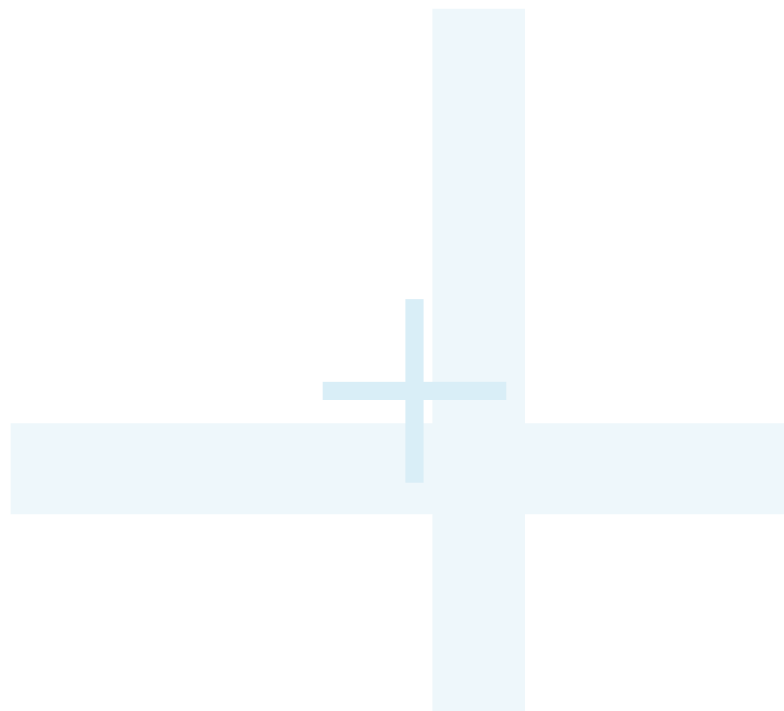


# LEADING THE HEALTHCARE ENTERPRISE THROUGH UNPRECEDENTED CHANGE



Insights from the Wellspring+Stockamp, Huron Healthcare 2010 CEO Forum



## Leading the Healthcare Enterprise Through Unprecedented Change: Insights from the Wellspring+Stockamp, Huron Healthcare CEO Forum

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In October 2010, Wellspring+Stockamp, Huron Healthcare convened a summit of CEOs from some of the top healthcare organizations in the United States. The purpose of this invitation-only CEO Forum was to provide an environment in which executives could discuss ideas and best-practice strategies for achieving excellence in managing the healthcare enterprise through a time of unprecedented change.

Facilitated by Chairman Dean Harrison, CEO of Northwestern Memorial Health System, over the course of two days, the executives' peer-to-peer discussions centered around two principle areas: 1) best practices for addressing key industry issues critical for long-term success, and 2) achieving transformative leadership.

CEOs realize they need to lead through major transition over the next 5 to 10 years regardless of healthcare reform—and that not all organizations will still be standing at the end of this period.

How will healthcare executives address these pressing issues facing their organizations? *Leading the Healthcare Enterprise Through Unprecedented Change: Insights from the Wellspring+Stockamp, Huron Healthcare CEO Forum* shares insights and analyses from the Wellspring+Stockamp CEO Forum attendees. The report also shares the perspectives of experts from the field of aviation who joined to present best business practices and lessons learned in an industry that is, like healthcare, highly regulated and ever-changing.

Jim Roth  
CEO, Huron Consulting Group

## 2010 CEO FORUM ATTENDEES

See full attendee bios on pages 25-26

Dean M. Harrison  
2010 CEO Forum Chair  
President & CEO  
Northwestern Memorial HealthCare

Marna P. Borgstrom  
President & CEO  
Yale-New Haven Hospital and  
Yale New Haven Health System

Scott W. Bosch, MHA, FACHE  
President & CEO  
Harrison Medical Center

Stephen G. Carlson  
President & CEO  
Community Medical Center

Mitchell R. Creem  
CEO  
USC University Hospital  
and USC Norris Cancer Hospital

David T. Feinberg, MD, MBA  
CEO & Associate Vice Chancellor  
UCLA Hospital System  
and Health Sciences

Peter S. Fine, FACHE  
President & CEO  
Banner Health

Rajiv K. Garg  
President & CEO  
Wyckoff Heights Medical Center

Kenneth D. Graham, FACHE  
President & CEO  
El Camino Hospital

M. Michelle Hood, FACHE  
President & CEO  
Eastern Maine Healthcare Systems

Robert Issai  
President & CEO  
Daughters of Charity Health System

Gary S. Kaplan, MD  
Chairman & CEO  
Virginia Mason Health System

Joseph M. Kortum  
President & CEO  
Southwest Washington Medical Center

Kevin D. Schoeplein  
Incoming CEO  
OSF HealthCare

Alfred G. Stubblefield  
President & CEO  
Baptist Health Care Corporation

## EXECUTIVE SUMMARY

It is clear what is at the peak of the healthcare delivery “mountain”—high quality, affordable care with universal access. There’s more than one way to reach that pinnacle, but the pressure is on to get there, and get there fast.

### THE ISSUES CEOs IDENTIFIED AS CRUCIAL AT THIS TIME ARE:

- » Cost Reduction & Utilization Management
- » Business Model Shifts: Risk Sharing & Population Management
- » Consolidation
- » Changing Role of IT & the Value of Data
- » Physician Integration & Clinical Process Improvement
- » Consumerism & the Patient Experience

CEOs at the Forum agreed: An unprecedented confluence of industry trends—healthcare reform being just one of them—is creating an environment in which healthcare delivery and payment in the United States must be fundamentally changed.

To survive in the short term, hospitals must contain and reduce costs wherever possible and capture all revenue they are due. In the longer term, cost-containment alone will not create the savings needed to operate at declining reimbursement rates.

