On August 4, 2017, members of the HLNDV Board of Directors gathered in Plymouth Meeting, PA to welcome a few new board members, review our previous year, and plan our strategy for the upcoming calendar year. Each committee presented highlights and the group discussed opportunities to enhance value for our members.

Some highlights included:

- ACHE fall conference in the region
- Partnering with healthcare groups in the area for programs and education on topics in diversity and inclusion
- Enhancing student mentorships program
- Collaborating with our sponsors for enhanced by networking
- Events and education calendar review
- Many fall programs are lined up starting with our Annual meeting in September and our Lee White event
- Ways to enhance communication by considering an electronic newsletter format for our members
- Social media expansion with Instagram added on to our portfolio of Facebook, LinkedIn, Flicker and Twitter
- Engage veterans and military personnel by creating programming specific to our former and active duty members

With today’s emphasis on population health and the demand by a new generation for technology, healthcare leaders are looking at innovative avenues to reach patients and engage healthcare workers to improve the healthcare consumer experience, increase patient loyalty, and optimize clinical outcomes. Hear from these local healthcare and technology leaders in our featured panel discussion focusing on the concept of Gaming.

Friday, September 22, 2017
7:30am-10:30am
VIRTUA, Barry D. Brown Health Education Center, 106 Carnie Blvd., Voorhees, NJ 08043
$45 Member/$55 Non-member/$35 Full-time Students/$25 In Transition

1.5 Category I Credits will be offered
Dear Healthcare Leaders,

I hope that each of you has enjoyed this summer and that the transition into your new fall routine will be a positive one. I am personally looking forward to the changes that the new season brings, as well as the chance to connect with many of you at our upcoming events.

Last month, the HLNDV Board of Directors conducted our annual planning meeting to focus on innovative strategies to support our mission. Many thanks are due to each member for their time and excellent ideas. We’ll be moving forward with a number of new strategies, including an expanded mentoring program for students and targeted efforts to connect with veterans and active duty military personnel.

As indicated in our bylaws, we also recently appointed four dedicated individuals to the HLNDV Board: Joe Crandall, CLSSBB (Director-At-Large, Special Projects), Ellen Nassberg, FACHE (Director Emeritus), Brian Sweeney, RN, MBA, FACHE (Director Emeritus), and Christine Winn, FACHE (Director Emeritus). Each will serve a unique role to help support HLNDV operations. In addition, I am also pleased to welcome our new ACHE Regent for Delaware to the Board:

Michael Eppehimer, MHSA, FACHE.

We have many excellent events that will occur this fall. Our HLNDV Annual Meeting will be hosted by Virtua the morning of September 22. The event will offer 1.5 ACHE Face-to-Face credits on the topic of “Gamification,” a novel way of utilizing technology to improve outcomes by increasing patient and staff engagement. On October 18, early careerists and students can join us for a mock interview session. And, November 7 marks the 10th Anniversary of our Lee White Institute at Main Line Health, where we will highlight Innovation in Healthcare Policy. Please visit www.hlndv.org to register for these events.

Finally, in light of the challenges that so many people are currently facing, please step up and lead by volunteering, donating to a cause, or getting involved with a service activity. HLNDV offers many great community service activities throughout the year, and, the option to join a committee. Please see our Events page on the website for service opportunities, or, contact our Volunteer Coordinator if you would like to get involved with one of our committees.

Please feel free to reach out to me at any time. Thank you and have a great fall season!

Chris Fraser, MBA, FACHE, President, HLNDV

**JUNE 21, 2017: GENERATIONAL DIVERSITY, A PANEL DISCUSSION**

On June 21st, 2017, CHOPS’s Young Professional Network, NAHSE’s Delaware Valley Chapter and HLNDV hosted *A Panel Discussion on Generational Diversity*.

