Patient Safety and High Performance Leadership Summit
Issues in Governance, National Collaboratives, and H.I.T.:
Advanced Leadership – Boardroom Action

April 27, 2012
Webinar Transcript

Charles Denham: It gives me great pleasure to welcome our audience at the National Press Club here in Washington, DC, and a terrific panel. We've moved up our agenda. Congressman Rohrabacher had to return to Congress and it's great to know that he's back hard at work to serve us here. We're going to move to our event leadership panel and have a group discussion from some terrific leaders from multiple sectors in our national scene, and really address some of the principles of advanced leadership. This group has recently seen, in the last couple of hours, a documentary that'll be premiered tonight at the National Press Club, and then be shown on the Discovery channel.

What I'd like to do before we get started, though, is to go through a few housekeeping details for our audience that is logging in. Typically TMIT has a WebEx system, so those of you [who] are on the WebEx system today, you'll be able to hear audio. There will not be a large slide deck, because we're streaming video from our website. If you go to www.safetyleaders.org, you'll have the opportunity of being able to log on for the streaming video. You must have a fast line, so those [who] are logging on now, and if you aren't able to watch the streaming video, we just want to remind everyone that the videotape will be entirely edited with the panels. They'll be available in the next ten business days, because we have an entire day of panels that we're covering. They'll be edited together. Word-searchable transcripts will also be on www.safetyleaders.org, and it'll likely take two to three weeks, but continuing medical education, continuing education units will be available as well; although there will be a little bit more of a delay. For those of you [who] are on the WebEx, we'd like to remind you that if your audio is not working well, make sure the audio on your computer is turned up as high as it can be. If that doesn't work, then go onto our website or go in the lower left-hand corner of your screen and you'll be able to identify how to ask for a phone line that will then allow you to have better audio. Those [who] are streaming, if you have interruptions in service, you can go back to the WebEx, and, if you miss that, you can watch this [synchronously].

We moved up our schedule because Congressman Rohrabacher, who gave us, I think, a wonderful, inspirational introduction to the focus of what we're doing here today, and Nancy Conrad, wife of Pete Conrad – who died a preventable death of a systems failure, although he lived his life in a high-risk environment – is a very dedicated patient-safety champion, and also shared her sentiments and thoughts with us. We also have given our 2012 Patient-Safety Pete Conrad Award to some wonderful recipients who are also with me on the panel today.

So we'll start off with our Advanced Leadership Initiative discussion and the concepts of advanced leadership and how we really can apply that to the challenges of quality and safety that we are focused on today. It's a wonderful honor to be working almost every week with Dr. Steve Swensen, who has been the leader of quality at the Mayo Clinic and – you work at the Cleveland Clinic too? – yeah, along with Audrey Henderson. No, Dr. Swensen has been the Chairman of Radiology, a wonderful contributor to that field. He has been a wonderful champion to patient safety, working with us over the years, and now is taking the helm of leadership development for the Mayo Clinic, but we're not going to let go of you yet, Steve. He is also one of our 2012 Pete Conrad Award winners. Steve, why don't you kick us off with – we've had discussions with all of our panelists on what their primary messages are around these topics. Steve, just go ahead and we'll keep my talking short. What is important about this area?

Stephen Swensen: The leadership of an organization starts with the patient first. They'll always make the right decision. Then quality, safety, and outcomes and [inaudible] care becomes the central part of the

business strategy, and that makes sense. So through the patients' eyes, they don't want a variation of waste or defect in their care, and if you deliver that methodically, then it also aligns with the business strategy [inaudible].

Charles Denham: At the Mayo Clinic, you've shown a terrific ROI. You've been able to show that focusing on doing the right thing has a financial impact and that leadership is a good investment.

Stephen Swensen: Exactly. Doing the right thing for the patients, driving out waste, variation, and defect also has important financial dividends. So with systems engineering, with a methodical look at the whole practice, the standardized excellence, we've shown a five-to-one return investment analyzed by our financial colleagues. We're doing the right thing for the best care for every patient every day.

