE, to senior vice president of communications, Oceans Healthcare, Plano, Texas, from senior vice president, marketing and communications, Platinum Dermatology Partners, Dallas.

Allison Viramontes, CPA, FACHE, to vice president/CFO, Jupiter (Fla.) Medical Center, from CFO, Mayo Clinic in Arizona.

Tanner White, FACHE, to CEO, Altru Hospital, Devils Lake, N.D., from vice president, Network Operations, Avera Health, Aberdeen, S.D.

GRIEF OR GRATITUDE?

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

LEIGH ANNE | cancer survivor

Leigh Anne received travel reimbursement for this campaign.

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

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

In a large study, those who were not up to date on screening were **nearly 3X** more likely to die from CRC than patients who were.[5]

See how Exact Sciences can help your health system **maximize CRC screenings**

CRC=colorectal cancer.

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

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