WHITE PAPER

Efficiency Is a Design Choice

Using Technology, AI and Operating Discipline to Expand Healthcare Capacity

Eliminate → Simplify → Standardize → Automate → Augment → Measure

Deja Gilbert, PhD, MBA, FACHE

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Personal examples are drawn from across the author's career and are generalized; they do not describe any single organization.

Introduction

I started my career as a therapist. I spent my days in sessions and too many of my nights on documentation, finishing notes that existed as much to satisfy a system as to support care. More than twenty-five years later, I'm the one who signs the software contracts.

In between, I've sat in nearly every seat a healthcare workflow touches: clinician, regional director, executive director, chief business officer, chief operating officer, and CEO, in both for-profit and nonprofit organizations. From every one of those seats I've seen the same thing, and I'll say it plainly:

> Most of healthcare's capacity problem is not a people problem or a technology problem. It is a design problem that leaders keep trying to solve with people and technology.

I've been on both ends of that problem. As a clinician, I lived with systems nobody had redesigned the work for. As an executive, I've looked at a clinical documentation technology contract and realized most of what we were paying for was going unused. That isn't a technology failure. It's what happens when you buy the tool before you design the work. Most executives have been there. Few say so out loud.

The pressures are real. Demand for care keeps rising. Federal projections point to a shortage of more than 141,000 physicians and nearly 109,000 registered nurses by 2038.[1] Administrative burden keeps growing. Margins remain thin. And the standard playbook hasn't changed in decades: add staff when you can find them, add technology when you can afford it, cut costs when you can't do either.

Every one of those responses skips the question I now ask before any other:

How much of the work itself is poorly designed?

The evidence says: a lot. In a widely cited time-and-motion study, physicians in ambulatory practice spent nearly two hours on electronic health record and desk work for every hour of direct clinical time with patients, then another one to two hours each night on additional computer and clerical work.[2] I didn't need the study to believe it. I lived a version of it.

The same pattern shows up at the system level. Administrative spending accounts for roughly a quarter of total US healthcare spending, and McKinsey has estimated that about 30 known interventions could reduce it by up to $265 billion a year while holding or improving access and quality.[3] That isn't a shortage. That's time and money we are choosing to spend on badly designed work.

Here is where I've landed:

Efficiency is a design choice.

It is not a byproduct of hard work, the automatic result of a technology purchase, or a polite word for cost cutting. Leaders create it deliberately, or it doesn't happen.

Technology alone is not transformation. AI alone is not efficiency. Automation applied to a bad process simply makes a bad process move faster.

The executive responsibility is to redesign work before digitizing it. This paper lays out the sequence I use to do that, why the order matters, and what it demands of the people at the top, including me.

SECTION 1

The Wrong Definition of Efficiency

I've run P&Ls on both sides of healthcare: as CEO of a multi-state, for-profit company accountable for profitability, and as a nonprofit CEO working on Medicaid-dependent margins. The language is different. The mistake is the same.

Efficiency has become one of the most loaded words in healthcare. Staff hear it and brace for cuts, and I understand why. Every executive who has led through a hard financial stretch, myself included, has had to make workforce decisions. Those decisions are sometimes necessary. But they are not the same thing as efficiency, and treating them as interchangeable is how organizations lose the trust they need for real redesign.

The distinction matters because the confusion is expensive. Cost cutting that isn't paired with redesign makes an organization *less* efficient. When a role goes away but the work attached to it stays, that work moves to someone else, usually someone with less time, less context, or less authority to do it well. Reduce a support function without redesigning the process it supported, and you get delay, rework, and burnout further down the line. Expense goes down on paper. Capacity goes down in practice.

The opposite also works. Some of the cleanest savings I've seen across my career came from removing things, not people: auditing every mobile line and cancelling the ones nobody could justify, retiring forms nobody used, consolidating internet circuits under one contract. That's efficiency without taking it out of people.

True efficiency is the better use of time, talent, systems, and capital. Its purpose is to improve the organization's ability to deliver care, not to shrink expense for its own sake.