The panel was moderated by Children’s Hospital of Philadelphia’s Clinical Lab Section Manager Adam Bidegary with multi-generational leadership from four more tristate representatives, including:

- **Joseph Hill**, Chief Diversity & Inclusion Officer, Jefferson Health System
- **Rob Croner**, SVP of Human Resources, Children’s Hospital of Philadelphia
- **Dana Beckton**, Director of Diversity & Inclusion, Christiana Care Health System
- **Rebecca Fogerty**, Manager of Diversity & Inclusion, Children’s Hospital of Philadelphia

This discussion highlighted the importance of recognizing and managing generational diversity in today’s workforce as it relates to workforce planning and development and utilization of generational strengths to meet organizational goals and objectives. They discussed the importance of healthcare leaders recognizing generational differences as each generation brings a different set of perceptions and expectations to the organization, some arising from those generations’ economic, political and social events.

Generations can sometimes fall under defined characteristics related to challenges, perceptions and communications, however, it is imperative for leaders to also recognize the overlap in characteristics to work effectively with generations. A proactive approach that involves understanding differences and adapting management styles in recognition of generational strengths enhances collaboration between healthcare leaders and team members and further aligns an organization’s culture with its own vision and mission in providing exceptional healthcare.

This insightful discussion left colleagues with a better awareness of generational diversity and what it means for today’s workforce. In a dynamic healthcare environment, leaders need to recognize generational differences and engage their teams in a dialogue to further understand individual strengths. In this manner, relationships and organizational culture can be enhanced.
THE ULTIMATE GIFT OF LIFE: ORGAN DONORS SAVE LIVES

By Howard M. Nathan
President and CEO
Gift of Life Donor Program

Currently in the United States, more than 117,000 people are waiting for a life-saving organ transplant. And on average, 20 people die waiting for an organ every day. Registering as an organ and tissue donor is a heroic and selfless decision; it saves and transforms lives, impacting not only the individual in need of a transplant, but their loved ones as well.

Just one organ donor can save up to eight lives, one tissue donor can benefit as many as 75 others. One person can donate their kidneys, pancreas, liver, lungs, heart, and intestines. Tissue donation includes bone donations to repair fractures and prevent amputations, skin donations to heal burn patients, and heart valve donations to repair life-threatening defects. Donors can also donate their corneas, which can give the gift of sight to two recipients. All major religions support organ donation as one of the highest expressions of compassion and generosity.

Typically, organ donors are hospital patients who have been declared dead after they have suffered complete and irreversible loss of all brain function. Mechanical ventilation and medications are utilized to continue blood flow to the organs, so they can be transplanted. In the United States, less than two percent of all deaths occur in a way that allow organ donation to be possible. That is why it is critical that everyone who can register does, regardless of age or health. At the time of death, medical tests are conducted to determine suitability for transplant.

Living Donors

Although most organ donations take place after a donor has died, some organs can be donated from living donors. With the transplant waiting list increasing, living organ donation is another way to save lives. Living donors may be able to donate a kidney, a segment of their liver, a lobe of their lung, and portions of their intestine and pancreas.

Hospitals and transplant centers in this region work in partnership with Gift of Life Donor Program, the non-profit, federally-designated organ procurement organization (OPO) which serves 11 million people across the eastern half of Pennsylvania, southern New Jersey and Delaware. Gift of Life is one of the largest organ donation programs in the world. It is a part of the national network, UNOS, the United Network for Organ Sharing. Since 1974, Gift of Life has coordinated more than 44,000 organs for transplantation and more than 750,000 life-enhancing tissue transplants.

A Second Chance at Life

“Since our inception, Gift of Life has advocated for donor families, transplant recipients and the thousands of people on the transplant waiting list,” said Gift of Life President & CEO Howard M. Nathan. “We are extremely grateful for the exceptional talent and commitment of our hospital partners – the 15 transplant centers and 131 acute care hospitals in the region – and our incredibly skilled and dedicated staff who work 24/7. They truly give people a second chance at life.”

Gift of Life’s devotion to the transplant community includes a “home away from home” for transplant patients and their families. The Family House provides affordable lodging and supportive services to those who travel to Philadelphia for transplant-related care. Since its founding in July 2011, the Family House has provided more than 42,500 lodging nights and served 161,668 meals.

Gift of Life Donor Program is recognized internationally for its leadership and scholarship in the field of organ and tissue donation. The Gift of Life Institute, an affiliate of Gift of Life, is the international leader in organ and tissue donation education, training close to 9,000 professionals from 37 countries since 2004.