To do that, CEOs are beginning to once again use those charged terms, “care management” and “managing utilization.” However, the framework of the discussion has changed substantively from the 1990s when utilization management was vilified as an attempt to drive healthcare costs down through “rationing.”

The Forum participants discussed managing care in the framework of how a core shift from the fee-for-service business model towards a risk sharing model is the most likely solution to fundamentally improving

care quality, as well as driving waste—and therefore cost—out of the system, making care more affordable for both patients and payers.

Among many other significant challenges, that shift will mean aligning the interests of many stakeholders—from patients to physicians to payers—to an unprecedented degree. It will also mean developing organizational capabilities of managing clinical and financial risk.

To manage this transition from the old business model to the new, and to “reach the peak,” executives from a range of organizations—large health systems, academic medical centers, integrated delivery systems, and community hospitals—shared the opinion that there is a need for transformative leadership and thoughtful innovation in healthcare. There was also consensus on the need to look outside the healthcare industry for successful models for doing so. To that end, Rick Stephens, Senior Vice President of The Boeing Company and Captain Chesley B. “Sully” Sullenberger, both shared their insights with Forum participants on key elements of transformative leadership.

Forum participants also agreed that they must address key industry issues outlined in this report head-on—with energy and excitement. As one CEO pointed out, “Misery is optional.”

Another noted that this is “one of the most exciting times in my career.” The issues CEOs identified as crucial at this time are:

- » Cost Reduction  
& Utilization Management
- » Business Model Shifts:  
Risk Sharing & Population Management
- » Consolidation
- » Changing Role of IT & the Value of Data
- » Physician Integration &  
Clinical Process Improvement
- » Consumerism & the Patient Experience

Changing incentives and new imperatives for quality, affordability and service are requiring a new course for providers. It will be up to CEOs to establish a new approach to healthcare within their own organizations, create a plan for achieving change, and lead the cultural shifts needed to make the transition successful. While there’s not one right answer for every organization, CEOs must identify and address the few key priorities for their organizations to capitalize on new opportunities and succeed in the new healthcare environment.

#### A NOTE ON CHALLENGING TERMINOLOGY

The need for a fundamental business shift from fee-for-service to a risk sharing model is a crucial point of discussion for healthcare executives. And yet it is difficult to talk about this without using trigger terminology that is loaded with baggage from prior initiatives. “Managing utilization,” “bundled payments,” etc.—these terms can invoke strong reactions from executives who have been in the healthcare business for any length of time. However, these terms are also key in describing where the industry needs to go. To the extent possible we have avoided using trigger terms. However, when they appear, they are meant to be purely descriptive, and seek to move the discussion forward, rather than continue to be mired in the past.

## COST REDUCTION & UTILIZATION MANAGEMENT

In the near-term, cost reduction to offset reimbursement reductions from payers is a key activity. In response to a question posed to the room: “Can anyone make it today on Medicare rates?” no one could say yes, but everyone agreed that’s where they needed to be.

“We have to take costs out in ways we have never seen before. One serious question we are contemplating at Baptist, is just how ‘disruptive’ these changes will have to be. What are our organizations going to do to get 5-10% cost reductions on an annual basis?”  
— Al Stubblefield

However, to operate on projected reimbursement levels, traditional cost-cutting strategies are unlikely to be enough. To get there, many of the Forum participants believe it will be imperative to address the more fundamental issue of managing utilization. As one executive put it, “at some point cutting costs on what we do now is like rearranging deck chairs on the Titanic.”

“It’s not the cost of supplies, it’s over usage. It’s hard to get at that issue, but that’s the source of the problem. It’s usage you have to address to get costs down.”  
— Peter Fine

Managing utilization doesn’t have a great reputation in the marketplace, and negative perceptions about it must be addressed. However, many CEOs felt strongly that, executed in the right ways, right-sizing utilization will create an increase in quality of care and cut waste out of the system, thereby reducing costs.

“My big realization several years ago was that the pathway to increasing quality, safety and patient experience can also be the pathway to reducing costs. Those two paths are not mutually divergent.”  
— Gary Kaplan

Several CEOs mentioned specific programs they are developing that manage utilization. One is working on building a medical home model for chronically ill children; another is building a bundled payment program with transplant patients. Both expect that these initiatives will accomplish an increase in the quality of care, as well as a reduction in the cost of delivering that care.

In addition to utilization management, executives also discussed the changing role of hospitals in care delivery as a key area of cost reduction and containment. Delivering care in lower cost care settings—from ambulatory centers and community clinics—to medical home models, with clinicians who have a lower “cost per minute” for providing care is an area many will be exploring.

“A lot of CEOs in the ‘80s and ‘90s retired early chasing the capitation train, and trying to put together health information exchanges. They tried to jump to a curve the industry wasn’t ready for yet. It wasn’t their core business. We are in a better place today, though we still have some distance to cover before we can jump.”

AL STUBBLEFIELD  
President and CEO  
Baptist Health Care Corporation  
Pensacola, FL

## BUSINESS MODEL SHIFTS: RISK SHARING & POPULATION MANAGEMENT

Taking on risk and managing patient populations under different payment methodologies will be both a market-based and reform-based necessity—and arguably the only way healthcare organizations can survive in the long term. Effective care coordination and a reduction in unnecessary and duplicative services would achieve the dual imperatives of increasing care quality and reducing costs.

Accountable Care Organizations (ACOs) are the Federal Government's proposal for moving healthcare in this direction. As defined by the Centers for Medicare and Medicaid Services (CMS), an ACO is: "An organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it." The goals for ACOs are to lower costs and improve quality by increasing coordination among providers.

Some CEOs felt that, unlike the Health Management Organizations (HMOs) of the 1990s, ACOs will succeed because they will be enabled by technology. The ability to capture and communicate information within their own organizations—and with provider networks outside their systems—will make effective managed care possible.

