



**KEVIN E. LOFTON**  
**In First Person: An Oral History**

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**KEVIN E. LOFTON**

**In First Person: An Oral History**

**Interviewed by Kim M. Garber  
On March 29, 2022**

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**EDITED TRANSCRIPT**  
**Virtual Interview in Chicago**

**KIM GARBER:** Good morning. Today is Tuesday, March 29, 2022. My name is Kim Garber. I'm going to be interviewing Kevin Lofton, who served in leadership at university teaching hospitals and also with the large health system, Catholic Health Initiatives, and later with CommonSpirit Health. He served as Chair of the American Hospital Association Board of Trustees and in leadership positions with the Catholic Health Association of the United States, the National Association of Health Services Executives and many other organizations. Kevin, it's great to have the opportunity to meet you and talk with you today.

**KEVIN LOFTON:** It's my pleasure, Kim. I've been looking forward to today.

**GARBER:** Me, too! To open, tell us about your grandparents and your parents and how their values shaped you.

**LOFTON:** My paternal grandparents lived in New York City and I grew up in Manhattan and the Bronx. My maternal grandparents lived in Beaumont, Texas. My father was about nine years old when his family moved to New York and my mother was 13 when she came to New York. My father went to technical school and became an electrician. For most of my early years, my mother was a dental assistant. She later went back and received her associate's degree and became a dental hygienist. I was the middle of three boys. My older brother Dwight was an accountant and auditor. My younger brother Rodney was a career educator, with an Ed.D from Columbia University Teacher's College. Our parents imparted upon us the importance of education. Neither of them had graduated from a four-year college and they made sure that we knew that we were all going to graduate from college.

Work ethic was another key area. My father worked for the Board of Education in New York by day and at the Brooklyn Navy Yards at night. My mother worked evenings at a private dentist's office in Harlem. They wanted us to enrich ourselves. My father taught me how to play chess, and I played competitively around New York. My mother encouraged me to take up the piano and I was able to play at Carnegie Hall, at Town Hall, at the New York World's Fair.

**GARBER:** Were there others who served as role models or mentors when you were young?

**LOFTON:** My mother worked for a dentist, Dr. Alberto Robertson, in Harlem.<sup>1</sup> He treated me and my brothers the same as he did his own children. He was a benefactor for me to go to the Carmen Shepperd Music School, a very prestigious music school in Harlem,<sup>2</sup> and his wife was the first Black woman to play in the New York Lincoln Center Orchestra. She was a bass cellist. As a young kid, I got to go to concerts at Lincoln Center.

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<sup>1</sup> Alberto Robertson, D.D.S., opened his dental practice in 1956 in Harlem. [Harlem Center for Aesthetic Dentistry. <https://unilocal.net/united-states/new-york/harlem-center-for-aesthetic-dentistry/>]

<sup>2</sup> Carmen V. Shepperd (1910-1997) was a noted performer and educator who established a music school in Harlem in 1930. [Carmen Velma Shepperd. *Black Past*. <https://www.blackpast.org/african-american-history/carmen-velma-shepperd-1910-1997/>]

My great-aunt, Mother Agnes Eugenia,<sup>3</sup> was mother superior of a Black Catholic religious order of nuns. She was a big influence in my life. She was in today's parlance the president of the religious order and their convent was in Harlem. We spent a lot of time over there seeing my aunt in a leadership role, knowing she was always praying for me. Later, when I was in college, she would send me prayer cards, and I knew I had her as a guardian angel.

**GARBER:** How did the experience of being taken care of by these various mentors shape your own desire to give back to others?

**LOFTON:** You advance in life, in your career, personal activities, athletics, whatever endeavor, because people have helped you along the way. It's a rare person who advances without some assistance, some guidance, some mentorship. I recognized that and made it a cornerstone that I would reach out and try to help as many other people as I could. I've never forgotten where I came from. My life could have turned out a different way a number of times. There were people who helped me, professionally as well as personally, to stay on a straight path. Also they helped me know that there were no barriers or ceilings that I couldn't overcome if I put in the work and chose to do so.

**GARBER:** In a creative example of mentorship, you and your wife, Sabrina Shannon, endowed the Lofton Family Professorship at Georgia State University, which is where you earned your master's degree. What was the process for establishing this professorship?

**LOFTON:** That was really fun. I moved back to Atlanta about four years ago. It didn't take Georgia State long to invite me to serve on the Foundation Board, and I'm now the Vice Chair of that board. Recognizing the opportunity that Georgia State had given me when I went to graduate school there, I wanted to see if there was a way that I could give back in a meaningful way. Sabrina and I put our heads together. We met with Rich Phillips, the Dean of the Business School,<sup>4</sup> and Jay Kahn,<sup>5</sup> who is Vice President of Institutional Advancement. I listened to the dean to see what his need was and then looked to see how that matched up with what was important to Sabrina and me.

One thing that's important to us is advancing Black people in all endeavors. You can give scholarship money, which I've done. I've contributed in other ways, too – sponsoring students at Georgia State to compete in case competitions and things like that. We also wanted to make sure that we are advancing faculty who will be the ones to help teach and mold and shape these young individuals as they achieve their educational goals.

The faculty sponsorship is one which will help young faculty who are having difficulty getting started in terms of accessing research grants and pursuing their academic endeavors. This is helpful in recruiting a young faculty member. From there, they can move up in promotion and grade and then the money is used to help the next ones coming along. It's meant to give them a jump start in their

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<sup>3</sup> Mother [Mary/Miriam] Cecilia (Agnes) (Eugenia) Cormier was a professed sister of the Franciscan Handmaids of the Most Pure Heart of Mary and served as their fourth superior general. She also served as the first Black school principal in the Archdiocese of New York. [Williams SD. *Subversive Habits: Black Catholic Nuns in the Long African American Freedom Struggle*. Duke University Press, 2022.]

<sup>4</sup> Richard D. Phillips, Ph.D., is dean and C.V. Starr Professor of Risk Management and Insurance at Georgia State University's J. Mack Robinson College of Business. [Georgia State University. *Directory*. <https://robinson.gsu.edu/profile/richard-d-phillips/>]

<sup>5</sup> Jay Kahn was named vice president for development and alumni affairs at Georgia State University in 2020. [Georgia State names new vice president for development and alumni affairs. *Press Release*, July 16, 2020. <https://news.gsu.edu/2020/07/16/georgia-state-names-new-vice-president-for-development-and-alumni-affairs/>]

careers by offering them monies that they can then use to help to seed other projects that will in time produce major research grants.

**GARBER:** How does this differ from an endowed chair?

**LOFTON:** The mechanics are the same in that you're providing funds for an individual on the faculty. The biggest difference is that when you endow a chair, by definition, that person has already achieved heights in academia. This is someone who is already a professor. You are providing funds for them to further pursue their academic and research endeavors but essentially they're already established. Our focus is more on early careerist faculty who haven't already achieved the high level and standing of being a department chair.

**GARBER:** Do you know of other professorships like yours?

**LOFTON:** I can't honestly say that I do. That doesn't mean that they don't exist. This was in keeping with what we specifically worked out with Dean Phillips in terms of what his greatest needs were. I've pressed the school to make sure that they have a more diverse faculty. This was one way where I could put my money where my mouth was to help make that happen.

**GARBER:** Returning to your childhood in New York City, did you experience segregation or discrimination during that time you were growing up during the '50s and '60s?

**LOFTON:** You have to separate the two – they don't exactly go hand in hand. Let's take segregation first. I lived in a segregated society until the age of 15 because I grew up in Harlem. When I was growing up and to a large degree even today, Harlem was the cultural epicenter of Black America. When you look at many of the important things that happened for Blacks in this country, whether in entertainment or athletics or politics, they had direct ties to Harlem. In that regard, I did live in a segregated area. My elementary school was probably 98% Black and Puerto Rican. It was segregated but we weren't missing anything. We were self-contained. We had first-run movie theaters, we had the Apollo Theater. We were segregated but it wasn't a penalty in our minds.

My first experience of integration was that I knew that my family was planning to move to the Bronx two years out from when I would start high school, so I decided to choose a high school in the Bronx and commuted the first two years. I took a bus and a subway – 75 to 90 minutes one way. When I went to high school at Cardinal Spellman in the Bronx was the first time I was actually in an integrated environment. When I was there, the school was probably 40% to 45% Irish, about 40% to 45% Italian and about 10% to 15% minority, predominantly Black and Puerto Rican. When we moved to the Bronx, we lived in Co-op City, which was majority Jewish.<sup>6</sup>

My first encounter with racism and discrimination was when I went to college. While I was in Boston in the early '70s, they were integrating the Boston Public Schools. It was a tumultuous time. I was nineteen, twenty years old and was feeling the wrath of discrimination on a fairly regular basis.

My mother was from Beaumont, Texas, and we would travel during the summer months to

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<sup>6</sup> Built in the '60s in the Bronx, Co-op City – which has been called the largest co-op development in the world – is a complex of 35 high-rise buildings housing an estimated 35,000 people. [Co-op City for affordability and open spaces. *New York Times*, February 24, 2016. <https://www.nytimes.com/2016/02/28/realestate/co-op-city-for-affordability-and-open-spaces.html>]

Texas to visit my grandparents. It was a two-day train ride from New York to New Orleans, then we would transfer to another train to go to Beaumont. That was the first time that segregation and discrimination hit me front and center because they had separate colored-only water fountains and separate rest rooms in the train stations. I'm old enough to have experienced those types of things growing up.

**GARBER:** You were on the track team at Spellman High School. With your long commute, it must have been challenging to add sports to your schedule.

**LOFTON:** I mentioned earlier that I played the piano, and piano practice could take at least two hours a day. When I went to high school, piano was what I gave up. I ran track all four years that I was there. I wasn't the fastest in the city but I could hold my own. I enjoyed the camaraderie among my teammates on the track team and the competition.

My track coach had a plan for me that I didn't see and didn't like at first. Having me run the 800 my first two years helped build up my endurance and my stamina. My junior year was when he dropped me down to the 400. The 400, in my opinion, is the hardest race in track because it's the biggest balance between endurance and speed. Everything below that distance is purely speed, and everything above it, you get into the endurance. He made us run cross-country, even though I was terrible at that. It was all about building up our stamina and ability to run better at the shorter distances.