Post-Transplant Parenthood

Gift of Life Institute’s Transplant Pregnancy Registry International (TPR) studies post-transplant parenthood and the effects of medications on fertility and pregnancy. Since 1991, TPR has tracked more than 4,000 post-transplant pregnancies, sharing information with countless transplant recipients making family planning decisions.

With ongoing advancement in transplantation, the overall need for organ donation grows, as does the need for more registrants. Currently, in Gift of Life’s region, there are more than 5,400 men, women, and children awaiting life-saving transplants. The organization encourages everyone to discuss organ donation with loved ones to make their personal preferences known.

For more information on organ donation or to register, go to www.donors1.org. It only takes 30 seconds to register.
Imagine going to your doctor for a sick visit. You report that you have a fever and sore throat. Instead of receiving a physical examination or a test for strep throat, your doctor asks you to fill out a subjective questionnaire and bases your diagnosis solely on the results from this form. Chances are, you would be confused and wonder how accurate this diagnosis could be. If this scenario is perplexing, why are we okay with the same procedure for our diagnostic model of mental health?

Physical healthcare takes priority over mental healthcare in nearly every situation. Mental health can be just as tangible as physical health, since many mental illnesses often present somatic symptoms, yet physical health continues to be more important. This disparity arises in many different forms, from the negative stigma surrounding mental health disorders to inadequate health coverage for mental health treatments. Until this discrepancy is resolved and patient healthcare is not divided into “physical” and “mental,” millions of people will continue to face barriers to accessing mental health services.

**Overcoming Treatment Barriers**

For a problem that affects one in four people, you would expect mental health disorders to be a top priority. However, many barriers prevent accessing care. The consequences of untreated mental illness can be tragic and irreversible. More than 90% of people in the United States who committed suicide had a diagnosable mental disorder; however, only about half of these people were diagnosed and treated appropriately. Even more disturbing, most of those who completed suicide contacted health services in the days to months before their death. It is clearly essential that we identify and address barriers people face when seeking mental healthcare, so that proper treatments can be prescribed before irreversible damage is done.

**Mental Health Systems**

The fragmented organization and delivery of mental health services is a known barrier to receiving treatment. It is the result of several reform movements, separate funding, and variable eligibility, which has siloed treatment settings and sectors. An integrated approach at the provider, health facility, and community levels will be essential for sustainable mental healthcare delivery. This offers the chance to treat the “whole patient” and addresses the access issues faced by many of those suffering from mental health disorders.

A few programs have already shown promising results for the integration of mental health services into primary care. In the context of care for HIV and noncommunicable diseases, an integrative approach to addressing mental health has been cost-effective and efficient. Additionally, the WHO Mental Health Gap Action Programme (mhGAP) has efficiently provided resources to support the provision of frontline mental health services to be delivered through primary healthcare and other non-specialist settings (Corrigan, Druss, & Perlick). By implementing mental healthcare into the workflow of existing primary care services, providers can provide treatment from the “whole patient” perspective and reach patients in need more effectively.

**Legislation and Financial**

The cost of care is one of the most regularly cited barriers to mental health treatment. When compared to other types of health services, mental healthcare utilization is highly price sensitive and increases with improved insurance coverage. The passing of the 2008 Mental Health Parity Act intended to mandate the same coverage for both physical and mental healthcare. Currently, 25 percent of health plans do not have equal benefits for general and mental healthcare. This could be due to the fear that expanding coverage for mental health services will increase healthcare expenditures. However, the opposite was found to be true. An evaluation of the Federal Employees Health Benefits Program of 2001, which required insurers offering mental health benefits to federal employees to provide them on par with other medical benefits, found that parity did not yield an overall increase in plan premiums, but instead reduced out-of-pocket expenditures for individuals using mental health services. This suggests that parity could be implemented with minimal cost to purchasers, a frequently raised concern. However, it did not address the problem in fragmentation of services seen for people in treatment (Corrigan, Druss, & Perlick).