The difference shows up in the question you start with.

COST REDUCTION ASKS	OPERATIONAL DESIGN ASKS
"What can we spend less on?"	*"How should the work function?"*

The first question produces a list of line items. The second produces a better operating model, and in my experience, better economics follow as a consequence rather than as the only goal.

A cost lens looks for spending. A design lens looks for friction: handoffs that add delay, approvals that add no value, reports nobody reads, documentation captured twice, and coordination work that eats the time of your most skilled people.

That friction is where most of healthcare's lost capacity lives. It rarely shows up on a budget. In my years on the revenue side of healthcare, I learned it shows up somewhere else: in authorizations that sit, claims that bounce, and schedules that never quite fill.

So before my team decides what to cut or what to buy, I ask one question: do we actually understand how the work flows? If the answer is no, we're not ready to do either.

SECTION 2

Technology Is Not Transformation

When capacity problems get urgent, technology looks like the fastest answer. A new platform promises visibility. A new tool promises automation. A new system promises to replace the spreadsheets, the email chains, and the workarounds.

Sometimes it delivers. Usually it delivers less than promised, and the reason is almost never the software.

A software purchase is not a workflow change.

The pattern is predictable. Organizations take a process that was never designed well and move it, intact, into a new system. An approval chain that required five signatures on paper now requires five clicks. A report built for a meeting that no longer happens becomes an automated dashboard that still gets produced every week. Communication that was scattered across inboxes moves into a new channel and stays just as scattered.

The inefficiency hasn't been removed. It's been digitized, and now it's harder to change, because it lives in configuration, training, and habit.

> *A bad process does not become a good process because it has a login screen.*

I'll take a position here that some of my peers won't love: **the EHR didn't burn out our clinicians. We did.**

Electronic health records brought real advances in access to information, safety checks, and data. But too many organizations, at times including ones I've helped lead, paved over paper-era documentation instead of rethinking it. I started as a therapist. I know what it feels like to finish a note late at night that satisfied the system but did nothing to improve care. That isn't a technology failure. It's a leadership failure to redesign the work before automating it.

I'm not anti-technology. I've led technology modernization at enterprise scale, and I'd do it again. My argument is about sequence.

Technology should support a redesigned operating model. It should not *be* the operating model. When organizations treat a system selection as the transformation, they skip the harder and more valuable work: deciding what the process should look like before deciding what tool will run it.

I've tested this on myself. When frustration with an EHR peaks, the easy answer is a new EHR. In one organization I've led, we went to market: a formal RFP, multiple vendors, our incumbent invited to bid against them. The best answer turned out not to be a migration. It was a redesign on the platform we already had, with clinical, medical, and operations leaders jointly setting build priorities. A migration would have moved the old workflows behind a new login screen. The redesign forced us to decide what the workflows should be.

MY RULE

No new system gets approved until someone can show me the redesigned workflow and a viable plan to implement it. Not a demo. Not a vendor timeline. A workflow and a plan.

SECTION 3

The Six-Step Framework

If efficiency is a design choice, leaders need a practical way to make that choice well. This is the sequence I use:

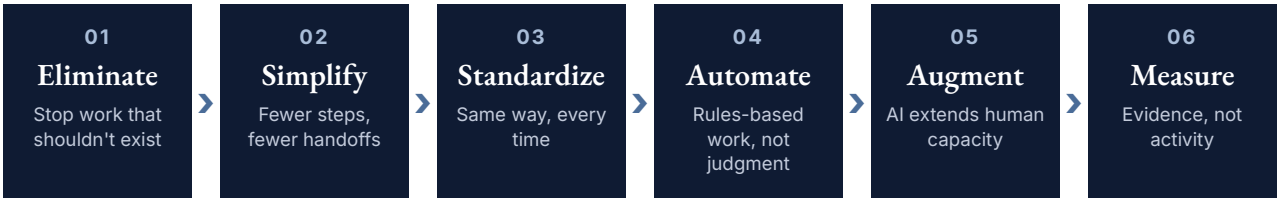


Figure 1. A practical sequence for technology-enabled healthcare efficiency. Each step earns the right to the next.