Charles Denham: Fantastic. Dr. David Parda, another radiation oncologist – I kind of feel whenever we talk about radiation safety, which we did in the movie a little earlier, I think we both have a little heart flutter because this is an area that we've been trained in. Dr. David Parda is the Chairman of Radiation/Oncology at West Penn Allegheny Healthcare System. More importantly, I think, he's a Trustee. So he is a clinically trained trustee who is practicing at the same system where he now is a trustee in the full measure of the word. He's also a champion for cultural transformation and has an MBA, so he understands the business part and runs a very substantial business that is as big as many businesses out there within that system. David, your thoughts – you know, where you stand depends on where you sit and you sit on the board.

David Parda: It's very difficult for board members, just like doctors, to keep their complete focus on patients. The patients have all of the answers for us, yet we get busy with many activities outside of that direct patient focus. At the board level, most of that is related to assessing financial performance and multiple corporate and hospital entities, and that really does hurt the focus on care, the continuum of care, and it really doesn't allow for us to integrate clinical, operational, and financial activities. That's been my take-home message for three years on our health system board, and with more of a focus on the patient, everything else falls into place.

Charles Denham: So do you think that doctors can make good board members, and do they need to be trained in being able to be good board members?

David Parda: I must say that it took me a little while to learn how to treat board meetings less like a morbidity-and-mortality conference and more like a little bit more of a civilized discussion where we have an eye on the clinical and operational environment, but we have four physicians out of 20 board members there, and that clinical and operational context is critical. That educational component – to help educate the other board members on the clinical and operational environment – is critical, and I certainly have been very well educated by the other board members on how to organize things at a macro level better.

Charles Denham: Fantastic. John Nance is so accomplished that I would take thirty minutes to read his bio – an airline pilot, a lawyer, a best-selling author, but more importantly a fabulous champion and leader and teacher of leaders at hospitals, really impassioned. I give his books to everyone. Sometimes I give more than one of the same book to them. "Have you read John's book yet? Chuck just sent me two of them." I have to keep track, because I have a stack of them and [to] everyone we mentor, we send John's books because they're fabulous. John, last night we talked about the transfer of aviation and the principles of aviation with Sully Sullenberger and members of Congress and that kind of thing – you're in a place where you're in the boards constantly and you see the potential crossover. Is there a place for us to really develop leadership – take it to a whole new level and maybe learn from other industries?

John Nance: This is one of the hidden, critical elements, I think, is leadership. My definition of leadership is you define your worth as a leader by how well you can extract, orchestrate, and apply all the human talent available to you. That means it transcends all the elements that we have boards considering all the time. Just as you were saying, the finances get in the way. There are a lot of things that get in the way of understanding and we have to change to a patient-centered system. I think it's centered – you can say a lot of things, but that's my take on it. The basic idea is that everything has to be subordinate for the best

interest of the patient. The news in this, if you will, and I guess it's probably hackneyed, but it is the 100th anniversary of the sinking of the Titanic and the old saw about moving deck chairs around on the Titanic is still very appropriate. We tend to still do that to try to readjust things. This is a major cultural revolution if we are going to focus on what we need to do for the patient. That takes leadership at all levels – leadership in the boardroom, leadership in the C-suite, and leadership down on the front lines where they really do have the answers that they don't even know they have. So what we're talking about is a total revolution. That requires the leadership and the involvement of everybody, and it requires also understanding that you can't make this a priority. Safety and quality have to be core values. If they're not core values, we're never going to get where we need to go.

Charles Denham: So we just started with a checklist. There's more that we can learn from aviation, nuclear power, and other areas.

John Nance: I tend to get on my soapbox and sometimes I even forget about aviation, but we've got – when you're in this kind of a revolutionary situation, you need to look outside the borders of even the most complex thing we've got in life, which is, I think, medical practice in so many different areas. But you look outside and you say first, last, and always, it's a human system. What other human systems have achieved high reliability status, and if we can identify them, what have they done to do that? Well, we have aviation as probably the clearest one in terms of all the things that we've learned, because we learn in very embarrassing fashions when we make mistakes – nuclear power generation, nuclear submarines, and nuclear navy, on and on – manufacturing. Atul Gawande did a brilliant job in his book *The Checklist Manifesto*, pointing out that those who build large buildings also engage in exactly the same type of rigorous planning and discipline and minimization of variables and best practices, which we have not seen – not imposed, but incorporated in the medical practice.