"A lot of CEOs in the '80s and '90s retired early chasing the capitation train, and trying to put together health information exchanges. They tried to jump to a curve the industry wasn't ready for yet. It wasn't their core business. We are in a better place today, though we still have some distance to cover before we can jump."

— Al Stubblefield

While CEOs expressed general optimism about ACOs in concept, many critical questions remain: How big do you need to be—hundreds of thousands of lives? Will there be multi-state ACOs? Do we form an ACO by ourselves or with our competitors? How do you align physicians into an ACO?

"I expect that every Federally-funded patient will be pushed to an ACO within a very short time."

— Robert Issai

Several executives indicated that they are considering becoming part of multiple ACOs. Others noted that they have already begun pilot ACO projects for their own employees.

"Being a sponsor or a part of an ACO is great, but if you don't possess the core competencies to manage the care delivered to our patients and to assume the risk, it can be a disaster.



Sponsoring their own ACO provides health systems the opportunity to connect directly with insurance carriers and self-funded employers. As with an ACO, and other relationship models, health systems will have to make the case of value and differentiation—as defined by such metrics as improved access, affordability, better quality and clinical outcomes. If we can't, then we will likely be treated as a commodity by purchasers.”

— Kevin Schoeplein

#### UNDERSTANDING AND ANTICIPATING THE ROLE OF PAYERS

There was wide agreement that a major problem of the current fee-for-service model is that, when hospitals drive down costs by effectively managing utilization, all benefit flows to the payer.

“I’m not so worried about the Federal Government and reform; my concern is big insurance companies and cost shifting. Insurance companies are saying that if they can get 10% off of hospitals, that will fund 50% of their costs to build ACOs and medical homes. Hospitals are a big target right now.”

— Kenneth Graham

Several CEOs shared stories about innovative chronic disease management and advanced medical home pilots they had explored with large employers and payers in their regions. The pilots resulted in substantial cost savings, but hospitals operated them at a loss. And when the pilots were over, the payer reaped the benefits—and naturally wanted to continue the programs.

“Insurance companies are afraid to do something different or change to meet the needs of one provider. This is why demonstration projects are important. Then again, I don’t know if we will really need insurance companies in the future.”

— Mitchell Creem

“We are discussing pilots with several insurance companies in our area. They have suggested we ‘rent’ ACO expertise from them rather than forming our own ACO.”

— Dean Harrison

For hospitals to succeed in transitioning their business model to risk assumption and managed care, there must be a clear “dual upside” of shared savings between providers and payers.

## CONSOLIDATION

The question of whether consolidation among hospitals is a necessary strategy was a source of debate among Forum participants. Should hospitals stay alone and be autonomous, or seek economies of scale?

By spreading fixed costs over a larger revenue base, consolidation represents a possible road to driving down healthcare costs. However, because of the inherent execution challenges and the intensity of capital needed to do it well, consolidation might not be the answer for every organization.

However there are also many potential benefits for a large, consolidated organization. But those benefits can only be fully leveraged when a consolidated organization functions as an operating company, not just a holding company. Doing so leverages their scope, their size and their buying power to drive costs down in many areas, from supply purchasing and information technology to employee health benefit negotiations.

“In the next ten years, I believe we will see the greatest hospital consolidation in U.S. history. But until multi-hospital systems begin to operate as a single organization with standard policies, IT systems, clinical management initiatives, etc., they will not gain the benefit of mergers and acquisitions.”

— Peter Fine

“Virtual integration” through joint operating agreements is another path that some participants are exploring. These agreements would take away incentives for regional healthcare providers to duplicate services (essentially competing in a medical arms race), and create incentives to provide the best care in the best setting for all patients in the region, theoretically driving down costs and increasing quality. This may be a viable alternative to consolidation for some organizations—particularly if they are both operating in the same ACO.

“Size matters. Getting cost per unit down further is going to be nearly impossible without some structural changes. Consolidation—or virtual integration—might be the answer for many organizations.”

— Steve Carlson

“Sustainable, successful transformation is more likely to occur than it was in the ‘90s because of the enabling power of our IT investment and unprecedented clinical connectedness. IT is the enabler that will make many of these visions come true.”

KEVIN SCHOEPLIN  
Incoming CEO  
OSF HealthCare  
Peoria, IL

## CHANGING ROLE OF IT & THE VALUE OF DATA

Despite strides made in the past 10 years, healthcare continues to lag behind in IT implementation when compared to other industries like financial services, communications and entertainment.

“It seems that the promise of IT has been around for over 20 years. Is it really the enabler that we think? Does anyone have IT that’s fully functional and that they consider to be a strategic advantage? I just heard of another major hospital that ripped out an expensive system and is starting over.”  
— Joseph Kortum

However, by creating conduits for effective capture and communication of clinical and financial data on patients in real time—both within and between organizations—IT will be a crucial enabler for successfully managing care.

“Sustainable, successful transformation is more likely to occur than it was in the ‘90s because of the enabling power of our IT investment and unprecedented clinical connectedness. IT is the enabler that will make many of these visions come true.”  
— Kevin Schoeplein