The order matters as much as the steps. Most organizations start in the middle, at Automate, because that's where the vendor conversation starts. Early in my career, I did too. It took a few expensive lessons to learn that the order is the strategy. The framework forces leaders to earn the right to automate by doing the design work first.

1 Eliminate

The first question is not how to do the work faster. It's whether the work should exist at all.

- Is this report still used, and by whom?
- Is this meeting necessary?
- Is this approval step adding value, or only time?
- Is this documentation duplicating something already captured elsewhere?
- Is this work being done only because "we've always done it"?

The most efficient process is the one you stop doing. Elimination is uncomfortable because every task has an owner, a history, and sometimes an identity attached to it. But it's the cheapest, highest-return step in the sequence, and it's the one almost everyone skips.

I was a COO during the height of COVID. Like every operator, I watched organizations stop doing in weeks what they had defended for years, and a lot of it never came back because nobody missed it. Elimination isn't a capacity problem. It's a permission problem.

I've also seen what happens when leaders give that permission on purpose. In one standardization effort, the menu of lab orders clinicians could choose from went from hundreds of options to a few dozen. A data governance review retired dozens of EHR forms nobody needed. And my favorite example is a project that never happened: a team was about to build a new assessment form until someone asked whether it was actually required. A compliance check said it wasn't. The cheapest software build is the one you cancel.

> **MY RULE**
> *Don't automate waste. Kill something before you buy something.*

2 Simplify

Once unnecessary work is gone, simplify what remains: fewer steps, fewer handoffs, consolidated approvals, shorter forms, clearer responsibility.

Complexity consumes labor, attention, time, and management bandwidth. Every handoff is a chance for delay; every extra step is a chance for error. On the revenue side of healthcare, where I spent years as a chief business officer, a handoff isn't just an inefficiency. It's the moment a patient waiting for care decides to go somewhere else.

That's why some of the most valuable redesign work I've seen is unglamorous: an admissions pre-screen rebuilt to ask fewer questions, or a four-page PDF with more than ninety fillable fields turned into a single tracked form. Nobody puts that in a press release. Everyone who touches the work feels it.

> **MY RULE**
> *Simplify on a whiteboard before anyone touches configuration.*

3 Standardize

With a simpler process in place, decide what should work the same way every time, across sites, departments, and teams, and give it a defined owner, trigger, and escalation path.

Standardization is not bureaucracy. Done well, it frees people from reinventing routine work so they can save their judgment for where judgment is needed. Leading organizations across as many as five states at once taught me that unmanaged variation isn't local flexibility. It's hidden cost.

Variation hides in small places. Discharge reasons coded differently on different forms. The same data captured in three places with three sets of picklists. Each one looks harmless at a single site. Across dozens of programs, it means reports leaders can't trust and decisions made on bad numbers. Standardizing those codes isn't exciting work, but it's what makes every report, dashboard, and AI summary built on top of them worth reading.

> **MY RULE**
> *You cannot automate chaos consistently.*

4 Automate

Only now does automation enter the picture, aimed at repetitive, rules-based work: notifications, reminders, routing, data transfers, and the coordination that eats time meant for judgment. Automation should remove low-value administrative friction. Applied to a process that has already been eliminated, simplified, and standardized, it compounds the gains. Applied before that work, it locks in the problems.

> **MY RULE**
> *Automation is not the goal. Capacity is.*

5 Augment

AI belongs here, after the work has been designed, and its job is to extend human capacity rather than replace human judgment. **AI should create more human capacity, not merely fewer humans.** Section 4 goes deeper.

> **MY RULE**
> *Point AI at the work that keeps your best people from doing their best work.*

6 Measure

Finally, leaders have to know whether the redesign worked: cycle time, labor hours, quality, decision speed, employee burden, access, and financial performance. Without measurement, you have activity, not evidence.