**Stigmas**

The stigma attached to mental illness is common knowledge. Only 25 percent of people with mental disorders feel that other people are compassionate and sympathetic toward them, according to the CDC. Mental illness is often interpreted as a weakness or something that the person suffering can
control. People often receive blame for their mental disorder, causing shame and guilt for having something “wrong” with them. In reality, mental illness can be caused by a combination of biological and environmental factors. Educating the population about mental health illness can reduce this stigma and encourage those affected to seek care. Research on mental health literacy has been very encouraging. Individuals who better recognize their mental illness and its indicators, as well as the treatment options, may seek out and benefit from those options. This is especially important for facilitating rapid and early care seeking; mental illness outcomes are less severe the faster the person receives treatment (Corrigan, Druss, & Perlick).

Treating the Whole Person
There is a compelling case for reorganizing services into a decentralized, integrated community-based model of delivery for mental healthcare. Decades of research has shown the extensive interconnection of mental and physical health. Mental health is directly linked to numerous health issues, either as an outcome or as a determinant. Heart disease has been directly linked to depression; anxiety is a commonly known factor contributing to digestive diseases; and stress is often associated with skeleton-muscular issues. Similarly, the biological effects of certain physical conditions or disorders can result in a mental health issue. Depression can result from many central nervous system disorders, such as Parkinson’s disease or multiple sclerosis, as well as endocrine disorders (Simon).

The fragmentation of the mental health system impedes providers from detecting, diagnosing, and treating mental health disorders. Links between different care settings are crucial for detecting and treating mental health illnesses. (Goldsmith). Not only will this address the untreated cases of mental illness, but it will enhance the treatment of many physical illnesses, as well.

Sources


HLNDV WELCOMES MIKE EPPEHIMER, MHSA, FACHE AS ITS NEW DELAWARE REGENT

HLNDV is please to announce that Mike Eppehimer, MHSA, FACHE, Senior Vice President, Service Line Operations, Christiana Care Health System, has accepted the position of Delaware Regent.

As senior vice president, service line operations, at Christiana Care, Mike Eppehimer, MHSA, FACHE provides operational leadership of eight service lines organized around patients and their experience across the continuum of care. These service lines are Acute Medicine, Cancer, Heart & Vascular Health, Musculoskeletal Health, Neurosciences, Primary Care & Community Medicine, Surgical Services, and Women and Children.

Before assuming his current role in April 2015, Eppehimer was vice president, Acute Medicine and Neurosciences.

Eppehimer came to Christiana Care in 2010 from George Washington University Hospital in Washington, D.C., where he was an associate administrator with operational authority for a number of clinical and support services, including pharmacy, environmental services and physician relations. He also previously worked at the Advisory Board Company, a healthcare consulting firm in Washington, D.C.

He holds a black belt in Lean Six Sigma from the American Society for Quality, a bachelor’s degree from the University of Maryland and a master’s degree in health services administration from the George Washington University.
Introducing Executive Diversity Career Navigator.

See It ... To Be It?

Specifically for diverse healthcare professionals, the Executive Diversity Career Navigator Version 1.0, which launched April 27, features an array of career development tools and resources (the vast majority are complimentary) designed to empower diverse healthcare professionals through every stage of their careers. Unlike any other career development website, EDCN features the “voice” of diverse senior-level healthcare executives, sharing the successful strategies they have developed through their unique career journeys. EDCN is a collaborative effort between the following healthcare organizations dedicated to advancing executive diversity:

- American College of Healthcare Executives
- Asian Healthcare Leaders Forum
- Institute for Diversity in Health Management
- LGBT Forum
- National Association of Health Services Executives
- National Association for Latino Healthcare Executives

We invite diverse healthcare executives to visit edcnavigator.org, and let us know what you think! Please share news of this new resource with your diverse healthcare professional colleagues. We look forward to hearing from you.

The Thomas C. Dolan Executive Diversity Program—Now Accepting Applicants

Please help us spread the word about the open application period for the 2018 Thomas C. Dolan Executive Diversity Program (ache.org/ExecutiveDiversity).

During this year-long program, scholars benefit from specialized curriculum opportunities to develop strategies for successful navigation of potential career challenges and enhance executive presence, one-on-one interaction with a specially selected mentor, and participation in formal leadership education and career assessments. Enhanced self-awareness, critical leadership skills, and an expanded network of leaders will help prepare scholars to ascend to C-suite roles in hospitals, health systems and other healthcare organizations.