Once hospitals are able to achieve data capture with precision, the true costs

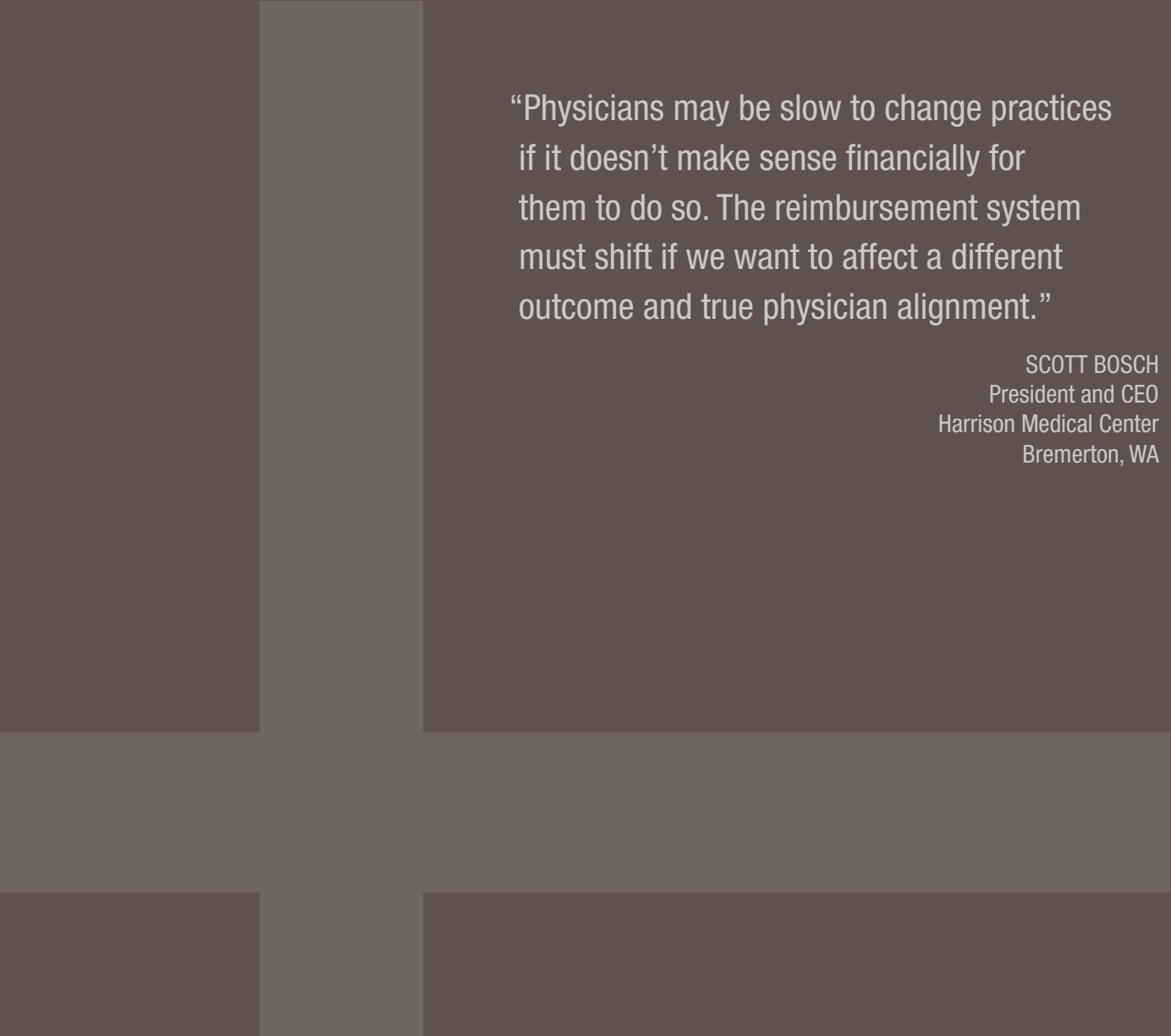
of every element of patient care will be become clearer; clinical outcomes can be measured and captured, process efficiencies can be realized, and employee productivity improvements will become a major area of focus. CEOs did express frustration about the inability to access key data captured by payers, CMS and other entities relating to clinical outcomes, quality of care including readmission rates, and pricing. This data is highly valuable, but frequently inaccessible.

“We don’t know if one of our patients is readmitted at a different hospital, because insurance carriers don’t share that information. An all-payer database would give us transparency.”  
— Mitchell Creem

### VALUE OF DATA IN CHANGING PHYSICIAN BEHAVIOR

One of the most valuable applications of data will be its use as a key lever for changing physician behavior. Data that reveals the effect of clinical practices on outcomes is far more likely to change a physician’s behavior than anecdotal evidence or even hospital policy mandates.

Constant and accurate measurement leads to process improvement and reductions of wasteful activity. If the last decades were about leveraging IT for cost accounting, billing and advanced financial strategies, the coming decades will focus on using IT in clinical process improvement and improving outcomes of care.



“Physicians may be slow to change practices if it doesn’t make sense financially for them to do so. The reimbursement system must shift if we want to affect a different outcome and true physician alignment.”

SCOTT BOSCH  
President and CEO  
Harrison Medical Center  
Bremerton, WA

## PHYSICIAN INTEGRATION & CLINICAL PROCESS IMPROVEMENT

The topic of physician integration and the need for clinical process improvement threaded through nearly every discussion at the Forum. The two issues go hand in hand, and an effective strategy for addressing both is crucial.

The key question for CEOs was: how does physician alignment become real? As one executive noted, “Without physician alignment, we can’t move clinical quality. And you can’t do an ACO.” No one had a silver bullet for achieving physician alignment, but four key strategies mentioned were:

**Creating a Physician Compact:** Developing a “physician compact” to establish a shared vision and objectives between physicians and hospitals—including targets for patient safety, quality and satisfaction—has been crucial for some organizations.

“There are a lot of attributes that make physicians change resistant. But they will rally to engage in a vision which is ‘bigger than they are.’”

— Gary Kaplan

**Developing Financial Incentives:** Clear financial incentives are essential for achieving physician alignment. As one executive said, “If at the end of the day the volume through our network is not more than 15%, then the physician won’t care about alignment. Their stake has to be substantial.”

“Physicians may be slow to change practices if it doesn’t make sense financially for them to do so. The reimbursement system must shift if we want to affect a different outcome and true physician alignment.”