Running in New York City, you can imagine the high level of competition. One of the biggest track meets that you could go to as a high school competitor was the Penn Relays in Philadelphia. You are at the same track meet as collegiate and Olympic runners. I'm proud to say that my 4x400 relay team won a silver medal at the Penn Relays.

**GARBER:** What attracted you to apply to Boston University for college?

**LOFTON:** I was accepted to seven different schools, all in close proximity to New York. Besides having an academic reputation, B.U. has a great track record of having prestigious Black alumni. I was aware of that. Examples include Dr. Martin Luther King, Edward Brooke and Barbara Jordan. So, B.U. had prestigious alumni, proximity to New York and they offered the most money in terms of scholarship and loan. My best high school friend, Joe Williams,<sup>7</sup> also went to B.U. We were college roommates and even today, he is my longest running and best friend in life. A lot of my long-term friends are people that I met in college. My wife, Sabrina, marvels at how we've stayed together over all of these years and are still close.

My older brother Dwight went to Howard University, and a lot of other people went to historically Black colleges and universities. In choosing a large, predominantly white university, you also look at their track record. That continues today. Representative Ayanna Pressley<sup>8</sup> from

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<sup>7</sup> Joseph Williams graduated from Boston University, received his M.B.A. from The Wharton School at the University of Pennsylvania and became a financial advisor. He served for eight years on the Catholic Health Initiative Investment Committee. [*LinkedIn*.]

<sup>8</sup> Ayanna Pressley was elected to Congress in 2018 and reelected in 2020, representing the Massachusetts 7<sup>th</sup> Congressional District. [*Meet Ayanna*. <https://pressley.house.gov/about>]

Massachusetts attended B.U. and Alexandria Ocasio-Cortez<sup>9</sup> from my hometown, the Bronx, New York, is a B.U. graduate.

**GARBER:** Were you involved in activism or protests of any nature during your college years?

**LOFTON:** It was more of a negative thing for me. Whether we chose to or not we were forced into it. Boston is the greatest college town in the United States. It's seen as a very enlightened place. It's generally a liberal place. At the same time, unfortunately, during the '70s when I was in college, it was also one of the most racist cities in the United States. Everything was kept under wraps until they were integrating the Boston Public School system. That started major unrest in the city. A lot of the activism that I was involved in as a college student was related to the discrimination that Blacks and other minorities were subject to during those years in Boston.

My first two years, the things that took place happened in the city, but in my junior year things migrated onto the college campuses. It was not an easy time there. We had to set up escort schedules just to go to the library because you could not walk the streets alone at night. It was a very challenging time. I was for the first time experiencing racial discrimination firsthand. I had times of being approached by Boston police. I would quickly pull out my B.U. student badge, and then they would kind of leave you alone. I learned a lot about racial discrimination in Boston that I had never experienced any time growing up in New York City.

**GARBER:** Who were the escorts?

**LOFTON:** Fellow students. There would always be a Black doctoral student in the School of Theology who would head up the King Center on B.U.'s campus. At the time I was in college, this was the Reverend Floyd Flake, from Queens, who later became a U.S. Congressman.<sup>10</sup> A lot of organizational things came under his guidance and direction. We set up schedules. B.U.'s campus is right in the middle of the city sprawling a couple of miles up and down Commonwealth Avenue. My dormitory was the furthest east dormitory on B.U.'s campus. I walked at least two miles each way going to classes. We would set up schedules for people who were going in the same direction so that you could walk together coming to and from classes if you had evening classes. Nothing was happening during the daytime. This was all in the evening and night.

**GARBER:** After you graduated from B.U. with your degree in Management, you got a job at Harvard Medical School.

**LOFTON:** Yes. I decided not to go straight back home, and I also did not go straight into graduate school. One of my other close friends, Phil Burrows, and I got an apartment together in Boston. I wound up working at Harvard Medical School in the Office of Admissions. I was a staff assistant to the committee that selected applicants to the Medical School. Dr. Alvin Poussaint,<sup>11</sup> who

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<sup>9</sup> Alexandria Ocasio-Cortez was elected to represent the New York 14<sup>th</sup> Congressional District in 2018 and reelected in 2020. [About. <https://ocasio-cortez.house.gov/about>]

<sup>10</sup> Currently senior pastor at the Greater Allen A.M.E. Cathedral of New York (Queens, New York), the Rev. Floyd H. Flake was elected to represent New York's 6<sup>th</sup> Congressional District from 1987 to 1997. [Rep. Floyd Flake. [https://www.govtrack.us/congress/members/floyd\\_flake/404139](https://www.govtrack.us/congress/members/floyd_flake/404139)]

<sup>11</sup> Alvin F. Poussaint, M.D. (b. 1934) is Professor of Psychiatry Emeritus at the Harvard Medical School where he served for 50 years prior to his retirement in 2019. [Harvard School of Medicine. Alvin F. Poussaint, MD. <https://meded.hms.harvard.edu/people/alvin-poussaint-md>]



was a psychiatry professor at Harvard, was the chair of the committee. I reported to Dr. Cheever,<sup>12</sup> the director of admissions but I worked most closely with the committee that made the selections to the Medical School. I processed applications and did all of the interaction with prospective students. My job would sometimes, “Take me inside some of the Boston hospitals to have preparatory meetings with the doctors who are on my committee.” That was the first time I started traipsing through hospitals.

Dr. Poussaint, a prestigious professor at Harvard, was also what they called back then the “technical consultant” to the Cosby Show. The Cosby Show was groundbreaking because it was the first time that there was a weekly series that depicted a professional Black family, where Dr. Huxtable was a doctor and his wife was an attorney. We all know the importance of messaging. Dr. Poussaint focused on social determinants – before we even used that term – race-related types of things in his psychiatry practice. When they brought him on, he was the one who said, okay, this is what you’re trying to do, how does the language that you’re using get across the positive type of message that you want? He consulted with that TV show for many years.

Dr. Poussaint asked me if I knew what I was going to do with my life, what career direction I might take. Other than having a business degree, I really did not know what my next step would be. He asked if I had thought of hospital administration. I told him no, and he made some introductions to hospital administrators. I met with administrators at the Brigham, at the Deaconess, and that was where I said, this is what I think I really want to do.<sup>13</sup> After working a year there, I applied to graduate schools, and then wound up getting my degree in health administration from Georgia State University.

**GARBER:** Did you consider any schools other than Georgia State?

**LOFTON:** Yes, I applied to four schools and was accepted to all four. B.U. had just started their health administration program and it was not yet accredited which was one of the reasons I didn’t consider going there. Things that attracted me to Georgia State included that it was, if not the only one, then the first health administration program that was in a college of business. Most of the HSA programs were either in a public health school, an allied health school or even in a medical school. I wanted to make sure that I got a masters that was from a business school. That was a big distinction that Georgia State brought to the table.

Secondly, Atlanta was the antithesis of Boston in many ways, the weather being just one of them. For a long time it was seen as kind of “Black city,” where you had Blacks in leadership positions. Maynard Jackson was the mayor of Atlanta when I was in grad school and was credited with many things that helped to build Atlanta. UN Ambassador Andrew Young was another mayor of that city.

Atlanta was a joy because it was the first time since I left Harlem that you could see Blacks in leadership roles, Black businesses, elected officials, on and on and on. It was a great place for me to be at that stage in my life.

Georgia State took a chance with me. I was the first Black to ever go through the graduate

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<sup>12</sup> Francis Sargent Cheever, M.D. (1909-1997) became director of admissions at Harvard Medical School in 1974 after serving in leadership positions for many years at the University of Pittsburgh. [Francis Sargent Cheever. *University Times*, September 25, 1997. <https://www.utimes.pitt.edu/archives/?p=3200>]

<sup>13</sup> The Boston hospitals referred to are the current Brigham and Women’s Hospital and Beth Israel Deaconess Medical Center.

program there at Georgia State, so I was the only Black in my class. There were those aspects of transition, but my classmates were very warm and supportive. I felt like I was treated just like anybody else in that program and I still have long-term friendships from there.

**GARBER:** Do you recall who the program director was?

**LOFTON:** Dr. George Wren was the program director.<sup>14</sup> The professor who had the biggest impact on me was Dr. Roland Knobel.<sup>15</sup> Everybody affectionately called him “Nob.” He was a philosopher type of professor. He pressed you to express yourself in many different ways and he was all about, “What’s the right question?” as opposed to, “What’s the right answer?” If you get to the right question and pursue that, you’re going to more often than not land at the right answer. Nob was everybody’s favorite at school. Dr. Max Holland<sup>16</sup> was my other favorite. He was also my faculty advisor. He always made himself available when I needed help.

**GARBER:** Other leaders who have been interviewed in this series have commented in a very positive way about their administrative residency, typically the second year of a two-year program. You did an administrative residency at Memorial Medical Center in Corpus Christi, Texas. Do you recall your first impressions of that very large hospital? I realize this was a long time ago!

**LOFTON:** It was a long time ago. I was one of only two students of the thirty students in my class who had never worked in a hospital. The administrative residency was invaluable for me because it was my first time working directly in a hospital.

The program for our residency had been set up so that you got the maximum exposure across every aspect of the hospital. You would spend anywhere from one day to maybe even a week learning all of the ins and outs about how every single part worked. I spent two days with the medical examiner and spent time outside the hospital in the city morgue.

My first impression was that I was welcomed. Memorial at that time took two residents. My fellow resident, Scott Henry, came from the Trinity University program in San Antonio. Mr. McCuiston<sup>17</sup> set it up so that we each had separate rotations the first six months, in addition to all the other assignments that we got. One was assigned to be staff to the board and the other was staff to the medical executive committee. Then we flip-flopped for the second six months.

There were things that we were exposed to that you wouldn’t normally think might happen to you. I remember while we were in the midst of a construction project and before they finished the roof, we had a torrential downpour. The next thing I knew, I was mopping floors. We were exposed to things that helped us in our careers but, at the same time, even little things like that gave an appreciation for what people in the hospital do.