Charles Denham: Sharon, you are such a wonderful, just breath of fresh air to us, to have a trustee [who's] outside of our field of healthcare, and to be dedicating yourself to be a great trustee. Sharon entered through the American Hospital Association Minority Trustee Development Program. When I talked to Maulik Joshi, another one of my wonderful committee members working with the National Quality Forum, he said, "We've got a terrific set of people," and he said, "I bet we've got a really great one for you," and Sharon was in the movie and really inspirational, dedicated. I think she proves that you don't have to be a clinical person to really wade in. She is the Chair of Patient Safety at Sinai Health Systems in Chicago. John so aptly addressed that the Titanic issue, which is such a great learning for us, and it was a board decision to go with a minimum number of lifeboats and not go with an adequate number of lifeboats, and 1,500 people died, 700 people made it, but it was a board decision. It was a resource allocation decision; that was how that disaster occurred. I'm sure they didn't really dig into the safety of the Titanic and it was unthinkable, and they had the best technology of their time, which is what we talk about in healthcare, and yet some of these very fundamental decisions are there. Sharon, your message. We've talked with every panelist and kind of prepared. What's the kernel of the most important message for this issue of leadership?

Sharon Rossmark: I think the message actually builds upon just that. One: embrace people from outside the industry. Bring them in, but within that be very deliberate and intentional and on-boarding, and that was one of the things that I was initially afraid of is that I didn't have a clinical background; so be intentional about the on-boarding process and the engaging. If you accept them, you want them to be engaged and help them be engaged. Probably the final message would really be around insisting on boardroom training, trust that they want to learn. So that partnership between the clinical and nonclinical, it's exactly your point. It's exactly what helped me really learn a new passion in this field. My partner was the Chief Medical Officer. What we found out is that there was equal learning; my business background with his clinical background really helped us emerge in the boardroom and have conversations that probably would not have existed previously if they had not engaged the business people [whom] they brought on board. So I really think it's important to embrace business people and embrace people from outside the field and bring them in and make them feel welcome.

Charles Denham: What's your message to other potential trustees or trustees about the invisible safety net? How do you communicate, as you did so eloquently, that they own it; they need to know what it is and it might take a little more than a couple of minutes to learn?

Sharon Rossmark: To the point earlier, become engaged. I make rounds with the CEO, the COO, and the Chief Medical Officer. These aren't staged rounds, this is just a normal rounding process. So become engaged. Understand the complexities of the hospital system, but then also take a step back and understand the patients' perspective. If you haven't been in that position, understand that someone has and then understand what's going on around you.

Charles Denham: Great. It's so much fun to know all of you and to know all of the panelists and to have the history that we've had and the shake-our-head moments and the humorous moments. David tells a wonderful story about sterilization, which is so apt in sterilization of instruments [laughter] – I saw somebody look at me over here – for those [who] are on the global streaming or on the WebEx, we're not talking about anything other than sterilizing surgical instruments, as I reiterate. I don't want to get somebody, a public servant, in trouble here. We haven't even started our morning yet. But David, tell the story of the tale of two surgeons and how it applies to what we are doing today in safety and quality.

David Parda: I love to tell this story, because it's actually the story of the intersection in the lives of two of the most prominent surgeons that we've ever had, Joseph Lister and Theodor Billroth. So many of you who are in surgery or know about surgery will understand that the history of surgery, to a large extent, can be divided into the time before Lister and after Lister. The improvements that he made actually allowed us to develop modern surgical technique; that is, they used aseptic technique. The interesting thing about his story, though, is that, even in his own hospital, Lister was not able to actually convince his fellow surgeons about the benefits of his work. It took a surgeon hundreds of miles away, and that person was Theodor Billroth. He was actually able to implement a system that actually propelled surgery into the modern age. Now, Theodor Billroth was the Chief Executive Officer at Allgemeine, a clinic in Vienna. The reason he was able to do what he was able to do – he understood the work of Lister and he saw the potential. He was also the CEO effectively and the board, and actually, at that time it was in the form of one person, so he had the leadership. He knew what was needed to be done and he had that quintessential manifestation of leadership. He had a good team. He had a team that was willing to work within a system. Because of his advancement and his support of the system of aseptic technique of Joseph Lister, it actually took hold within the world of surgery. The rest, as you say, is history. Later, Lister was acknowledged for his work, but it was very interesting how in the very first days it was the leadership of Theodor Billroth that made the day.