— Scott Bosch

**Changing the Paradigm of Hospital/Physician Relationships:** The rapid change in employment models—from pure employment, to joint ventures and other collaborations—combined with a hospital’s culture and organizational history all affect their relationships with physicians. Regardless of the model, physician/hospital relationships must be built and nurtured over time, with discussions and negotiations focused on the intersection of physician and hospital interests.

“We just bought a physician practice of 40 doctors. In our discussions we told them, ‘we’re just a bunch of faculty running a hospital.’ This break from the old paradigm of hospitals beating up doctors or vice versa was a selling point for the physicians in the practice who could have chosen to partner with a number of other hospitals in our area.”

— David Feinberg

### Cultivating and Leveraging Physician

**Leaders:** Some organizations have had historical and mainly positive relationships with their physicians; for others, relationships have been rockier. Cultivating physician leaders, and leveraging their relationships with their peers is a powerful alignment strategy.

“Having a host of physician leaders in the field is the most important factor for effecting physician change. Physician leaders must be part of the fabric of the organization.”

— Peter Fine

### COLLABORATION & CLINICAL PROCESS IMPROVEMENT

The ideal for CEOs is that physicians are “part of our team.” The ultimate objective of that relationship is to produce a better quality product. There was also broad recognition among CEOs that more horizontal, non-traditional collaboration between care teams, advanced nurse practitioners, physicians, hospitals, payers, boards and senior leadership teams will be necessary to transform healthcare delivery and improve outcomes. Physicians who understand how to manage risk will be especially valued team members.

“Team medicine will help reduce costs. We need to ask ‘how do I best use physicians?’ We need to engage the doctors in this conversation, and make them part of the team and part of the solution. We need to educate them, and incentivize them to step up and change

their thinking about their roles and the value they bring—even when that change is hard.”

— Rajiv Garg

One barrier to achieving the kind of collaboration hospitals want to have with physicians is clinician training. If structures for clinician training don’t change, health organizations could fail in trying to implement new models of care delivery.

“We need to think about how the current approach to training clinicians is or is not supporting what we need to do to enhance patient care. We’ve got to get training right or we won’t achieve the outcomes we need to achieve. We need people who can work not only in the acute care environment, but in the community, too. Right now, there is not a lot of unanimity.”

— Marna Borgstrom

Medical schools have traditionally trained physicians to be independent, self-responsible decision makers. Physicians who understand the need to work in teams, and who understand process improvement are currently in the minority.

“We are trying to identify the doctors who seem to ‘get it’ and educate them about processes of change, so they can be the leaders of future change in our organization. This is a major effort and investment in human capital for us.”

— Al Stubblefield

## CONSUMERISM & THE PATIENT EXPERIENCE

Advances in technology—including smart phones, social media and the availability of medical information on the internet—have exponentially increased patients’ expectations and demands.

Technological advances in the consumer marketplace have outpaced most hospitals’ IT advances, and are poised to continue widening the gap between the kind and quality of care patients want and the care they receive.

“The next generation of patients will have a whole different demand profile. Our challenge will be to increase their health IQ, and help people make better choices.”

— Michelle Hood

One executive told the group that patients at his hospital have been engaging not just finance personnel, but also physicians in conversations about costs, asking for price lists, and refusing services they feel they can’t afford—an unprecedented and disorienting interaction for physicians, but one that is likely to continue to occur.

One key to achieving high levels of patient satisfaction is to create a patient-centered experience from both technical (clinical) and service (relationship) perspectives. As one executive noted, while patients do not always know whether they are receiving high quality healthcare, they can tell whether they are being treated with respect.

“Hospitals’ attitudes are often: ‘Aren’t you lucky we’re here to take care of you?’ That attitude impacts patient experience. And HCAHPS is the tip of the iceberg compared to patients reporting their experience online and in social media.”

— Gary Kaplan

The patient experience will be increasingly important as patients continue to pay a larger percentage of their healthcare costs, and make decisions based on more and more publicly available data.

“We have traditionally defined value as a ratio of cost divided by the perception of quality (usually patient satisfaction). In the near future, patients will become more empowered with expectations of verifiable quality and cost.”

— Dean Harrison

“Quality is difficult to measure, because it depends on who is measuring, and who is talking. But when patients have things explained in compassionate ways and a bill they can understand, we’ve made a connection. Our commitment to patients is to take care of them in the way we’d want to be taken care of.”

— David Feinberg



“Our responsibility as healthcare leaders is to get in front of healthcare reform. We have the opportunity to define what healthcare delivery looks like in the future. This is one of the most exciting times in my career.”

MITCHELL CREEM  
CEO

USC University Hospital and USC Norris Cancer Hospital  
Los Angeles, CA

## TRANSFORMATIVE LEADERSHIP

The widespread, deep, yet uncertain impact of healthcare reform creates a pressing need for insightful, transformative leadership. So what does this mean to the Forum participants?

First, CEOs felt that they have an opportunity to help define what healthcare delivery is going to look like in the future, helping create fundamental shifts in the way hospitals operate, creating higher quality, more affordable care.

The Forum participants' discussions revealed five key imperatives for transformational leaders:

### 1) CREATE A CLEAR VISION

One of a CEO's most important roles is to create a clear, compelling vision for the organization, and be part of creating a plan to achieve that vision. The coming years promise to launch a period of uncertainty, with a growing inability to predict normal business trends, such as the rate of growth or decline in hospital admissions. A well-articulated vision that is owned by the CEO will work to bring together the key stakeholders of the health system.

### 2) BUILD NIMBLE TEAMS

Several executives noted that, when they started at their organization, their executive teams were larger than they are today. One CEO had narrowed his team down from 24 to six. Nimble teams create the ability for the organization to be decisive and swift in their decision-making processes.

### 3) IDENTIFY PEER-TO-PEER KEY COMMUNICATORS

Identifying and deploying key communicators in the organization helps effect change management on a micro level; Peer-to-peer communicators translate complex messages into clear, simple language that meets the needs of different groups of stakeholders. Several executives cited that this approach is especially crucial when communicating with clinicians—and particularly physicians.