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<sup>14</sup> George R. Wren was director of the Institute of Health Administration at Georgia State University. [*George R. Wren Papers*. Georgia State University. <https://archivesspace.library.gsu.edu/repositories/4/resources/1688>]

<sup>15</sup> Roland Jefferson Knobel, Jr., Ph.D. (1923-2010) was a professor at Georgia State University and at Emory University where he helped in the development of the School of Public Health. [Roland Jefferson Knobel, Jr. Obituary. <https://www.wagesandsons.com/obits/knobel-jr-roland-jefferson/>]

<sup>16</sup> Max G. Holland served as faculty at Georgia State University from 1976-1989. [Georgia State University. Press release, April 7, 2020). <http://readme.readmedia.com/Max-G-Holland-Memorial-Scholarship/merit-120277> ]

<sup>17</sup> Robert W. McCuiston, J.D. (1927-2016) served as president of Memorial Medical Center in Corpus Christi from 1970 to 1979. [American College of Healthcare Executives. *2000 Directory*, 2000.]

One of the other major aspects of the residency was when you got put on the administrator-on-call rotation. What that means is that 24/7, if something happens after 5 pm, you're the first administrator that they call. My very first night of taking admin-on-call, there was a bomb threat. They called me. The first thing we did was to have the operators track the origin of the call. It came from a phone in our locked psych unit. That was the first indication that this was probably a false alarm but we still had to call the fire department and get the bomb people out.

I had a marvelous time and great experiences in my residency. We did a lot of project work. That type of practical experience, where your preceptor is the CEO of the hospital, gets you exposure at the highest levels.

**GARBER:** Are grad students still doing administrative residencies?

**LOFTON:** It's probably 50/50. Some schools still require it. The master's degree itself has morphed over the years. Many schools have a dual degree – MHA/MBA. There are different variations on the degree. In some cases, it's not a requirement. In the cases where it's not a requirement, most students would then seek what they call an administrative fellowship, which would be the next level of experience after you graduate.

Going back to your earlier question about discrimination – I had wanted to stay in Atlanta. Keep in mind that I was the first Black to go through the program at GSU and when it came to interviews for my residency, I know that I was discriminated against. I was not even given an interview after it had been set up at a hospital in the greater Atlanta area. The opportunity in Corpus Christi came about because Dr. Wren, the program director, spoke to Mr. McCuiston, an old colleague of his, and asked if he would consider me. This was one case where my Texas roots didn't hurt.

Atlanta was the smallest city I had lived in. I had lived in New York, Atlanta and Boston. Corpus Christi had about 100,000 people back then. It was a major change for me to live in a city that small, a city that was about 70% Mexican-American. Hospitals across America were about 65% to 70% female. There were not more than ten to twelve Black men working in the entire hospital, and there was only one person who was a department director at that time.

Living in a city that small was an experience outside of the residency itself. New York, where the city is so large, nobody knows who you are. In a smaller city, I stood out because I was in a leadership role very early in my career.

**GARBER:** Did you like being recognized?

**LOFTON:** Not for that reason, no. It wasn't something that I thought was an honor or distinction. It was just a matter of fact.

**GARBER:** A benefit of going through an administrative residency at a hospital is that a job offer may follow. That did not happen to you in Corpus. You did get a job at the University Hospital in Jacksonville.

**LOFTON:** Yes, I didn't feel bad that I wasn't offered a position. There wasn't one that fit. I interviewed at two other Texas-based organizations. One was at MD Anderson and the other was the University of Texas Medical Branch in Galveston. I chose the position in Jacksonville principally because both the MD Anderson and UTMB opportunities both carried the title "Assistant

Administrator.” Generally what that meant was that you were doing somebody else’s work, not that there was anything wrong with that. It wasn’t a management position where you were managing a department or a service but was an extension of what you did in your residency, doing more projects and doing projects for someone else.

I chose University Hospital in Jacksonville because I would be the Administrator of Emergency Services, which was a direct line management job. That was one of the major things that attracted me there.

**GARBER:** That was a very large emergency department. Why was it so busy?

**LOFTON:** It goes back to the foundational discussion that we’ve had about segregation and how societies work. In Jacksonville at that time, University was the county hospital. Other hospitals did take patients who couldn’t pay but we took ninety-plus percent of them. From that perspective, a large Black population and otherwise poor population, all of those patients came to University, as we were known as the charity care hospital.

Secondly, I went to Jacksonville in 1979, long before there were systems for primary care delivery. The large majority of these patients did not have access to primary care physicians. We served as their primary care provider. Some 50% to 60% of them were basic primary care and not true urgent care or emergency care.

Another factor was that we had the only accredited emergency medicine residency in Florida. We received patients not just from Jacksonville but from a larger surrounding area. One of the things that we were able to do when I was there was to establish the Life Flight helicopter program, which then brought even more patients from a longer distance away.

This very, very busy E.D. was, in many ways, an ideal job for me because we were a totally self-contained emergency department. I had an 18-bed adult ICU, a 6-bed ped ICU, burn center designation. We had a 6-bed psych holding area. I had my own lab and x-ray. It was like Grand Central Station on a daily basis.

In addition to having one of the busiest emergency departments, we also ran about 360,000 ambulatory visits a year because of people coming in for follow-up care. One year after I arrived, I was promoted to be over all of ambulatory services. I had both the clinics and the emergency department.

I used to say that virtually everything that happens out there in the world, eventually we see the results of it walk through our doors. I couldn’t have asked for a better place for me to cut my teeth and it was the place where I had my most direct hands-on patient care experience in my entire career.

**GARBER:** This does sound like a terrific opportunity for a young person. You were in your mid-20s at the time?

**LOFTON:** I was about 24, yes.

**GARBER:** I can see how that would be a great place to work, particularly as you were starting new programs – the Life Flight service, the burn unit, and I think you had a hand in the trauma center. Did you need to gain certificate of need (CON) approval to start these new programs?

**LOFTON:** Yes, for each of the ones that you mentioned. We functioned as a level one trauma center, with all of the volume that we had, but we did not have the official designation. At the time we received the designation, we were the second designated level one trauma center in the entire state. The other was Jackson Memorial in Miami.

We went through the CON process. Later on, when I was at another level in the organization, we also went through CON process to build a new tower and to expand the capability of the emergency department. We had those types of regulatory things that I also was able to get good experience with when I was at Jacksonville.

**GARBER:** Has certificate of need, which still exists in some states, been a helpful regulatory program?

**LOFTON:** The CON process has had varied success in varied locations. At University, we stood out from all the other hospitals based on the mission that we had. We never had any difficulty achieving success with the CON process. No other hospital would fight us in achieving those things because we were taking care of patients that they didn't want to take care of themselves.

In Jacksonville and other places later in my career, I saw that the CON process could get very contentious because, whereas the federal government was looking to help control costs, at the local level, competitor hospitals were looking to make sure that they had fewer competitors in a given space.

A lot of times, even when a new service that a hospital was fighting for might actually be needed for the community, competitor hospitals still fought it. Most often the real need won out. Overall, it wasn't an impediment for us because of our unique standing and mission, but I can't honestly say that the objective of containing costs really worked. I will say that it was good that it made people put pen to paper and go through the process of justifying adding another service. It did keep down the proliferation of unnecessary duplicated programs.

**GARBER:** Another accomplishment associated with your time in Jacksonville was that you set up a management by objectives program. What is that concept?

**LOFTON:** Where I would have to start before directly answering your question is that the biggest change that happened at that hospital was in 1981. We were a county-owned hospital – a teaching hospital for the University of Florida out of Gainesville – but an affiliated teaching hospital. In 1981, Dr. Roy Baker,<sup>18</sup> who was a private practice cardiologist and the chair of the board of the hospital, set it in motion for us to become one of the first public hospitals in the country to set up as a private non-profit 501(c)(3) structure. That changed the whole objective and mission of the hospital. We went from being strictly an indigent care hospital to one that had to continue to improve to attract paying patients if we were going to survive over the long-term. It also set in motion our eventually becoming fully a part of the University of Florida Health Science Center in Gainesville.

That was the backdrop. When we were set on our own and the amount of money that we received from the city to help support our mission was capped, we had to start doing things better to generate revenue. One of those things was to implement improved management systems so that we could be more efficient. We could operate more like the private non-profit hospital that we now were.

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<sup>18</sup> Roy Baker, M.D., a specialist in pediatric cardiology, founded the Baker-Gilmour Cardiovascular Institute in Jacksonville, Florida. [About Baker-Gilmour Cardiovascular Institute. <https://www.bakerandgilmour.com/about-us>]

The MBO structure that Peter Drucker initially pioneered was something that we put in motion.<sup>19</sup>

Management by objectives is all about improved communications, goal setting and, very importantly, following those goals up with metrics that you can measure your progress against. A big component of that, which is something that I carried through in my career, was the line around improved communications. You have to be able to have people want to follow you because it's the right thing to do and follow you with their hearts. You can't think that because you have a title and can give directives that people are going to follow you if you're just barking out orders.

Those were some of the elements of the MBO programs that we put in place. One of the cornerstones of my career, particularly during the first 20 years when I was a hospital executive before moving into the system role, was my ability to connect with the employees and to figure out ways to win over the hearts of employees. One of those ways is to be open with your communications and explain why we want to try things. Those Drucker principles went over well in Jacksonville and helped us to begin the process to migrate to the great organization that it is today.

**GARBER:** Is the MBO concept still popular?

**LOFTON:** I've used the basic principles throughout my career and I know others do. Whether we still refer to it in the pure Peter Drucker sense is one thing. You could say that there are certain aspects of lean management that follow the same tenets of management by objectives and other types of things that have come to be over the last three decades. Peter Drucker was ahead of his time.

**GARBER:** A big change happened nationally in 1983, which was when you were in Jacksonville. This was the Prospective Payment System (PPS) which was a huge change in the way that Medicare reimbursement was determined. Why was this such a big deal? How did it impact the departments that you were responsible for?

**LOFTON:** I had been promoted about that time to vice president of professional services which meant that I had all of the patient care departments in the hospital except nursing, so everything from cardiology, radiology, pathology, all of those kinds of departments, in addition to the ones that I previously had. The prospective payment system introduced diagnosis related groups, or DRGs.

That was also the year that I applied for fellowship at the American College of Healthcare Executives. You had to take the test and then go through an oral exam. I remember studying and studying and studying about prospective payment because I was sure that it was going to be on the test but they had only one question on it!