Charles Denham: David, apply that to the challenges that you face in your division. Your part of our government is really focused on health information and technology adoption. Is that a fair statement? And then how does that apply?

David Parda: Exactly. First of all, it's wonderful to see the story come back around full circle into the discussion of leadership. So many times in medicine we get attracted to and we gravitate to that new technology, that new gee-whiz thing. First it was a new drug or a new gene therapy, and people will start to talk about this new technology – information technology, oh that will be the savior. But that's just the path, and that's not the whole answer. It really is all about leadership. A lot of times people will say, "Oh, your office is into technology," and I say, "No, no. We're actually agents of change. The technology is the path." It's the way that we'll do things, but, really, our job is to improve the quality, the safety and the efficiency of healthcare services that are delivered in the United States. It just happens that we're doing that through the propagation and through the empowerment of providers using information technology. But this is not a technology enterprise. This is really about leadership and the development of a culture that trusts leaders.

Charles Denham: What a great introduction to Bob Chapman. So I took a course at Harvard, an intense course with CEOs from all over the world. It was an experiment by Bill George, who was at the end of the movie who wrote *True North*: *Authentic Leadership*. He took Medtronic, a company at one point had six-billion dollars and said on his first day of employment, "In ten years, I will be resigning and retiring

regardless of what happens." He did. He took it from $1.6 billion to $16 billion. He went into operating rooms for 2,000 operations partnering with a clinical partner so that he could learn. He had no knowledge of the clinical area. I took this course, and the course was about your own journey as a leader. It was all about leadership and what your crucibles were. One of the exercises was to write down the three most inspirational people in your life. I went, "Wow, that is a great question. I've only known Bob for a couple of years, and Bob Chapman is on my list." Because Bob really, as you saw in the movie, in our first decade at TMIT – for those [who] are on the webinar, you'll see it, and you can see it tomorrow on the Discovery Channel – in our first decade we were a technology accelerator, thinking – as David said – the whiz-bang stuff was the technology. Then we thought it was best practices and David and I and Steve Swensen and a number of us have all been working on best practices enabled by technology; but in the end, it begins with leadership, it ends with leadership. It's all about leadership. Bob has really given us new inspiration about what leadership really is. Bob?

Robert Chapman: As I heard the Congressman talk earlier, and as I watched the movie, what occurs to me is the crisis in America is not a financial crisis. The crisis in America is the lack of leadership. Leadership is the stewardship of the lives under which we have the opportunity to influence. But when I think of healthcare and I think of the caregivers, those people who dedicate their lives to the care of others, who enter for a noble purpose a very demanding profession where people's lives are at stake, the leadership model in healthcare is broken. We talk about it being about the patient. It is about the caregivers as much as the patients. We talk about the convergence of leadership, safe practices, and technology. Unfortunately, technology and safe practices are progressing dramatically, but what does not exist is the leadership where we care for the caregivers. In the work we have done, it is very clear that people just want to know that they matter. Until we engage people's heads and hearts in caregiving, we will never provide safe and compassionate care to the extent our technology and safe practices exist. We are not creating leaders who understand the profound significance of their leadership. It is not all about the patient. It is about all the people who are in the process of delivering healthcare. Therefore, if they feel cared for, they will engage their head and heart and yield the safe practices, bring the technology, but it is not all about the patient. The Congressman talked about his triplets, and he had great emotion when he talked about his triplets. Some of those triplets, someday, may enter a healthcare organization, not as a patient, but as a caregiver. Are they going to be treated the way he would like his daughters, his triplets treated? That is the issue we face in all facets in America. We face it in our government; we face it in healthcare; we face it in industry. In industry, we talk about how the customer is number one. The customer is not number one; people are number one. We just are not creating leaders; and therefore our healthcare system is suffering the same challenges. It creates all this great technology and great safe practices, but it's not saving lives as we thought it would do. What about the caregivers? What in our boardrooms, what in the trustees of the hospitals, how are we caring for the caregivers so they can render space and compassion and care?