> **MY RULE**
> *A go-live is not evidence of anything.*

Why the sequence matters

Each step makes the next one more effective. Eliminating work reduces what needs to be simplified. Simplifying makes standardization easier. Standardization makes automation reliable. Automation clears the administrative noise so AI can focus on higher-value work. Measurement closes the loop and tells leaders where to go next.

Skip the early steps and the later ones get expensive. The cheapest, highest-return decisions come first, and they are leadership decisions, not technology decisions. No vendor can make them for you.

SECTION 4

AI Should Create Human Capacity

Few topics in healthcare leadership generate more noise right now than artificial intelligence. The conversation splits into two camps: AI will change everything, or AI is overhyped. Neither is much use to an operator trying to decide what to do on Monday.

I felt that noise firsthand at a recent industry conference. I stopped trying to count the AI vendors. Every booth, every hallway, every panel had a platform, a plug-in, or an agent promising to transform something. Here's what I took home: the world is changing, and healthcare leaders who refuse to adapt will end up running yesterday's organization. But adapting doesn't mean buying. When every vendor in the room has an AI answer, the scarce skill isn't access to technology. It's knowing which work deserves it. That's what this framework is for.

I come at this as a clinician first. I've sat across from people in some of the hardest moments of their lives. I know, in a way no vendor demo can teach, which parts of care only a human can do. That shapes everything I believe about AI.

> *The question is not where AI can replace people. It's where AI can give time back to the work only people can do.*

I'll be blunt about the other side of that: **if your AI business case is headcount reduction, you've already lost your workforce, and your patients will feel it next.** In a sector where workforce shortages are structural, organizations that use AI mainly to thin out their teams will end up with fewer people and the same broken workflows.

In most healthcare organizations, highly trained people spend a large share of their day on work that doesn't require their training: searching for information, re-entering data, summarizing records, drafting routine communication, preparing for meetings, and chasing status. That's where AI delivers its clearest value today: summarizing and synthesizing records, drafting routine documents, surfacing trends and priorities sooner, retrieving knowledge, removing coordination overhead, and organizing information so executives can decide faster. Every good use case supports high-value human work rather than substituting for it.

Ambient clinical documentation is the instructive example. In one large medical group, ambient AI scribes were used more than 2.5 million times in roughly their first year, with an estimated 15,700-plus hours of documentation time saved for physician users, roughly the equivalent of 1,794 working days. Most physicians reported a positive experience, and patients reported a positive or neutral

15,700+

estimated hours of documentation time saved for physician users of ambient AI scribes in one large medical group, across more than 2.5 million uses in roughly their first year.[4]

effect on their visits.[4] Notably, the benefits were concentrated among the physicians who used the tool most consistently. The technology created capacity, but adoption decided how much.

Some things stay human. Clinical judgment, ethical decisions, empathy, accountability, and leadership cannot be delegated to a model. AI can inform those decisions. It should not make them. As a therapist, I'd add one more: the therapeutic relationship itself. Nothing about it is automatable, and leaders who forget that will design the humanity out of care.

Finally, AI strategy belongs to workflow design, not novelty. Before I ask "which AI tool should we buy?" I ask "what work should this free up, and what will we do with that time?" If I can't answer the second question, I'm not ready for the first.

I've learned this the expensive way. I once reviewed a clinical documentation tool that was licensed broadly and used narrowly. Clinicians relied mostly on its lightest mode. High-volume and group care settings, where documentation burden is heaviest, weren't using it at all, partly because of connectivity and device issues nobody had designed around. The capabilities that could have supported supervision, training, and quality review were sitting idle.

The task I put on my own list was blunt: **assess and eliminate, or actually use.** My position then is my position now: we know the potential of these tools and we're willing to invest in them, but we won't keep paying for a product we can't fully use and justify.

The next implementation looked different, and the difference was design, not software. We started with a small pilot in one region. We built documentation templates for the way care is actually delivered, individual and group encounters alike, instead of forcing clinicians into a generic format. We updated consent workflows before training began, not after. Adoption, not installation, decides how much capacity any tool actually creates, and that applies to AI more than anything that came before it.