The prospective payment system affected University a lot less than other organizations because less of our revenue was dependent upon Medicare or private payers. The private payers followed suit with the government after PPS was put in. As we started attracting more private payer patients, we knew that we would have to streamline our operations. Because we were always so underfunded, we were already more streamlined than many other organizations. At least during that

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<sup>19</sup> Peter F. Drucker popularized management by objectives concepts in his book, *The Practice of Management*, published in 1954. [Management by objectives. (2009, October 21). *The Economist*. <https://www.economist.com/news/2009/10/21/management-by-objectives>]

part of my career, we were less affected by PPS than some other hospitals.

**GARBER:** After you had served in Jacksonville for a little over a decade, you were offered your first chance to be a CEO and the offer was from a historically significant place – Howard University Hospital in Washington, D.C.

**LOFTON:** That was a big deal. I was torn – having spent 11 years in Jacksonville, where my kids were born – I had become a big part of the community. We had good family support and were entrenched in the community. We’d done some really great things, transforming that hospital.

The opportunity at Howard was too good to pass up. Howard University is a prestigious place. We’ve talked already about some of the luminaries who graduated from B.U., you can’t even begin to compare those to the number of Black luminaries who graduated from Howard University. Howard University is the most comprehensive university of any of the historically Black colleges and universities. Law School alums include Supreme Court Justice Thurgood Marshall.<sup>20</sup> Medical School, alums include Dr. LaSalle Leffall and Charles Drew<sup>21</sup>. My older brother and my wife, Sabrina, went to Howard. Haynes Rice,<sup>22</sup> who had a legendary career, was the CEO of Howard.

I didn’t want to leave Jacksonville but I threw my name in the hat. The opportunity to potentially become the next CEO at Howard University Hospital was something that I knew I needed to pursue. Just as with many other aspects of my career, they took a big chance with me. I was 36 years old, going to our nation’s capital to become the CEO of a major university hospital.

My age was a big factor. Dr. Franklyn Jenifer,<sup>23</sup> the President at Howard, gave a reception at his home to introduce me to the deans and the hierarchy of the university. When he introduced me, he said, “Yeah, when I first met Kevin, I didn’t know whether to shake his hand or burp him!” They wondered whether I was ready for the job, particularly with the heavy lifting that we would have because the hospital was in a bad financial position.

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<sup>20</sup> Thurgood Marshall (1908-1993), the first Black justice of the U.S. Supreme Court, served in that role from 1967 to 1991. [Greenhouse L. (1993, January 25). Thurgood Marshall, civil rights hero, dies at 84. *The New York Times*. <https://www.nytimes.com/1993/01/25/us/thurgood-marshall-civil-rights-hero-dies-at-84.html>]

<sup>21</sup> LaSalle D. Leffall, Jr., M.D. (1930-2019), served as the Charles R. Drew Professor of Surgery at Howard University and as department chair for 25 years. [Roberts S. (2019, May 31). LaSalle Leffall Jr., 89, dies: Cancer Society’s first Black leader. *The New York Times*. <https://www.nytimes.com/2019/05/31/obituaries/dr-lasalle-d-leffall-jr-dead.html>]; Charles R. Drew, M.D. (1904-1950), served as chief surgeon at Freedman’s Hospital and pioneered a method for storing blood plasma. [Kelly J. (2020, April 6). The untimely death of his sister from the flu inspired this D.C. doctor to greatness. *The Washington Post*. [https://www.washingtonpost.com/local/the-untimely-death-of-his-sister-from-the-flu-inspired-this-dc-doctor-to-greatness/2020/04/06/1bcafa44-779a-11ea-a130-df573469f094\\_story.html](https://www.washingtonpost.com/local/the-untimely-death-of-his-sister-from-the-flu-inspired-this-dc-doctor-to-greatness/2020/04/06/1bcafa44-779a-11ea-a130-df573469f094_story.html)]

<sup>22</sup> Haynes Rice (1932-1991), acting director and then director of Howard University Hospital from 1978 until his retirement in 1990, was a founder of the National Association of Health Service Executives. [(1991, August 4). Haynes Rice, hospital chief, dies at age 59. *The Washington Post*. <https://www.washingtonpost.com/archive/local/1991/08/04/haynes-rice-hospital-chief-dies-at-age-59/3d4c0f68-1702-4299-a916-1115db001473/>]

<sup>23</sup> Franklyn G. Jenifer, Ph.D. became the 14<sup>th</sup> president of Howard University in 1990, serving in that position until 1994. [Howard University. No. 23: Franklyn Jenifer. *150 Facts from 150 Years*. <https://150.howard.edu/facts/franklyn-jenifer/>]

**GARBER:** Why do you think they did hire you?

**LOFTON:** A couple of reasons. One was the track record that I had in Jacksonville. They did major due diligence in terms of trying to verify if some of the things that were on my resume or that I had said in the interview were true in terms of the things that I accomplished. Another factor was that given the state of the hospital and the work that needed to be done, they probably figured that maybe a younger person would come in with fresh ideas and look at perhaps unorthodox approaches to getting the job done. I did well enough in the interview that I convinced them that I was up to the task.

The foundation of my career was laid in Jacksonville but the coming-out of my career occurred at Howard. In a two-year period, despite major deficits and lack of cash and a lot of other things, we were able to successfully turn around and operate in the black. That drew the attention of the American College of Healthcare Executives. In 1993, I was the recipient of the ACHE Hudgens, which is given to the young health care administrator – someone under age 40 – who had distinguished themselves. I became a household name and was much more recognized on a national basis.

Being a CEO in the nation's capital was how I became a lot more active with the American Hospital Association and became a Washington insider, understanding and knowing and learning how Washington works. The AHA oftentimes would have a Congressional panel or something like that going on where they would need to provide a last-minute representative. Instead of having someone come in from a different part of the country, they would ask one of the local CEOs to come and be the one to represent the AHA.

Someone who was one of the biggest influences in my career was Sister Carol , who was at that time the president of Providence Hospital in D.C.<sup>24</sup> In other places, you are elected to the state hospital association board, but because the District of Columbia has so few hospitals, every CEO in D.C. is automatically on the D.C. Hospital Association board. Others I met there included Ed Eckenhoff<sup>25</sup> and Ken Samet,<sup>26</sup> who was still the CEO at MedStar. Ken and I started together in D.C. Ken got his first CEO job at the Washington Hospital Center. He was in his mid-thirties. My overall experiences in D.C. definitely played a major role in my career development.

**GARBER:** I had the opportunity to meet Ed Eckenhoff and interview him for this oral history series. What a great experience!

**LOFTON:** Ed was a character, but you talk about a profile in courage! He was the CEO of the National Rehabilitation Hospital. The experience of sitting around the hospital association table with people like Sister Carol and Ed and Ken and others – I hopefully contributed, but I obviously learned a lot. I remember going through his hospital with Ed and seeing the way that everyone looked

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<sup>24</sup> Sr. Carol Keehan served for 14 years as president and CEO of the Catholic Health Association of the United States until her retirement in 2019. [Sr. Carol Keehan will leave big shoes to fill in Catholic health care. (2019, January 7). *Global Sisters Report*. <https://www.globalsistersreport.org/news/ministry/sr-carol-keehan-will-leave-big-shoes-fill-catholic-health-care-55760>]

<sup>25</sup> Edward A. Eckenhoff (1943-2018) served as the founding president and CEO of the National Rehabilitation Hospital (Washington, D.C.). [American Hospital Association. (2015). *Edward A. Eckenhoff: In First Person, An Oral History*. <https://www.aha.org/system/files/2018-03/Eckenhoff-Transcript-FINAL-ONLINE-050115.pdf>]

<sup>26</sup> Kenneth A. Samet has served as president and CEO of MedStar Health, a 10-hospital system, since 2008. [MedStar Health. (2022). *Kenneth A. Samet, FACHE*. <https://www.medstarhealth.org/about/medstar-health-leadership/kenneth-a-samet-fache>]



at him, this was something I modeled myself. I wanted to know that my employees saw me as a plus.

My mother worked at a dental clinic in a large teaching hospital in New York City. I remember her telling me one day that she had never met her CEO. I remember saying to myself that if I ever became a hospital CEO that my employees would know me. It would not be a situation where if the CEO shows up on a unit people say, “Something must be wrong – he’s here now.” Ed knew almost every employee by first name and that was something I modeled myself on as well.

**GARBER:** What did you do to make sure that everybody did know you?

**LOFTON:** Howard University was formal. Employees didn’t call me “Kevin.” I was “Mr. Lofton,” even at my young age. One of the things I did was to make sure that I was accessible to the employees and associates. At Howard, I formed an employee steering committee. I had a once-a-month meeting with this focus group of rank-and-file employees from across the hospital. They were allowed to talk to me about anything and everything that was happening that they thought could improve their work life or what could improve our patient care or what would make it easier to work at the hospital.

At the next meeting after an issue was raised, a department head or vice president had to appear before this work group and tell them what they were going to do to work on improving whatever the issue was. If it was something that was off the wall, we didn’t do that. Most times, that was not the case.

I also held monthly open forum employee meetings where any employee could come to my meeting and everything was on the table. We would talk about everything happening in the hospital. What you find is that when you empower people, they want to work as hard as they can for you to help to improve things. They know you have their back, and you in turn are working to improve their work life, the environment that they work in, helping them to be able to ultimately help our patients.

People couldn’t call me by my first name – there wasn’t that type of familiarity – but if I showed up on a nursing unit or in a department, smiles would come across employees’ faces. They would be greeting me. They would be happy to see me because they knew that I was there for them. All of that contributed to our quick turnaround at Howard.

In the early ‘90s, one of the most successful companies in America was Southwest Airlines. They came in with a different model. One of the things that I borrowed from their CEO was a way to help rank-and-file employees understand and connect with big numbers.

One of the things that Kelleher<sup>27</sup> did at Southwest was what he called, “The Anatomy of an Empty Seat.” He was able to compute for every seat that was empty in the plane when it took off, here is what we lose in revenue, here is what this means in terms of our profitability, here’s what this means in terms of you getting pay raises.