### 4) HAVE "PASSION FOR COMPLEXITY AND HIGH TOLERANCE FOR AMBIGUITY"

Healthcare is an extremely complex industry, and it's not getting any simpler. To effectively lead in healthcare, CEOs—as well as senior leadership—must have, as Peter Fine put it: "A passion for complexity, and a high tolerance for ambiguity. If you don't have those, you probably need to move on."

### 5) EMBRACE AND ACCELERATE CHANGE

Change is always accompanied by rising anxiety. The leadership key is to anticipate it and use educational tools to quickly move the management team ahead along the curve.

# INSIGHTS ON TRANSFORMATIVE LEADERSHIP FROM AVIATION INDUSTRY EXPERTS

At the Forum, Rick Stephens, Senior Vice President of The Boeing Company and Captain Chesley B. “Sully” Sullenberger, both shared thoughts on key elements of transformational leadership. Several common threads emerged, which are clearly applicable to healthcare leadership.

## COLLABORATION IS CRUCIAL

At The Boeing Company, CEO Jim McNerny’s philosophy is “as leaders grow, so Boeing grows.” The company has made deep investments in developing leaders and cultivating a culture of collaboration using the lean management methodology, wherein managers and employees work on solving problems together, rather than creating a punitive culture.

In his remarks, Captain Sullenberger stressed that landing his plane on the Hudson was not a one-person success. “My first officer, the flight attendants, the passengers, the flight controllers, the police and fire departments, the ferry boat captains and crew, the Coast Guard, and the American Red Cross all contributed to the successful outcome of Flight 1549.”

**Healthcare Application:** A team-based, collaborative approach to healthcare will be a core competency for effective care coordination and population management.

“If you’re a solo act and not a team player, you’ll not only fail, but fail spectacularly.”

— Captain Sullenberger

## CLEARLY DEFINING ROLES AND EXPECTATIONS

Working to improve their leadership development efforts, Boeing executives identified a collection of 140 different leadership attributes in different departments across the company. They narrowed that list down to six, which now form the foundation of how they train and reward performance. (See sidebar: “Boeing Leadership Imperatives”) “To be a leader and cultivate leadership,” said Stephens, “you need a common language about measurements and results pushed down through the entire organization.”

One key problem to overcome, Stephens added, is “the illusion of communication happening.” Defined roles and expectations need to make sense to all employees, and leaders must talk about them using common language.

For Captain Sullenberger, colleagues following their defined roles in a highly volatile situation meant that each knew what to expect of the other. He and his first officer were able to work seamlessly together to accomplish the series of tasks that led to a successful landing. Implementation of industry-wide best practices has significantly reduced variance in pilot behavior and led to safer air travel.

## BOEING LEADERSHIP IMPERATIVES

- » Chart the course
- » Set high expectations
- » Inspire others
- » Find a way
- » Live Boeing values
- » Deliver results

Likewise in healthcare, Sullenberger feels that “Physician autonomy must yield to best practices.”

*Healthcare Application:* When healthcare leaders ensure that every member of the organization understands how their role contributes to fulfilling the mission and vision of an organization, patients not only experience higher quality care, they experience safer, more affordable care.

#### PREPARING FOR EXCELLENCE

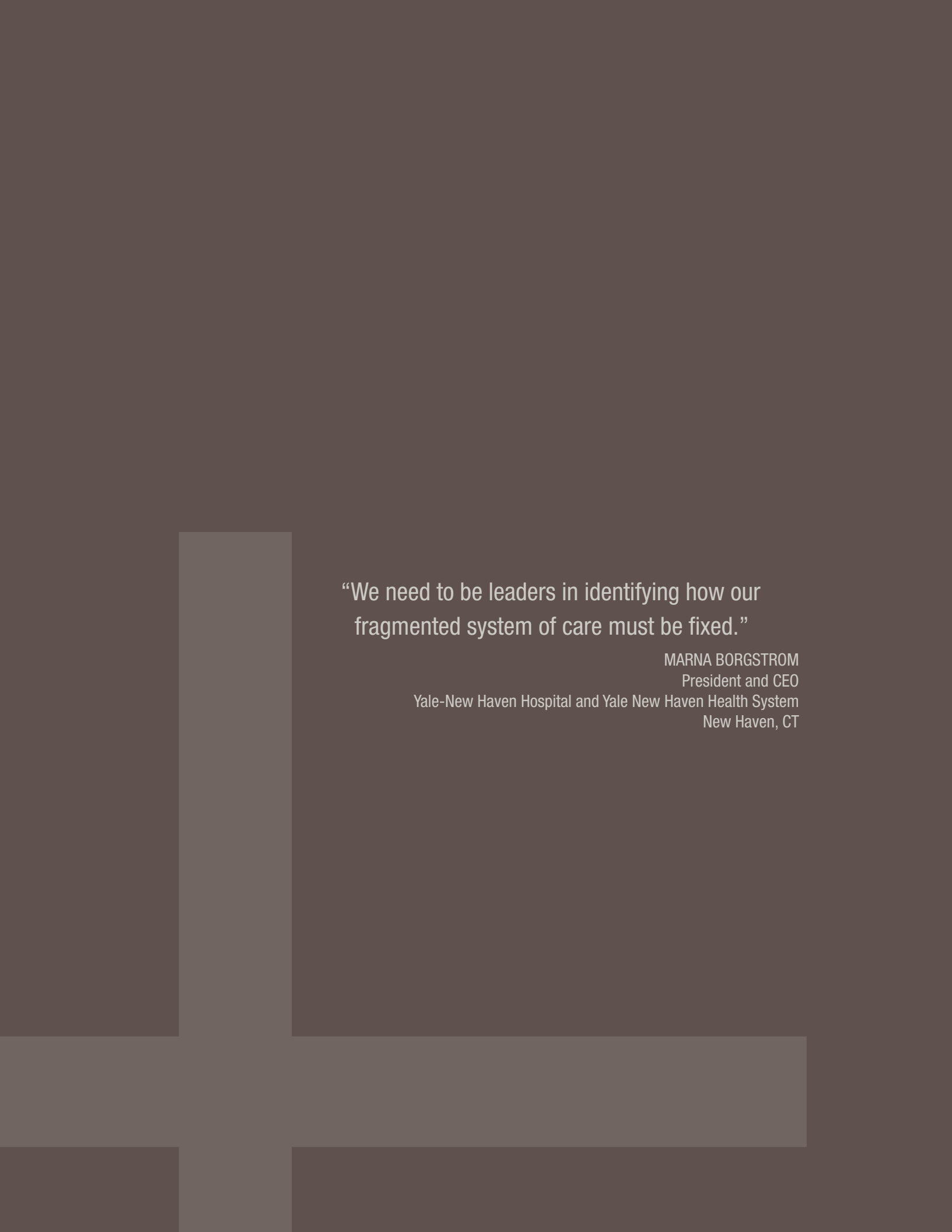
Boeing has been preparing for excellence for many years, developing strong leadership, and creating a culture of safety innovation. This relentless focus on excellence allowed them to create the 787 Dreamliner, the most advanced, fuel efficient, far-reaching plane to date—and the most successful in their company’s history in terms of preorders.