SECTION 5

Executive Teams Need an Operating System

I know what it's like to be the person everyone emails when they want to know where something stands. And I can tell you: **most strategies don't fail because the strategy was wrong. They fail because execution lives in too many places.**

Priorities live in slide decks. Decisions live in inboxes. Commitments live in meeting notes no one revisits. Accountability lives in someone's memory. When a leader wants to know where something stands, they send an email, schedule a meeting, or ask someone to build a status report, and each of those eats time that should have gone to the work itself.

For most of healthcare's history, that was simply the cost of running a complex organization. It doesn't have to be anymore. Work management platforms and AI have matured to the point where the status chase, the rebuilt decks, and the hunt for the latest version can largely disappear. That is a genuinely new opportunity for executive teams, and most haven't taken it yet.

> *Email is not an operating system. Meetings are not an operating system. Neither is a shared drive full of spreadsheets.*

A real executive operating system creates **ownership, visibility, due dates, dependencies, escalation, accountability, recorded decisions, and institutional memory**: a shared view of what's happening, who owns it, and what's stuck, without anyone having to ask.

Technology plays an important role here, but its job is not more dashboards. Its job is to connect strategy to execution, so the organization's top priorities become owned, sequenced, trackable work, and leaders can manage by exception instead of by status meeting.

In practice, that means moving executive work onto a shared work management platform, standardizing how priorities, projects, and decisions are captured, and using AI to summarize progress, surface risks, and cut the administrative load of keeping everyone aligned. The specific tool matters far less than the discipline: one source of truth, consistent structure, and leaders who actually use it.

One version of this I've used: every executive's recurring report goes into a single shared intake point, and an AI agent reads each report and routes every update to the specific initiative it belongs to, so progress lands next to the work instead of in an inbox. Nobody rebuilds a status deck before a meeting. I don't have to ask for updates; I read them where the work lives, and the meeting time goes to decisions and escalations instead of recitations.

> **MY STANDARD**
> *If my executive team can't answer "where does this stand?" without an email chain, the problem isn't effort. It's design. And it's mine to fix.*

SECTION 6

Adoption Starts at the Top

I've said it before and I'll say it here: every interaction in the business world is one of psychology. I'm trained in behavior change, so let me say clearly what I think most technology rollouts get wrong:

Adoption is a behavior problem before it is a technical one, and the behavior that matters most is the CEO's.

The pattern is common across healthcare. A new system launches. Frontline teams are trained and told to adopt it. Managers are asked to enforce it. Meanwhile, the senior leadership team keeps running the organization the way it always has: through email, side conversations, personal spreadsheets, and informal workarounds.

Staff notice. Every time.

> *Digital transformation cannot be delegated to IT while the executive team keeps working exactly as it always has.*

Leaders model what they expect. When executives treat a new system as optional for themselves, they signal that it's optional for everyone. When they use it visibly, ask for updates through it, and make decisions in it, they signal that this is how the organization works now.

That's why my own behavior had to change first. My decisions, comments, and follow-ups go where the work is tracked, not into side emails. **If it isn't in the system, it isn't real yet.** That isn't about control. It's about making the system the place where the organization's work actually happens, starting with mine.

Three implications for senior leaders:

Adoption requires discipline, not optional participation. If the old way of working stays available and acceptable, most people will keep using it. Leaders have to retire the old channels deliberately, not just add new ones.

Leaders need enough fluency to challenge the design. You don't need to be a technologist. But I went back for an MBA twenty-five years into my career because I believe leaders never get to stop learning, and technology is no different. You need to understand the tools well enough to ask whether a workflow was redesigned or merely digitized, whether the configuration supports the operating model, and how value will be measured. Without that fluency, technology decisions default to vendors and implementation teams, and the hardest design questions never get asked.

Consistency is the multiplier. When an organization commits to one way of working, it gets one source of truth. When the old channels stay open alongside the new ones, people reasonably keep using what's familiar, and the new system never gets the chance to prove its value. That isn't a people failure. It's a design choice, and it starts with the CEO.