I did what I called, “The Anatomy of an Empty Bed” and “The Anatomy of a Complaint.”

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<sup>27</sup> Herbert D. Kelleher (1931-2019) one of the founders of Southwest Airlines, served as president and CEO from 1981 to 2001, when he became chairman. [Herb Kelleher, co-founder of Southwest Airlines, dies at 87. (2019, January 3). *Los Angeles Times*. <https://www.latimes.com/local/obituaries/la-fi-herb-kelleher-southwest-airlines-20190103-story.html>]

These used the same type of formula so that our employees would know the impact of a patient having had a bad experience at our hospital. These are generalizations but for every positive experience that a person has, they're going to tell one to two people but, for every negative experience that a person has, they're going to tell eight to ten people. We talked about what we had to do to improve the patient experience. We had to improve how families were treated when they came to our hospital. I kept a visualization, like a thermometer that you might see for a United Way Campaign, posted around the hospital showing our average daily census. Employees could see that our census was going up and they could take pride in knowing that they helped that to happen.

You can have a fancy title and sit in a nice office, but if the people who work in your organization can't relate to you, you're only going to go so far in terms of making the kind of progress that we needed to make.

**GARBER:** You referred to making a fast turnaround. Are you able to pin down one or two things that were instrumental in achieving that?

**LOFTON:** The top item was what I just talked about. You have to start with the employees and people need to know that everyone plays a major role in terms of the totality of what happens inside your hospital.

Another thing relates to calling people by their first name – there were three unions at Howard. The Service Worker Union leader was Mr. Anderson and he was the age of my parents. He had a job to do, I had a job to do. I respected him not only because he was the head of the union, but also from that standpoint. He called me Mr. Lofton but I also called him Mr. Anderson. If we were not in public, our relationship developed to the point that he called me “Baby Brother.” It wasn't that he was caving in on demands or anything like that. He was still doing his job. That's the kind of relationship that you have to develop where you respect everyone else for what their individual roles are.

Secondly, the quality had diminished at the hospital. Dr. Clive Callender was the associate chair of the surgery department, and a major influencer at the hospital.<sup>28</sup> I asked him to identify private practice physicians, many of them Howard alums, who used to practice at Howard University Hospital but had stopped practicing there.

He helped me gain access and introductions. I would meet with these prominent physicians and ask them candidly, “Why did you stop admitting patients at Howard?” They would give me their reasons. I would then say, “If I come back to you with a plan that would help to alleviate and fix the issue that you raise, would you consider bringing private payer patients back?” Every one of them said yes. Over time, we were able to demonstrate those improvements and over time we started having a lot more private pay patients being admitted back to Howard. Howard had a structure where it was not only a closed faculty hospital. We did have private practice physicians who also practiced there.

The third thing was budget sharpening. We were putting in systems to make sure that there was no waste in terms of the limited dollars that we had. I'm proud to say that we went from a \$30

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<sup>28</sup> Clive O. Callendar, M.D., is a professor and award-winning transplant surgeon practicing at Howard University Hospital, a pioneer in minority transplantation issues. [Freeman SZ (2021, August 3). Howard University surgeon Clive Callender heralded for minority organ transplantation achievements. *News Release*. <https://thedig.howard.edu/all-stories/howard-university-surgeon-clive-callender-heralded-minority-organ-transplantation-achievements>]

million deficit to being \$2 million in the black within two years. That may not sound like a lot but coming from \$30 million down, that's a \$32 million improvement in two years on a \$150 million budget.

We had loans. We had to borrow money from the university and get a bank loan to make payroll at one time. During that same time period, we paid off the debt to the university, we paid off the bank loans. We were able to put the hospital on a firm financial footing. Those are some of the key things. We had a great team and great support from the faculty and from the university.

With Howard University being such a prestigious university, one of the things that I had to get help from the university president was that the hospital itself didn't have its own identity. It was just considered Howard's hospital. The hospital didn't have a separate logo, we used the university shield. When I broached the subject of us getting our own logo, Dr. Jenifer said, "No, but this is Howard University." I said, "Dr. Jennifer, your students come from 50 states and 18 countries. My patients come from D.C." We had to begin to do things to further tie ourselves to the patients in D.C.

Howard University was founded by President Ulysses Grant. Many freed slaves moved to D.C. because that was the nation's capital. President Grant formed what he called the Freedmen's Bureau, which was set up to help the freed slaves in two areas – health care and education. A Union general, Otis Howard, was put in charge of the Freedmen's Bureau, which later evolved to be Howard University. Howard University is named after a Civil War general.

The original name of the hospital was Freedmen's Hospital from the time it was founded in the 1860s until 1979. When the new building was built, the name was changed to Howard University Hospital.

**GARBER:** The turnaround that you and others achieved at Howard caught the attention of the University of Alabama Hospital in Birmingham, which was your next opportunity. What intrigued you about pursuing this?

**LOFTON:** I talked about the prestige and significant standing of Howard University, but UAB's academic medical center was at another level as a top-tier academic research university and health science center. At the time I was there, it was the tenth-largest hospital in the United States. In large part the two principal areas where UAB stood out were in transplantation and in heart care. Today, UAB is the largest kidney transplant center in the United States. Overall, when you count all organs, we were the fifth largest transplant center in the United States, and we drew patients from a large geographic region in the south.

In heart care, Dr. John Kirklin,<sup>29</sup> who came to UAB in the '60s from the Mayo Clinic, was the person who was principally responsible for putting UAB on the map. Because of his national standing, he was able to attract people from a wide range in a short period of time. Under the leadership of Dr. Kirklin and the university presidents, they were able to raise the standing to the point that we were a top 15 academic research center. If you took the entire Southeastern part of the United States, we were the largest research center between Baltimore and Houston. Only Duke had more research

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<sup>29</sup> John W. Kirklin, M.D. (1917-2004), an internationally-known cardiovascular surgeon furthered technique in open-heart surgery and the use of the heart-lung machine. He began practicing at the University of Alabama in 1966. [Cooley DA. (2004). In Memoriam John W. Kirklin 1917-2004. *Texas Heart Institute Journal*;31(2):113. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC427366/>]

dollars coming in than UAB, when you look at the part of the country between Johns Hopkins and Texas Medical Center.

It was the attraction of moving to another level. At that time, there were about 125 medical schools in the United States and about 125 university hospitals. There were only two Black CEOs of university hospitals in the entire country. That was me and Percy Allen,<sup>30</sup> who was one of my mentors. There was a lot that UAB had to offer to take me to the next level in terms of experiences of running a major academic medical center hospital

**GARBER:** We also had the pleasure of interviewing Percy Allen at his home for this oral history series.

**LOFTON:** Percy was a giant of a person – especially in helping advance the careers of health care leaders, including myself. I could tell you more Percy Allen stories than we have time for today. During the time that Percy was the President of NAHSE,<sup>31</sup> he took me with him to South Africa to visit Nelson Mandela. We were part of a group along with Howard Jessamy,<sup>32</sup> who followed Percy as the NAHSE President (and I followed Howard as NAHSE President) – we were part of a group invited over by Nelson Mandela. There were seven of us who went to South Africa and had meetings in Nelson Mandela’s conference room after South Africa had been freed of apartheid and he had become president. We were invited to advise them on things that they should do to improve health care. Another example was during the Clinton health care reform initiatives, when a group of NAHSE leaders was invited to White House meetings to give our input into health care reform. Percy Allen led that.

**GARBER:** NAHSE, which is the National Association of Health Services Executives, has been around for a long time and you have been active in the organization. How have the objectives changed over the years?

**LOFTON:** I’ve been a member of NAHSE since 1981. I was the first Black hospital administrator in Jacksonville, Florida. I remember when I joined ACHE and went to my first ACHE Congress, and then saw other Black people there. I started meeting people like Haynes Rice and Elliott Roberts<sup>33</sup> and Everett Fox,<sup>34</sup> who were all founders of NAHSE. They were all CEOs, and I thought, *Wow, these people are CEOs!*

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<sup>30</sup> Percy Allen II (1941-2021) served as the CEO of Bon Secours Baltimore Health System in Baltimore and in other leadership positions. [*Percy Allen II in First Person: An Oral History*. Chicago: American Hospital Association, 2013. [https://www.aha.org/system/files/2018-01/Allen\\_022813\\_FINAL.pdf](https://www.aha.org/system/files/2018-01/Allen_022813_FINAL.pdf)]

<sup>31</sup> The National Association of Health Services Executives (NAHSE), founded in 1968, is a professional society for Black health care administrators. [National Association of Health Services Executives. *Mission & Vision*. <https://www.nahse.org/about/>]

<sup>32</sup> Howard T. Jessamy served as president of the District of Columbia Hospital Association and later worked for Witt/Kieffer. [*LinkedIn*]

<sup>33</sup> Elliott C. Roberts, Sr. (1927-2018) served as CEO of Charity Hospital (New Orleans, Louisiana) and, earlier, in other leadership and academic positions. [*Elliott C. Roberts, Sr., in First Person: An Oral History*. Chicago: American Hospital Association, 2011. <https://www.aha.org/system/files/2018-04/Roberts-FINAL-010512.pdf>]

<sup>34</sup> Everett Fox (1916-1997), who served in leadership at the New York University Medical Center, was the first president of NAHSE. [Howard DM (ed.) *Celebrating Our Future by Remembering Our Past: NAHSE at 50*. Washington, DC: National Association of Health Services Executives, 2018, p. 262. [https://www.nahse.org/wp-content/uploads/2020/11/NAHSE\\_50-1.pdf](https://www.nahse.org/wp-content/uploads/2020/11/NAHSE_50-1.pdf) ]

This is a nuance that most people don't know – but if an organization's name starts with the word “American,” then that's majority but if it starts with “National,” that's Black. NAHSE started as a similar organization to ACHE, but Black. You have the National Medical Association vs. the American Medical Association, and I can go on and on and on.

This was because the founders were still working in segregated hospitals. They also were not members of the American Hospital Association. That's why NAHSE was formed initially, because they wanted an organization where our people could be members.

Another historical nuance can be seen if you go back to not just our NAHSE founders but even looking at my own career – I'm about two decades behind the founders. Back in those days, more than 90% of Blacks who were in health care management were all working in public hospitals. We did not receive opportunities back then to work in private non-profit hospitals, let alone for-profit hospitals. We were all working in public hospitals back in that era.