“Our customers do not buy Boeing planes because they’re the lowest cost product available. They’re not. They’re buying a Boeing plane based on its life cycle value, which comes from our focus on innovation and excellence. That’s where we always win.”

— Rick Stephens

Captain Sullenberger had been preparing for excellence every day of his career before January 15, 2009 when he landed his plane in the river—something he’d never been specifically trained to do. His preparation saved lives.

*Healthcare Application:* Healthcare organizations continue to achieve excellence, and make important strides daily. Now a changing healthcare environment and unprecedented IT capabilities promises to create an inflection point where hospitals will find it possible to leapfrog forward, making huge strides in safety and quality. Sullenberger and Stephens both challenged CEOs to make that leap.



“We need to be leaders in identifying how our  
fragmented system of care must be fixed.”

MARNA BORGSTROM

President and CEO

Yale-New Haven Hospital and Yale New Haven Health System

New Haven, CT

## NEED TO INNOVATE

Forum participants were in unanimous agreement that both the intensity and the speed of change in the healthcare industry today are daunting.

For these executives, the core motivation for innovation in healthcare is to move hospitals and physicians toward delivering high quality, patient-centered care at a sustainable cost level. All were very concerned about the dichotomy that currently exists: trying to effect fundamental changes in the timing, setting and approach to care under new payment structures while living in a fee-for-service reality.

Making this seismic shift requires a deep rethinking of the nature of hospitals' relationships with all of their stakeholders, from patients and physicians to payers and boards, as well as a reconsideration of the hospital's role in overall care delivery. There was consensus that maintaining the status quo is not an option.

Many Forum participants expressed their excitement and optimism about change and innovation, feeling that they have an unprecedented opportunity to change the fabric of the way healthcare is delivered in this country.

"It is our responsibility and our privilege as healthcare leaders to define what care delivery is going to look like."  
— Mitchell Creem

### TIMING FOR CHANGE

CEOs agreed that to remain viable in the future—regardless of reform—hospitals must shift away from the fee-for-service business model and towards a model that shares—and rewards—taking on risk. But the pace of that movement was a point of discussion.

With reference to The Second Curve, "The business model we're on has a life cycle, and we're on the downward curve. The toughest business decision is when to jump, because the economic model is still on the first curve."

— Al Stubblefield

"Until payment structures change, if you move too soon, you may lose existing opportunities and weaken your organization. Move too late and you lose everything."

— Kenneth Graham

### PILOT PROGRAMS: A TOOL FOR TESTING NEW INNOVATIONS

One tool CEOs are using to set the right pace for change and explore new relationships and care models is through innovative pilot programs. Some CEOs cited pilot programs focused on developing relationships with large employers in their region to treat certain conditions at a fixed cost per patient. Other hospitals are trying out initiatives such

as virtual patient monitoring; developing new compensation models for physicians, and creating new alliances with other healthcare organizations.

### LOOKING BEYOND THE HEALTHCARE INDUSTRY


There was agreement among Forum attendees that new ideas for innovation will come not only from innovative healthcare leaders, but also from other industries' leaders who have successfully weathered dramatic changes in their business models.

"We need to reduce the hubris in our industry, and stop saying 'Well, we're healthcare, so we're different. Innovations in other industries can't be applied to us.'"

— Gary Kaplan

### INNOVATION REQUIRES A VISION

To truly innovate, you must create a vision for your organization, and a plan for executing against it. Peter Fine developed a 20-year plan with his Board of Directors, which has led to "purposeful disruption" in his organization. For Fine, one way to spark a new direction was to get his senior leadership to stop thinking of their hospital system as a healthcare delivery organization, and start thinking of it as a clinical quality organization. Part of that shift in perception meant building a multi-million dollar, world class data center that allowed them to track and use clinical data from their organization, including data relating to physician performance.



Paving the way forward will require a fundamental shift in the way healthcare providers deliver care. This will not only be an economic necessity, but will also be the “right thing to do” for patients, and for the country.



## CONCLUSION

There is no shortage of uncertainty in the healthcare industry, but the path forward promises to become clearer. Paving the way forward will require a fundamental shift in the way healthcare providers deliver care. This will not only be an economic necessity, but will also be the “right thing to do” for patients, and for the country.

This shift promises to achieve higher quality care, drive out waste, and make healthcare affordable for payers and patients alike as CEOs, along with their leadership teams and boards, address the key issues and challenges described in this report.