Visit ache.org/ExecutiveDiversity for more information or to apply. If you have questions about the program, please contact Cie Armstead, director, Diversity and Inclusion, ACHE, at carmstead@ache.org or (312) 424-9306.

The Foundation of ACHE’s Fund for Healthcare Leadership accepts donations to the Thomas C. Dolan Executive Diversity Program. Gifts—no matter the amount—help shape the future of healthcare leadership. Visit ache.org/ExecutiveDiversity to make your donation.

Healthcare Consultants and Physician Executives Forum Education Programs

The Physician Executives Forum and Healthcare Consultants Forum provide added value to physician executive and healthcare consultant members via tailored resources to meet these groups’ unique professional development needs. A one-day education program is a cornerstone benefit of the Forum offering an affordable learning and networking opportunity. Date and location of this program follows:

2017 Healthcare Consultants Forum Education Program
Sept. 22
Hyatt Regency O’Hare
Chicago
More details available soon at ache.org/HCForum

Forum Member Directory Connects Executives With Healthcare Consultants

ACHE is pleased to announce its latest member benefit exclusive to Healthcare Consultants Forum members... The Healthcare Consultants Forum Member Directory!

The new Healthcare Consultants Forum Member Directory is intended to serve as a resource for healthcare executives and organizations seeking the services of a healthcare consultant with a specific area of expertise.

Are you a healthcare executive searching for a consultant?
The Directory’s robust search functionality can help identify ACHE Consultant Forum Members who may meet your needs.

Questions? Please contact Liz Catalano, marketing specialist, Division of Member Services, ACHE, at ecatalano@ache.org or (312) 424-9374 or Erika Joyce, CAE, assistant director, Division of Member Services, ACHE, at ejoyce@ache.org or (312) 424-9373.
Crozer demands $100G a day from system’s buyer

**Daily Times:** The Crozer-Keystone Health System and Crozer-Keystone Community Foundation filed a petition in the Delaware County Common Please Court seeking a $100,000-per-day payment until a $21.8 million judgment filed Friday against the for-profit corporation that took over the health system last year is satisfied.

Bankruptcy judge tentatively approves Girard Medical Center sale

**Philadelphia Inquirer:** The bulk of the property, including Girard Medical Center and the associated Goldman Clinic, a methadone clinic, will go to Ironstone Real Estate Partners for $8.5 million. Ironstone intends to maintain the property as a behavioral-health and drug-treatment center.

The collapse of Community Health Systems

**Axios:** It began in 2013 and continued into January 2014. That's when CHS completed its acquisition of Health Management Associates, a for-profit hospital chain that had a slew of financial and legal problems.

UPMC announces definitive agreement to acquire Pinnacle Health

**Philadelphia Inquirer:** With the acquisition of Pinnacle — which had $1.05 billion in revenue in the fiscal year ended June 30, 2016 — UPMC moves into direct competition with the University of Pennsylvania Health System, which owns Lancaster General Health. Penn is the biggest health system in Southeastern Pennsylvania.

$650M bond issue OK’d for Reading Health System to help fund acquisition of 5 area hospitals

**Mercury:** The bond will also be used to pay for the design, construction, installation and furnishing of the Reading HealthPlex for Advanced Surgical and patient Care, a 476,000-square-foot surgical and inpatient tower in West Reading.

Data breach at Philly-area Ob/Gyn practice among this year’s largest nationally

**Philadelphia Inquirer:** Women’s Healthcare Group, which in March merged with Regional Women’s Health Group in New Jersey to form what the companies described as the largest U.S. Ob/Gyn practice, notified patients of the breach on July 18, more than two months after it discovered the ransomware.

Violence cost hospitals $2.7B in 2016, AHA report finds

**Fierce Healthcare:** Healthcare workers are at significant risk for workplace violence—between 2011 and 2013, nearly 75% of workplace assaults took place in healthcare settings.

Tandigm in deal with cancer network

**Philly.com:** Tandigm Health, a West Conshohocken firm working to help 460 primary-care doctors in Southeastern Pennsylvania reduce costs and improve care, has agreed to work with Vantage Cancer Care Network, a similar network of 70 cancer doctors in the region, the two companies said Monday.