Those were some of the reasons NAHSE came to be. Now over these many decades, it's evolved, and the current-day mission is a lot broader than it was back then. It was a place where we could go and interact with each other.

I was an active member around the time that NAHSE established its own annual national education conference. Back in the early days, we would go to ACHE in Chicago – it was ACHA back then – and have a NAHSE meeting during ACHE. Over time, we established our own national educational conference.

**GARBER:** We are recording your interview today during this year's ACHE Congress.

**LOFTON:** I'm presenting tomorrow at an ACHE panel discussion around diversity, equity and inclusion. There is a new acronym that adds “Justice” to DEI. The new term is JEDI – for justice, equity, diversity and inclusion.

**GARBER:** How did NAHSE years ago come to partner with ACHE, which eventually led to the creation of the Institute for Diversity and Health Equity?

**LOFTON:** One of NAHSE's founding premises was to help to advance the careers of Blacks in this country. Most of us were members of both NAHSE and ACHE. Nat Wesley, for a long time was the historian of NAHSE.<sup>35</sup> I hired Nat when I was at Howard to be my strategic planning and governmental/public affairs person.

We put together a study group and met with ACHE leadership and agreed to commission this study to look at paralleling career tracks for White health care executives and Black health care executives.

The original study did not include other races or ethnic groups. We set it up so that we could

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<sup>35</sup> Nathaniel Wesley, Jr., served in a variety of management and academic positions, authored the book, *Black Hospitals in America* and compiled archival documents related to the formation and history of the National Association of Health Services Executives. [Wesley publishes book on Black hospitals. (2010, December 10). *Rattler Nation*. <http://rattlernation.blogspot.com/2010/12/wesley-publishes-book-on-black.html>]

equate two people – one Black, one White – as far as years in their career, educational attainment, career position attainment and gender. We were able to balance to equate as close as you could apples-to-apples with these two groups.

To no one's surprise, people with the same educational levels, numbers of years working in the field, similar positions, all of those kinds of things, were equal, but at the end of the day, White health care executives' careers were advancing further, had bigger titles and they were making more money. It was the first study of its kind that validated what we already knew.

Because Tom Dolan<sup>36</sup> had commissioned this study at ACHE and we were working with the ACHE statisticians, people couldn't say that NAHSE had come up with self-serving results. I commend Tom Dolan over those many years for his leadership in this very area. The study was published, and then two years later, we did a repeat study and there were few changes if any.

We decided to call more attention to it. We started having more dialogue inside ACHE and the American Hospital Association also took an interest under Dick Davidson.<sup>37</sup> Although the original study was between NAHSE and ACHE, AHA came to the table as a third partner and the three organizations together founded the Institute for Diversity. For maybe up to a decade, the IFD was a stand-alone organization. Over time, the AHA became a larger portion in terms of supporting it and eventually it was folded into a wholly-owned entity of AHA.

When we set up the initial board, there were two representatives from AHA, two from ACHE, two from NAHSE, and then a couple of other people at large. I was one of the two NAHSE representatives who served on the founding board.

**GARBER:** Going back to the UAB Hospital – I'm curious if you encountered town-gown conflict, and if so, what strategies you took to overcome it?

**LOFTON:** One other thing that I would say to tie together the two last topics is that I was also the national NAHSE President during my first two years at UAB. Those two overlapped, and we formed a NAHSE chapter in Birmingham.

About your town-gown question, we really didn't experience that at UAB. The reason it didn't necessarily apply in Birmingham was because UAB was a closed shop. We were 100% faculty in terms of who practiced at the hospital. Inside the hospital, we didn't have that traditional town-gown dilemma. Many academic referral centers fall down in that town-gown relationship when they get the patient and then they keep the patient for everything else that they do beyond the specialty referral.

UAB went out of its way to make sure that the patients went back home. Another aspect at UAB was that we had a large international patient initiative. Fellows from other countries who had

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<sup>36</sup> Thomas C. Dolan, Ph.D., served as president/CEO of the American College of Healthcare Executives from 1991 to 2013. His oral history: Garber, K.M. (Ed.). (2014). *Thomas C. Dolan in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <https://www.aha.org/system/files/2018-03/Dolan--032114--FINAL.pdf>

<sup>37</sup> Richard J. Davidson (1936-2016), served as president and CEO of the American Hospital Association from 1991 to 2007. His oral history: Garber, K.M. (Ed.). (2015). *Richard J. Davidson in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <https://www.aha.org/oral-history-project/2018-03-14-richard-j-davidson-2010-oral-history-transcript>

trained at UAB would refer their patients to us knowing that they were going to get their patients back from us.

Later, when I was part of CHI we put together KentuckyOne Health<sup>38</sup> and the University of Louisville came under management of Catholic Health Initiatives. There was a major town-gown issue because we merged it with Jewish Hospital. At Jewish, they had private practice physicians who had adjunct faculty positions at the University but now we were one organization with the University of Louisville.

Part of the rationale was that the University of Louisville Hospital and Jewish Hospital were two blocks apart and the plan was to integrate the two operations into a single operation. That was difficult because of the town-gown issues. I won't go into detail but I had much more experience and angst about the town-gown thing in Louisville than I did in Birmingham.

**GARBER:** The next major change in your life and career arrived as you entered the world of Catholic health care systems. At that time you would have been in your fifties?

**LOFTON:** Oh, no, I was 44 when I went to CHI.

**GARBER:** At that time, Catholic Health Initiatives was itself a young organization, only a couple of years old.

**LOFTON:** Yes.

**GARBER:** How did that opportunity come about?

**LOFTON:** Catholic Health Initiatives – CHI – was founded in 1996. It was the coming together of three fairly large regional Catholic health systems: the Franciscan Sisters out of Philadelphia; the Sisters of Charity out of Cincinnati; and what was called Health Care Corporation out of Omaha, which was already the consolidation of several Catholic orders, principally the Mercy Sisters out of Omaha. A year later, the Sisters of Charity of Nazareth, Kentucky, joined.

At that time when they came together, if you put aside the HCAs and Tenets of the world,<sup>39</sup> CHI was the largest health system in the country. The principle reasons for it were that as health care continued to move into larger systems, the Sisters recognized two facts. One was that the number of women religious were declining. Secondly, they hadn't become women religious to run big business organizations. That's not why they went into health care. So they began to incorporate more lay leadership – leaders who were not women religious – to help them manage and run the hospitals.

I'm going to digress here but this is important to how and why CHI came to be. In Catholic Church parlance, an organization is Catholic because it is run by a body that is organized inside the Catholic Church. That could be a bishop or a group of religious sisters. In this case, it was a group of religious sisters. The second aspect of CHI was that they not only put it together to bring lay leaders

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<sup>38</sup> KentuckyOne Health later became CHI Saint Joseph Health (Lexington, Kentucky) in 2019. [KentuckyOne Health is now CHI Saint Joseph Health in Central, Eastern Kentucky. (2019, January 22). *News Release*. <https://www.chisaintjosephhealth.org/hospital-news/kentuckyone-health-is-now-chi-saint-joseph-health-in-central-eastern-kentucky>]

<sup>39</sup> Referring to large investor-owned health systems such as HCA Healthcare and Tenet Healthcare Corporation.

in to begin to run the health system but they were also the first to turn the church leadership role over to these same lay people. That was significant because if you named any other Catholic system that may have set up a non-profit 501(c)(3), but the nuns still ran it from the Church standpoint. That was the significance of CHI coming together.

In 1997, I interviewed for the CHI chief operating officer position with Pat Cahill,<sup>40</sup> who was the founding CEO and who became one of my great mentors. Pat didn't select me for that position – and I never let her forget that, either! A year later, when the Sisters of Charity of Nazareth joined CHI, they brought me in as the president of the southeast region.

At my first job with CHI, I had three states. Then, like the turnarounds that we talked about at Howard and at UAB, Pat Cahill did a restructuring and flattened the organization. We went from six regions to three groups and she promoted me. I went from managing three states to seven states. One year later, she made a change with the chief operating officer and promoted me to be the COO, and then I had the exact job two years later that I had interviewed with her about originally.

**GARBER:** Was the merger controversial or were people pretty much universally of the opinion that it needed to be done?

**LOFTON:** It wasn't controversial to the people who put it together, and there were many principals. Sister Maryanna Coyle<sup>41</sup> from the Sisters of Charity of Cincinnati was the principal architect and became the first board chair when CHI was put together. It was controversial, though, both to the congregations whose health system organizations were now part of CHI, and really to the country, because Catholic health care was very fragmented. Now you had this Catholic organization coming together. Back when I joined CHI, we were at \$4 billion in revenue, which is fairly large on a regional scale even today. It was controversial to the women religious congregations, because they later found out that in putting it together – that's why I digressed earlier about that sponsorship model – they learned that they actually gave the Church role up to CHI as well to the canonical body called Catholic Health Care Federation. So the Sisters didn't exactly like it either, other than the organizers.

When we were founded, CHI was in about 14 states. It also was the largest now national health system that was private non-profit, but also part of the Catholic Church.

For many of those reasons, people at the local level delivery system level felt that their ability to run things was now also being threatened because they now had this large parent. Among the biggest challenges that we had in the early years was getting people at the local level to realize, yes, you are part of our organization and in many ways you will still have the final say at a local level, but for many other things, we will make those decisions at the corporate level. It was very, very challenging during those early years.

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<sup>40</sup> Patricia A. Cahill, J.D. (1938-2021) served as the founding president of Catholic Health Initiatives from 1996 to 2003. [Patricia Cahill, first president and chief executive of CHI, dies. (2021, November 1). *News Release*. <https://www.chausa.org/publications/catholic-health-world/archives/issues/november-1-2021/patricia-cahill-first-president-and-chief-executive-of-chi-dies>]

<sup>41</sup> Coyle, Sr. Maryanna (1934-2007) served as chair of the Board of Stewardship Trustees during the first years of Catholic Health Initiatives. [Shook R, Folut L. (2001, July-August). CHI marks its fifth anniversary. *Health Progress*. <https://www.chausa.org/publications/health-progress/archives/issues/july-august-2001/chi-marks-its-fifth-anniversary>]



**GARBER:** This reorganization led to the creation of an even bigger organization, and that had to do with the relationship between CHI and Dignity Health. How did this idea come about?