Charles Denham: Mary Foley is the former president of the American Nursing Association. She is one of what we call our listening leadership team. Every other Saturday, a group of family members who've lost a loved one through healthcare harm are working together, mostly consumers, and there are two or three of us [who] are clinicians. Every morning, just like we have my son Charlie come up here, he'll crawl into my lap and be part of our meeting. She's one of a wonderful group of real champions, along with Jenny Dingman, who is also a consumer, [who] was in the film *Dedicated to Patient Safety and Quality*. Now what's different about Mary as a nurse is that she had an event happen in her own life. She also sees what's going on in healthcare and how we are putting the blame on nurses and pharmacists and front-line caregivers. When we have a systems accident, the easiest thing to do is to point our finger at the nurse, which is the most common one that we have. So, two issues, Mary. One is, what's your message to the leaders of our hospital systems, because you see both sides? You're trained and you have a PhD and have focused and dedicated your life to patient safety and quality. These two issues of – we saw the distress of the AHRQ study; 600,000 staffers; two-thirds of them believe that they can't trust their leaders. They can't trust their leaders. Thirty-seven percent are afraid to report when an error is evolving, and a majority of them believe that when an error happens, it specifically goes into their job files, goes into their employment record. Address those two issues for us.

Mary Foley: Thanks for the opportunity to speak from both of my roles. I gave a leadership talk last week, and one of the messages I gave to nursing faculty leaders is to be a good leader you have to be a good follower. I think the message that I heard in the film and I've heard here is front-line staff really know, as well as the patient and family, really know what's going on. If we actively listen as leaders to their information, their critical warning signs about how things are not feelings-based, then you'll be a better leader. Making rounds I think is great with the CEO, but people know who the CEO is. I would suggest self-trustee rounds, and partner up, perhaps, with one of the charge nurses or maybe one of the front-line pharmacists and just get out there and hear what staff really feel. They don't say "Yahoo!" at the beginning of the day. They grip their hands and say, "Let's get through today and see if we can keep it safe."

Charles Denham: The Lucy clip.

Mary Foley: It is, yes. So listening, learning really what the front-line staff are saying, they would then better trust you with the information about errors and harm, because they are afraid. They believe in the system, but they're not empowered to use the system. So I've been thinking very deeply about what is patient-centered care. I think patient-centered care is a goal, but I don't think we have the tools or the processes that are very clear, that are tangible, a word that I'm using more these days, to help people process patient centeredness to put in the hands of nurses, patients, and families, the checklist that will keep them safe, whether they're giving meds or administering a dressing change or instructing patients and families in the next transition in care. We're not working from systems guidelines, so there's a lot of variation in practice. But with leadership, those would be in place. With leadership, they would be enforced, and then staff would say, whew, I feel a lot better today that the structure is supporting my safer care.

Charles Denham: You know, I don't think there's a better example of a servant leader than Steve Swensen. Steve has now been given the charge at the Mayo Clinic to carry its culture forward. Anyone [who's] been to the Mayo Clinic can get a piece of that culture, and it's an honor for me to have an appointment there in Health Services Engineering. You're going to help take the Mayo Clinic to the whole next generation, and take the physicians and the administrators and the entire care force of over 55,000 employees to the next generation of leadership. Steve, you've been benchmarking the greatest leadership out there, and you're a great leader yourself. What's your advice and what have you learned? We'll close with that and then move to our next panel.

Stephen Swensen: All staff and organizations look at leaders for example. But the opportunity to role-model is powerful. To do work in healthcare, you've got two jobs: to do your work and to improve your work. So you have to have some basic understanding of the [inaudible]. At Mayo, now, we have 25,227 staff [who] are trained up as Quality Fellows, which is the basic level of [inaudible]: green belt, black belt, master black belt. That happened not because we required them to do it; it happened because the first people to get trained up as Mayo Clinic Quality Fellows were our CEO, Dr. John Noseworthy, and our CEO, Ms. Shirley Weis. Just by having that example up there, the staff said, "This looks like it's something to do" and just spontaneously happened. Role modeling believer of a respected leader in an organization is very powerful and we need to use it.