Making Rounds: Rothman signs naming rights deal, rehab hospital gets $1M gift

**Philadelphia Business Journal:** Bacharach Institute for Rehabilitation in Pomona, N.J., is creating a neurorecovery center thanks to a $1 million charitable donation from James Klinghoffer of Longport, N.J. Hospital officials said The James Klinghoffer Neurorecovery Center, set to open in late fall, will be a showcase for the latest developments in robotic technology for people recovering from stroke and other neurological disorders

LVH opens new pediatric cancer, infusion center

**Lehigh Valley Business and Express-Times:** Like other pediatric facilities on the campus, the center was designed with kid-friendly amenities to help put children and their families at ease. Infusion bays, for example, each have a television set equipped with a gaming system.
WELCOME NEW MEMBERS, CONGRATULATIONS NEW/RECERTIFIED FELLOWS [AS OF 8/17/17]

June
Jacqueline Anzalone, RN
Joshua Davis
Michael Giulian, Jr.
Sharon Grusemeyer
Stef Kuonen
Matthew W. Metzinger

July
Sibel Aras
Leslie D. Carey
Shaun Dela Cruz
Michele DiLauro
Keith Fessler
Barbara Granatir
Lindsey Howard

Lisa MacDowell
Richa Mandlewala
Megan Mincemoyer
Christopher Minnick
Thomas Regan
Stephen M. Sammut
Katherine Schleider, RN

August
Laura E. Drahms
Richard Kajim
Joy Ann Robinson
Richard J. Steffy
Tim Wager

July New Fellows
Priyanka D. Adusumalli, FACHE
Nathan P. Diller, FACHE
Alexander Fein, FACHE

July Recertified Fellows
Patricia M. Lubrano, RN, FACHE

HLNDV FALL CAREER DEVELOPMENT PROGRAM: MOCK INTERVIEW EVENT

Only 20 seats available!

Join HLNDV on October 18th in Philadelphia to learn how to best present yourself for your next professional opportunity! Experts in healthcare recruiting and seasoned healthcare professionals will provide an overview on interviewing skills, share best practices/tips and offer personalized coaching through two 30 minute one-on-one mock interview sessions.

Early and even mid-careerists often struggle with interviewing because school and early job experiences often do not provide the opportunity to develop and practice the skills needed to interview well. This event is a start at filling that gap. Learn how to put your best foot forward during interviews and other business interactions so you can successfully secure exciting professional opportunities!

SIX TIPS FOR WORKING WITH A POOR TEAM PLAYER

Working with someone who isn’t a team player is not just frustrating, it can also negatively affect an entire group’s performance, according to a recent Harvard Business Review article. Susan David, founder of the Harvard/McLean Institute of Coaching, and Allan Cohen, a professor of management at Babson College, provided the following strategies for working with someone who isn’t a team player.

1. Avoid making assumptions.
It may seem natural to jump to conclusions about the reasons behind someone’s actions but, the truth is, you never really know why people do the things they do. Instead of assuming someone is a slacker or has a bad attitude, explore first.

2. Be open to talking.
Rather than making accusations, ask friendly questions. Working with someone who isn’t a team player is an opportunity to practice your leadership skills and gain others’ perspectives.

3. Promote friendly group relations.
Problems can arise when team members turn on a colleague who isn’t pulling their weight. To foster cohesion and discourage ostracization, consider taking your colleague out to coffee or lunch with a few teammates.

4. Focus on the team’s shared mission.
When working with a poor team player, leaders should take the opportunity to “have a conversation with the entire team about what the group’s shared vision should be and the best methods for getting there,” according to David.

5. Define duties and deadlines.
Sometimes, people who seem like poor team players are simply confused about what their role entails. Take time to review your expectations and your colleague’s responsibilities, which eliminates ambiguity.

6. Play to your colleague’s strengths.
“People are highly motivated by not wanting to let their teammates down,” says Cohen. “Get them into the game, and they’ll go to great lengths to perform better for the team.”

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Delivers healthcare support service solutions to more than 1,000 hospitals and healthcare systems throughout America.

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Clinical technology and business management consultants for hospitals, health systems and physician organizations

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**Silver Sponsors**

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Our team of healthcare, tax and accounting professionals has expertise in all aspects of the Healthcare Reform Act.

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