**LOFTON:** CHI had gone through a process with another large organization about a potential merger that didn't come to be. From what I later learned, Dignity Health had done the same thing. We both learned a lot from that. I learned what things were positive to our board in looking at a merger partner and what things were not going to work.

Pat Cahill retired and I became CEO in 2003. It was now about 2017. Lloyd Dean<sup>42</sup> and I decided to meet and talk. Based on the learnings from our previous failed merger attempts, we were open and candid about what his organization was looking for, what my organization was looking for and also what wouldn't work. We believed that health care would continue to have consolidation upon consolidation. We wanted to be proactive and to look at partners that we thought would make the best sense to further advance and ensure the longevity of our organizations.

Many organizations, Catholic and otherwise, closed during those times. Hospitals were closing, mergers were taking place, consolidation was taking place. We wanted to make sure that we put together something that would be long lasting. Lloyd and I decided that we would take the notion of coming together back to our respective boards.

Because of the experience that we had had previously, my board was not interested in going through another merger attempt and wanted some more time to pass. They suggested a proof of concept. Rather than coming back with this grand plan, we should look and see how CHI and Dignity might work together on some smaller things so we could see if our cultures were compatible.

Lloyd and I put together a work group that looked at some of the things that CHI did maybe better than Dignity, other things in which Dignity might have been further advanced, and some things that we might be able to do together. We came up with a list of ten items – and later narrowed that down to five. We took that back to our boards but they thought that even five was too many. They wanted to pick just one and work on that. That wound up being precision medicine. We were both moving forward with initiatives on that. We decided to pool our resources and see whether a precision medicine alliance might be a place to start. We had some impressive successes early on that opened the door for both of our boards to be more open minded about what else we might do together.

**GARBER:** CHI and Dignity Health came together as CommonSpirit. An interesting feature of the new organization's leadership structure was creation of an Office of the CEO. I read that you wanted to avoid having the job title "co-CEO." What was the thinking behind this model and would you advise others to consider it?

**LOFTON:** I would say it's very hard to do. The only other organization that I'm aware of that attempted it was the Advocate Aurora merger here in Chicago and Milwaukee and they had

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<sup>42</sup> Lloyd H. Dean, CEO of CommonSpirit Health from 2019 until his retirement in 2022, previously served as CEO of Dignity Health, previously known as Catholic Healthcare West. [CEO Lloyd Dean will retire from CommonSpirit Health next year. (2021, October 12). *News Release*. <https://www.commonspirit.org/news-and-perspectives/news/ceo-lloyd-dean-will-retire-from-commonspirit-health-next-year>]

successes and other issues with that.<sup>43</sup>

Back to your original question, how did it come about? If you have management totally leading a merger initiative, you have to come back to the respective boards each time and do a whole lot of work getting people up to speed as to why you proposed doing something one way or another. What we did was form a board steering committee made up of five individuals from each board.

We provided the steering committee more routine check-ins so we cut through a lot of red tape later in terms of having someone say, “Well, that doesn’t make any sense.” Now when we went to the full board, we had members of the board who were able to speak up and say, “This is why we think that’s the way to go.” That expedited the approval process.

If you look through the literature of the last three to four years – the number of successful mergers of major organizations is very small. Again, I would point to Advocate Aurora as one that worked, but if you look at all of the failed attempts, many times it came down to leadership. It came down to who got board seats, who would be the CEO, what the name of the organization would be, where they were going to be located, those kinds of things.

Instead of going through a long process and getting 90% there and then finding out that you can’t come to terms with certain key things – Lloyd and I took on those things up front. One of those things was who was going to be the CEO. Right or wrong, the CHI board was not going to move forward if I was not part of it, and the Dignity board essentially took the same position about Lloyd. I told our board that I would gladly step aside if it meant putting this together because I believed in what we were trying to do.

In the end, they asked us to come back with a plan that we would propose back to them. The simple reality was – and this is not about ego, but of my 42-year career, I was a CEO for 27 years. I had two chief operating officer positions in my career in Jacksonville and with CHI, but, I made it clear, I’m not the right person to be a COO again. I also was not interested in being “Special Assistant to the President” or some such made-up title. I said that if I’m not going to be the CEO, I’d be happy to step aside.

We came up with a “two-CEO” structure – not a “co-CEO” structure. In our minds, “co” meant that both were running everything equally but nobody was responsible. We would have to check in with each other on every single thing and would get bogged down in making decisions.

With the two-CEO structure, we started by dividing up the organization. Lloyd and I agreed about what made sense to be grouped together and who would take what. Going in, since both of us had responsibility for everything, we could flip a coin to decide who had which side of the newly-structured organization. We came up with a structure in which I was CEO over defined parts of the organization, Lloyd was CEO over defined parts of the organization, and we came together into the Office of the CEO for those decisions that did need input from both of us. There were only two areas that we agreed did need both of our inputs before final decisions would be made, and those were the consolidation work that took place after the merger and on the strategy. Lloyd and I co-CEO’ed, if you will, those two areas – strategy and integration.

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<sup>43</sup> (2019, July 24). Advocate Aurora Health names Jim Skogsbergh president and CEO. *News Release*. <https://www.advocatehealth.com/news/advocate-aurora-health-names-jim-skogsbergh-president-and-ceo>

We made it clear to the organization that if I made a decision, there was no going back to Lloyd and saying, “Lloyd, what do you think?” For the most part, Lloyd and I were talking to each other, were respectful of each other, were partners in everything, even down to selecting the founding organization management leadership team, even though certain of the people reported directly to him and the others reported directly to me. We sat down together and interviewed every person from both organizations who applied and mutually agreed on the selection of each person, regardless of which side of the organization it was on.

Lloyd and the late Bernard Tyson,<sup>44</sup> at Kaiser, and I were the Blacks in health care who were running the three largest organizations that were headed up by Black CEOs. Lloyd and I made a pact that we were going to look out for the best interests of our respective organizations, of course. But we also were going to make this work.

A lot of the compromise that goes into putting something like this together, we made work. It was the largest merger ever accomplished on the provider side of health care in the history of the United States. The magnitude was CommonSpirit operating in 21 states and the founding organizational size was \$29 billion in revenue. We had to get approvals from states attorneys general, we had to get the FTC approval, we had to get Catholic Church approval, bishop’s approvals, congregations’ approvals and all of that. It was a major undertaking. I’m proud to say that we broke through some glass ceilings. Lloyd and I both heard naysayers who said it would never work. I am proud to say that I was part of putting CommonSpirit together.

**GARBER:** Turning to volunteer service, you’ve served with many professional and community service organizations. How did you fit this into your busy schedule?

**LOFTON:** It is an opportunity to contribute to the greater good. No matter how large your individual organization may be, you impact the communities that you serve. But when you work on national organizations, whether it was NAHSE, ACHE, where I was formerly a regent at large, or AHA, you have an even greater opportunity to contribute to the greater good.

Early in my career, in Jacksonville, I came under the tutelage of Dr. Gerold Schiebler,<sup>45</sup> who was Chairman of Pediatrics, but also the lobbyist for the University of Florida, and he would take me to Tallahassee with him. I started getting involved in public policy things there.

When I was at Howard, I understood and learned more about the AHA, because of being on the board of the DC Hospital Association. My first Regional Policy Board role with AHA was when I was at Howard.<sup>46</sup> I was on RPB3. When I went to Birmingham, I was in RPB4. Along the way, I

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<sup>44</sup> Bernard J. Tyson (1959-2019) served at Kaiser Permanente for over 30 years in various leadership positions including CEO and chairman of the board of directors. [(2019, November 11) Obituary: Renowned health care leader Bernard Tyson. *AHA News*. <https://www.aha.org/news/headline/2019-11-11-obituary-renowned-health-care-leader-bernard-tyson>]

<sup>45</sup> Gerold L. Schiebler, M.D. (b. 1928), a pediatric cardiologist, served as professor at the University of Florida and as legislative liaison for the University of Florida Health Science Center. [(2000, March 18). *Gerold L. Schiebler, MD: Oral History Project*. American Academy of Pediatrics, Pediatric History Project. <https://pediatrics.med.ufl.edu/wordpress/files/2021/05/Schiebler-Interview.pdf>]

<sup>46</sup> Regional advisory boards, later renamed Regional Policy Boards (RPBs) were established by the American Hospital Association in 1968 in each of the nine regions of the country to help foster discussion of issues and to advise AHA staff and board members. [American Hospital Association. *Regional Advisory (now Policy) Boards*. <https://www.aha.org/about/history>]

was tracking equally with AHA and ACHE. I love ACHE, so this is not in any way to diminish what they do.

When I joined CHI and moved to a whole different region for both organizations, I did some soul searching and realized that I couldn't continue to keep advancing in leadership in both organizations equally. My love was public policy. I was aware of the impact that you could have in that regard, so I chose AHA as the organization that I wanted to continue to devote a large part of my outside time with.

You learn things that you take back home so your own organization is always benefitting. I did begin to track in AHA and move into additional levels of responsibility. I was added to the Committee on Nominations as an at-large member. A former AHA chair, Gordon Sprenger,<sup>47</sup> was the first person to approach me and ask if I had ever considered the AHA board. I hadn't thought about moving up that high in the organization but Gordie counseled me and I began to think about it. I applied for an interview and was selected as an at-large member of the board.

At AHA, I had a vast array of experience. When I was an at-large board member, Dennis Barry was the AHA chair.<sup>48</sup> Dennis appointed me to one of the at-large seats on the board executive committee, which gave me additional exposure to the AHA. After my first term was up, I took a year off back home and then applied and was selected that next year for the chair elect position.

**GARBER:** What is the role of the American Hospital Association and how can the AHA add value to hospitals?

**LOFTON:** There are so many things that the AHA does as it continues to evolve. You look at the various initiatives and people might say, "Why is the AHA getting involved in trying to help our nation's hospitals improve their quality? Why is AHA getting involved in equity and inclusion?" That is a myopic view and under the leadership of AHA presidents Dick Davidson and Rich Umbdenstock and Rick Pollack,<sup>49</sup> and then the various AHA chairs and boards, we saw the role as broader than that. The AHA continues to morph based on what our nation's hospitals need at the time and I commend the leadership for being able and ready and willing to step out there and do what's necessary.