> **THE TEST I USE ON MYSELF**
> *If my own meetings, priorities, and decisions aren't running on the new system, we haven't adopted it. We've just bought it.*

SECTION 7

Implementation Is Not ROI

Technology projects in healthcare get managed toward a single date: go-live. Budgets, project plans, vendor milestones, and executive updates all point at the moment the system turns on. When that date arrives, the team celebrates, the project closes, and attention moves to the next initiative.

I've stopped celebrating go-lives. That's the moment most organizations stop asking the only question that matters.

I learned this as a patient before I learned it as an executive. Years ago, I had knee surgery to remove nodules that were causing pain. The procedure went exactly as planned. Every nodule came out. But the knee still didn't work right, and when I raised it at my follow-up, the answer was essentially this: the surgery was a success. The nodules were gone. What the knee did without them was a different issue.

By the definition of success we had agreed to, he was right. He did exactly what he set out to do. But I never wanted a nodule-free knee. I wanted a knee that worked. Years later, I'm still waiting on that part.

That's the gap between implementation and performance, and healthcare technology falls into it constantly. When the procedure is the deliverable, the outcome becomes someone else's problem.

> *Go-live is a milestone, not an outcome. Implementation is not ROI.*

The question isn't whether the tool was installed. It's whether the tool changed the work, and whether that change improved performance. I've watched an integrated platform launch on schedule, then spend months sending data late or into the wrong record. The project plan said "complete." The work said otherwise. Eventually the vendor conversation became very simple: resolve every open issue by a fixed date, or we don't renew.

Contrast that with a rollout where go-live was the start of measurement, not the end of the project. We set an initial utilization target, kept the project open to track it, and kept adding support until adoption caught up with the license.

Answering the real question takes three layers of measurement.

ADOPTION METRICS

Whether people are using the system as intended: active users, workflow completion inside the system, and the decline of parallel workarounds.

WORKFLOW METRICS

Whether the work itself changed: cycle time, handoffs, rework, error rates, and missed deadlines.

OPERATING & FINANCIAL METRICS

Whether the change mattered: staff productivity, overtime, vacancy coverage, throughput, access, collections, margin, and employee burden.

The discipline that makes measurement work happens before implementation, not after. **Define expected value before you buy.** What will be different six months after go-live? Which measures will show it? Who owns the result? If those questions can't be answered at the start, they won't be answered at the end.

> **MY STANDARD**
>
> *A technology proposal without a named owner and a six-month measure doesn't make it to my desk.*

The measure isn't whether the project finished on time. It's whether the organization works better because of it.

SECTION 8

Efficiency Eventually Shows Up in the Financials

I've been accountable for profitability as CEO of a multi-state, for-profit company, and accountable for sustainability on Medicaid-dependent margins as a nonprofit CEO. Investors and boards ask different questions in those two worlds. But they end up in the same place: **show me where it lands in the numbers.**

They're right to ask. Operational design is not an abstract exercise. Done well, it should eventually show up in the financials.

Not every redesign produces an immediate line-item saving, and less burnout, faster access, and fewer errors matter in their own right. But better-designed work should, over time, strengthen the organization's economics.

The mechanisms are practical:

- **Better workflow** can reduce labor waste and administrative overhead.
- **Faster decisions** in authorizations, billing, scheduling, and approvals can improve cash flow, throughput, and access.
- **Standardization** can reduce rework, errors, and re-entry.
- **Automation** can remove low-value manual coordination.
- **AI** can expand capacity without proportional headcount growth, so organizations can serve more people or absorb growth without adding staff at the same rate.

Taken together, these effects can support margin, cash, access, and growth capacity. In a sector where workforce shortages are structural and margins are narrow, creating capacity through design rather than headcount alone is a strategic advantage. Having led under both models, I'd argue it's the one that matters most.