That leaves healthcare CEOs with significant execution challenges during this time of unprecedented industry change; transformational leadership skills and vision-setting are more crucial than ever.

Some organizations are better positioned than others for the changes ahead and consolidation may be necessary for some to achieve the needed ends.

Regardless of whether an organization is a multi-hospital system or a rural community hospital, they still have to live with declining reimbursements, and find a sustainable way forward in the short-term, while planning for the future.

## EXECUTIVE ATTENDEES



**Dean M. Harrison,**  
**CEO Forum Chair\***  
is President and  
Chief Executive  
Officer of Chicago's

Northwestern Memorial HealthCare. Prior to joining Northwestern Memorial, he was President and Chief Operating Officer of the University of Chicago Health System. Mr. Harrison currently serves on the Member Board of Directors of the University HealthSystem Consortium, Board of Directors of United Way Metropolitan Chicago, Board of Directors of the Illinois Hospital Association and is a special advisor to Merrick Ventures.



**Marna P. Borgstrom\***  
is the President and  
Chief Executive Officer  
of Yale-New Haven  
Hospital and the Yale

New Haven Health System, based in New Haven, Connecticut. She joined Yale-New Haven Hospital nearly 32 years ago and has held her current position since 2005. Ms. Borgstrom is on the boards of the Connecticut Hospital Association, VHA and the AAMC.



**Scott W. Bosch,**  
**MHA, FACHE** is the  
President and Chief  
Executive Officer of  
Harrison Medical

Center in Bremerton, Washington. Previously, he served as President of Banner Health's Colorado region, where he oversaw nine hospitals in four states. Mr. Bosch is a fellow of the American College of Healthcare Executives.



**Stephen G. Carlson**  
is the President and  
Chief Executive Officer  
of Community Medical  
Center in Missoula,

Montana. His experience includes nine years heading Flagstaff Medical Center in Flagstaff, Arizona. He was also a Senior Executive Officer for Northern Arizona Healthcare.



**Mitchell R. Creem**  
is the Chief Executive  
Officer of USC  
University Hospital  
and USC Norris

Cancer Hospital in Los Angeles, California. Prior to joining USC, Mitchell served as Associate Vice Chancellor and Chief Financial Officer of the UCLA Medical Sciences, a group of institutions that includes the Geffen School of Medicine

at UCLA, UCLA Faculty Practice and the UCLA Hospital System. He has been a guest lecturer at USC, UCLA and Harvard University.



**David T. Feinberg,**  
**MD, MBA\*** is the  
Chief Executive Officer  
and Associate Vice  
Chancellor of UCLA

Hospital System and Health Sciences. Previously, he served as Medical Director of the Resnick Neuropsychiatric Hospital (NPH) and head of the NPH Faculty Practice Group. Dr. Feinberg is also a Clinical Professor of Psychiatry on the faculty of the David Geffen School of Medicine at UCLA.



**Peter S. Fine,**  
**FACHE\*** was appointed  
President and Chief  
Executive Officer of  
Phoenix, Arizona-

based Banner Health in 2000. Prior to his appointment, he was Executive Vice President and Chief Operating Officer of Milwaukee-based Aurora Health Care, a large integrated system serving all of eastern Wisconsin. He is a fellow in the American College of Healthcare Executives.

\* 2010 CEO Forum Cabinet Member



**Rajiv K. Garg** is the President and Chief Executive Officer of Wyckoff Heights Medical Center in

Brooklyn, New York. Mr. Garg has a banking and IT background and also serves on the Board of Governors of Greater New York Health Association.



**Kenneth D. Graham, FACHE** has served as the President and Chief Executive Officer of El Camino

Hospital in Mountain View, California since 2006. He previously served as President and Chief Executive Officer of Overlake Hospital Medical Center in Bellevue, WA for more than 12 years.



**M. Michelle Hood, FACHE** is the President and Chief Executive Officer at Eastern Maine Healthcare

Systems (EMHS) in Brewer, Maine. Prior to EMHS, Ms. Hood was President and Chief Executive Officer of the Sisters of Charity of Leavenworth Health System's Montana Region, as well as President and Chief Executive Officer of its flagship hospital, St. Vincent Healthcare.



**Robert Issai** is the President and Chief Executive Officer of the Daughters of Charity Health

System (DCHS). Prior to his appointment at DCHS, he served as its Executive Vice President and Chief Financial Officer. Mr. Issai is a member of the Catholic Health Association of the United States Board of Trustees.



**Gary S. Kaplan, MD, FACP, FACMPE, FACPE\*** has served as Chairman and Chief Executive Officer of

the Virginia Mason Health System since 2000. In addition to his patient-care duties and position as Chief Executive Officer, Dr. Kaplan is a clinical professor at the University of Washington.



**Joseph M. Kortum** is the President and Chief Executive Officer of Southwest Washington Medical

Center in Vancouver, Washington. Previously, he was the President and Chief Executive Officer at Northern Arizona Healthcare. Mr. Kortum is a fellow of the American College of Healthcare Executives and a member of the governing boards of Volunteer Hospitals of America West Coast and the Washington State Hospital Association.



**Kevin D. Schoepfle** is the incoming Chief Executive Officer of OSF HealthCare in

Peoria, Illinois. Mr. Schoepfle began his career at OSF in 1978 as an Assistant Administrator. Mr. Schoepfle has also served as Chief Executive Officer at OSF Saint Anthony Medical Center as well as President of OSF Saint Francis Inc.



**Alfred G. Stubblefield\*** is the President and Chief Executive Officer of Pensacola, Florida-based Baptist Health

Care Corporation. He joined Baptist nearly 25 years ago and has been in his current position since 1999. Mr. Stubblefield is currently serving on the VHA & FHA Board of Trustees and is a fellow of the American College of Healthcare Executives.

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