One area that AHA delved into that is near and dear to my heart is equity in care. When I was coming out of my chair role in 2007, I was asked if there was an area that I would want to see the

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<sup>47</sup> Gordon M. Sprenger served as administrator of Abbott Northwestern Hospital (Minneapolis) and later of LifeSpan and Allina Health. His oral history: Garber, K.M., (Ed.). (2019). *Gordon M. Sprenger in First Person: An Oral History*. Chicago: American Hospital Association, can be retrieved from:

<https://www.aha.org/system/files/media/file/2019/12/gordon-m-sprenger-oral-history-transcript-2019.pdf>

<sup>48</sup> Dennis R. Barry (1939-2019), served as president and CEO of Moses Cone Health System (Greensboro, North Carolina) from 1979 to 2004. [(2019, November 19). Obituary: Former AHA chairman and N.C. hospital leader Dennis Barry. *AHA News*. <https://www.aha.org/news/headline/2019-11-22-obituary-former-aha-chairman-and-nc-hospital-leader-dennis-barry>]

<sup>49</sup> Richard J. Davidson (1936-2016), served as president and CEO of the American Hospital Association from 1991 to 2007. His oral history: Garber, K.M. (Ed.). (2015). *Richard J. Davidson in First Person: An Oral History*.

Chicago: American Hospital Association, can be retrieved from <https://www.aha.org/system/files/2018-03/richard-davidson-2010.pdf>; Richard J. Umbdenstock served as president and CEO of the American Hospital Association from 2007 to 2015. His oral history: Garber, K.M. (Ed.). (2020). *Richard J. Umbdenstock in First Person: An Oral History*. Chicago: American Hospital Association, can be retrieved from

<https://www.aha.org/system/files/media/file/2021/03/Umbdenstock-Oral-History-FINAL-WEB.pdf>;

Richard J. Pollack has served as president and CEO of the American Hospital Association from 2015 to the present.

AHA go into. They wound up asking me to lead what they initially called a “special committee” looking at the disparities of care in this country. I’m proud to say that I was the founding chair of the Equity of Care initiative, which lives on today, and was helpful in organizing the founding committee, which included influential people not associated with AHA, who gave good input.

**GARBER:** Let’s wrap up by talking about governance. What are your learnings as far as effective ways for a CEO to work with a board?

**LOFTON:** The relationship of the CEO with the board and board chair is a great partnership that begins with trust. The board chair has a difficult role. The easy part of the job is to run the meetings and do the organizational things with committees and the like. The difficult part is managing a diverse group of people, all with various backgrounds and expertise. There’s the balancing of holding management accountable and, at the same time, being there supporting management when they do a good job.

The CommonSpirit board, operating across 21 states, had all kinds of regional issues to deal with and the difficulty of merging the two organizations. The board chair has to be a person of high integrity, needs to have excellent communication skills, needs to be willing to take on difficult tasks,

You look for a board chair to be the person who will orchestrate all of the varied interests and issues and be a confidante, be transparent and direct when the CEO needs to hear some very difficult things, but also be there to support management when necessary with the board.

**GARBER:** Is there anyone else you would like to mention before we close?

**LOFTON:** We talked about mentors and being a mentee. People like Haynes Rice and Percy Allen and Pat Cahill, who influenced me, all three of them are in the *Modern Healthcare* Health Care Hall of Fame. The things that they accomplished in their careers speak for themselves.

There are other kinds of mentors who are more unsung. One of them was my great aunt, Mother Eugenia, leader of an order of Black Catholic nuns. I saw her in leadership roles, not that I knew what leadership was about when I was a kid watching her, but those things stick with you.

One other person that I would mention is Elizabeth Means.<sup>50</sup> Usually, you think of a mentor as someone at a higher level in the organization than you are. In this case, Liz was the director of nursing in the emergency department when I started my career. She and I both moved up the organization together. She moved up to be over ambulatory nursing, eventually becoming the chief nursing officer. When I was the COO, she worked for me again. I learned a lot of practical things from Liz including how to hold my ground and not wilt in a difficult meeting.

As a result of my mentors, I spent a great deal of my time mentoring other people, sometimes not even directly. I’ve begun diversity fellowships. Throughout my career, I’ve held adjunct faculty positions and taught classes at the University of Iowa, the University of Colorado-Denver, UAB,

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<sup>50</sup> Elizabeth G. Means (1936-2011) served at Shands Jacksonville hospital, ultimately becoming vice president of community relations. [Kerr J-L. (2011, January 11). 1936-2011: Shands exec also mom to 9, nurse. *The Florida Times-Union*. <https://www.jacksonville.com/story/news/2011/02/01/elizabeth-g-means-1936-2011-shands-exec-also-mom-9-nurse/15916241007/>]

Howard, Yale, and Harvard.

I'm proud of accomplishments in my own career, but I'm also proud of the people that I've helped with their careers over the years, particularly many people who are African-American. There have been a number of people who worked for me who later went on to become CEOs of different organizations.

I've tried to make sure that I made myself available to young people so they could see what my experiences have been. Mentorship is important, and I've devoted a lot of time and attention to helping to develop the careers of other people.

**GARBER:** Thank you for your thoughts and your time today.

**LOFTON:** I enjoyed it. I can't wait to see how this turns out. I thank you.

### **EDUCATIONAL & PROFESSIONAL CHRONOLOGY**

1976	Boston University, Questrom School of Business Bachelor of Science, Management
1976-1977	Harvard Medical School (Boston) Staff assistant, Office of Admissions
1977	Harvard University (Cambridge) Accounting course work
1978-1979	Memorial Medical Center (Corpus Christi, Texas) Administrative resident
1979	Georgia State University (Atlanta), J. Mack Robinson College of Business Master's, Health services administration
1979-1990	UF Health-Jacksonville (Florida) fka Shands Jacksonville Medical Center 1979-1980 Administrator, Emergency Medicine Services 1980-1981 Administrator, Material Management 1981 Acting Associate Executive Director, Patient Services 1981-1982 Assistant Vice President, Ambulatory Services 1982-1986 Vice President, Professional Services 1986-1990 Executive Vice President and Chief Operating Officer
1990-1993	Howard University Hospital (Washington, DC) Executive Director and Chief Executive Officer
1993-1998	University of Alabama Hospital (Birmingham) Executive Director and Chief Executive Officer
1998-2020	Catholic Health Initiatives (Denver)

	1998-1999	President, Southeast Region (Louisville, Kentucky)
	1998-1999	Group President, Louisville office
	1999-2003	Executive Vice President and Chief Operating Officer
	2003-2020	Chief Executive Officer
2019-present	CommonSpirit Health (Chicago)	
	2019-2020	Chief Executive Officer
	2020-present	CEO Emeritus

## SELECTED MEMBERSHIPS AND AFFILIATIONS

### American College of Healthcare Executives

Life Fellow (LFACHE)  
Regent at Large, District 3

### American Hospital Association

Chairman, Board and Executive Committee  
Chair, AHA Political Action Committee  
Chair and Member, Committee on Nominations  
Founding Board Member, Institute for Diversity and Health Equity  
Founding Chair, Equity in Care Committee  
Member, Board

### Ascension Health

Member, Audit Committee  
Member, Board  
Member, Quality and Finance Committees

### Cardinal Spellman High School (Bronx, New York)

Member, Board  
Chair, Equity and Inclusion Committee

### Catholic Conference of Kentucky

Member

### Catholic Health Association of the United States

Chair, Finance Committee  
Diversity, Committee  
Member, Board of Trustees and Executive Committee  
Member, Committee on Nominations

### Executive Leadership Council

Member

### Georgia State University

Member, Dean's Advisory Board, J. Mack Robinson College of Business  
Member, GSU Foundation Board

Vice Chairman, GSU Foundation Board  
Chair, Nominations and Governance Committee

Health Research Development Institute  
Member

Healthcare Institute  
Chair, Membership Committee  
Chair, Program Committee  
Vice Chair, board

Morehouse School of Medicine  
Member, Academic Affairs Committee  
Member, Board  
Member, Clinical Services Committee

National Association of Health Services Executives (NAHSE)  
National President

Spalding University  
Member, Board of Trustees

University of Alabama School of Medicine  
Member, Board of Visitors

University of Colorado-Denver, Center for Health Administration  
Adjunct Faculty

### **AWARDS AND HONORS**

- 1987 Young Administrator of the Year, National Association of Health Services Executives
- 1993 Robert S. Hudgens Award, American College of Healthcare Executives
- 2001 Corporate Leader of the Year Award, *The Healthy Caregiver*
- 2001 Professional Achievement Award, Georgia State University
- 2002 100 Most Influential People in Healthcare, Modern Healthcare magazine (also annually 2004 through 2020)
- 2006 National Diversity Healthcare Leader of the Year Award, U.S. Hispanic Chamber of Commerce
- 2006 Top 25 Minority Healthcare Executives (biennial award, also 2008-2020)
- 2007 150 Most Influential Black People in America, *Ebony* magazine



- 2009 President's Leadership Award, National Association of Health Services Executives
- 2010 Pierre Toussaint Medallion, Archdiocese of New York
- 2014 Richard L. Clarke Board of Directors Award, Healthcare Financial Management Association
- 2015 Gold Medal Award, American College of Healthcare Executives
- 2016 Doctor of Humanities in Medicine, *Hon. Caus.*, Baylor College of Medicine (Houston)
- 2016 Hall of Fame Award, Georgia State University, J. Mack Robinson College of Business
- 2017 Distinguished Alumni Award, Georgia State University
- 2017 McKinley Harris Distinguished Warrior Award, Urban League of Metropolitan Denver
- 2021 Distinguished Service Award, American Hospital Association
- 2022 Influential Leaders Class of 2022, AACSB International

### **SELECTED PUBLICATIONS & INTERVIEWS**

Lofton KE. Administrative outlook: medical education in the emergency department. *Emerg Med Serv.* 1981 Jan-Feb;10(1):9-10, 13-20. PMID: 10249597.

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