A word of discipline. I've seen efficiency claims oversold in board rooms and investor decks, and I've seen what that does to the credibility of the next initiative. Describe what you redesigned with confidence. Describe financial outcomes with caution, grounded in measured results rather than projections. The credibility of your next initiative depends on the honesty of your last one.

The operating implication: connect efficiency work to the financial plan from the start, with clear hypotheses about where capacity will be created and how it will be used. Because here's the part most plans miss:

> *Capacity you don't redeploy is just a nicer word for slack. It never shows up in the financials. It simply disappears into the day.*

SECTION 9

What I Got Wrong

I want to be honest here, because it's the section most executives skip.

I didn't build this framework from a textbook. I built it from the order I wish I'd followed.

I reached for a mandate when the problem was design. With the underused documentation tool I described earlier, my first instinct was to require everyone to use the full version. It sounded decisive. It was the wrong fix. A mandate would have pushed people to automate a process that hadn't been designed for them. The real answer was to go back to the start of the sequence.

I once let go-live get ahead of support. On a rollout I led, the tool went fully live before the internal team had been trained to troubleshoot it. For the first weeks, staff with access problems had to be routed to the vendor because we couldn't help them ourselves. We closed the gap, and I've sequenced it differently ever since: internal support readiness is part of the design, not a follow-up task.

I've let technology move faster than the workflow. More than once, I've seen a system build scoped and ready while the business redesign it depended on wasn't finished, and the project stalled for months. That isn't IT's failure. It's a leadership failure to sequence the work, and it's the clearest argument I know for Eliminate and Simplify coming first.

What I take from all three is the reason this framework exists. I'd rather spend a month redesigning than three years living inside a digitized version of the old problem.

Conclusion

Healthcare's capacity problem is real, and no single lever will solve it. We'll need more clinicians, better technology, and disciplined financial management. But we also need what's usually missing from the conversation: deliberate attention to how the work itself is designed.

The framework in this paper is the sequence I use for that work:

Eliminate → Simplify → Standardize → Automate → Augment → Measure

For the CEO About to Sign a Software Contract

If there's a contract on your desk right now, here's what I'd ask before you sign it:

1. **What are we going to stop doing?** If the answer is nothing, you're about to automate waste.
2. **Can someone show me the redesigned workflow and a viable plan to implement it?** If not, you're buying a tool for a process that doesn't exist yet.
3. **Who owns the result, by name?** Not the project. The result.
4. **What will be measurably different six months after go-live?** Cycle time, rework, labor hours, access, margin. Pick them now.
5. **Will my executive team use it first?** If we won't, nobody will.

If you can't answer all five, don't sign yet. That isn't caution. That's leadership.

None of this depends on buying the newest tool. Most of it depends on leadership.

Healthcare organizations don't become efficient because leaders tell people to work harder. They become efficient because leaders deliberately design the work.

There will be more AI vendors at next year's conferences than this year's. That's a good thing. The pace of change is real, and leaders have to keep up. But the organizations that win won't be the ones that bought from the most of them.

> The future of healthcare efficiency will not be defined by who buys the most technology. It will be defined by who redesigns work most intelligently, and then uses technology and AI to make that design scale.

I've spent more than twenty-five years in nearly every seat this work touches, from the therapist's chair to the CEO's. From every one of them, the lesson has been the same.

Efficiency is a design choice. I'm making it deliberately. I hope you will too.

ABOUT THE AUTHOR

Deja Gilbert, PhD, MBA, FACHE, is a healthcare CEO and clinician-executive with more than 25 years of experience leading complex care-delivery organizations. Her expertise spans P&L leadership, finance, growth, multi-state operations, business development, healthcare economics, organizational transformation, real estate, healthcare facility design/build, capital allocation and clinical delivery.

She has served as CEO, COO and Chief Business Officer across commercial and nonprofit healthcare environments and has led organizations through expansion, restructuring, market change and significant enterprise transformation. A Fellow of the American College of Healthcare Executives, Gilbert also mentors developing healthcare leaders and writes and speaks on healthcare strategy, economics, organizational performance, technology, leadership and the future of care delivery.

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