Charles Denham: I've just been informed we're ahead of schedule. We've also got some folks [who] are delayed on flights coming in, so you get to give us more insight. [Laughter]. One of the areas, David, that we've talked about is – we need to let Steve give the last word again – David, we've talked about the fact that we're woefully unprepared to be trustees as physicians. We come into the boardroom with a mindset as a physician and we have our beast. We know why it's not working, how it's not working, and we're kind of ready to clean up the action and it's a big surprise, isn't it, to go into the boardroom and kind of find out how these big systems operate. As you look back and as you look to other folks [who] would then seek to be, hope [to], would go onto the boards of trustees of hospitals. What's your advice?

David Parda: My advice is that we have to work on both the knowledge base or cognitive gaps as well as the emotional gaps. If you're going to care for patients and family members – any human being – well, you really have to combine the analytic skills with the social and emotional skills.

Charles Denham: Doctors are really known for that.

David Parda: Yeah, right. You know, I went to school and trained until I was 34, and it really was a focus on optimizing critical and analytical skills. The humbling reality is that you can't be a good doctor, you can't be a good leader, if you're not really connecting with not only your patients, but every human being that you're interacting with in an emotional kind of way. Really, board members have to go beyond just the cognitive intellectual exercise. It has to be a people-connected exercise. So for me and my family, since from the time I was 11 years old when my 12-year-old sister, Debbie, was diagnosed with acute myelogenous leukemia and died within a year, it became clear to me that knowledge base was not enough. The disease itself impacted our family in a very negative way, but the type of care really impacted 1972 and 1973, impacted us in a very negative way. It indicated that really intellectual exercises aren't enough for patients. We were hurt by the disease less than we were really hurt by the lack of social and emotional connection. That's a real guiding principle for me as I take care of patients. To the other panelist's point, we're taking care of patients, healthcare professionals, everybody we come into contact with. And board members really want to serve, they want to have that connection, it's just a matter of finding a pathway forward.

Charles Denham: John, build on that, because you spend a lot of time in boardrooms and maybe we need a little dose of reality, because the group in this room are high performers with terrific track histories [who] are out on the leading edge of leadership. John, you were parachuted into a typical St. Elsewhere board. What are you seeing in America today? What's the reality so we can really….

John Nance: [inaudible] pretty good outcomes at Memorial, but the average board is filled with wonderfully dedicated folks who are trying to give back to their community. Many of them are business people. They are much more adept at dealing with dollars and cents than they are at dealing with the clinical realities. One of our problems – and there are a number of them here – one of them is that the Darling case back in 1965 in which basically the nation turned and said, you know, "Who's the final, responsible party for any clinical decision?" It's the board of directors. That went right past everyone. They turned around and put it on the CMO, the Chief Medical Officer or his or her equivalent. I always called this an ambassador without a country, because they're not a member, really, of the C-suite; and yet they crossed over to the dark side with the attitude of all the docs, and they're in this netherworld and the board has repeatedly, in so many thousands of instances, thrown things at them and said, "Well, that's a clinical decision, you just take care of it" – disruptive behavior by physicians, which is a small percentage, but extremely important, terribly deleterious to patient safety. It has been passed off to people who just do not have the horsepower to do anything about it. So when you look at the average board today, one of the things you have to say is, "First of all, we need accelerated education. We probably are going to have to start paying you at some point, because we're going to need to extract a tremendous amount of your time. Thirdly, if you cannot get engaged with the clinical and understand this, then it is time for us to thank you for your service and let's get somebody else on this board." This is why it's important to have physicians on the board – not dominating them, but physicians who understand, as David is indicating, the interface and the difficulty of trying to come out of the clinical and look at the big picture, but still stay engaged with the clinical. But this is going to be one of our keys, especially when we're trying to get things established here that we know – from aviation or otherwise – are necessary for patient safety; and one of them – and you read – I think everybody has – into this especially in terms of care for the caregiver – this is a human institution. Clinical distance can go too far. It has. We have to focus not only on the caregiver and the patient, and when I say patient-centered, one of the things I'm trying to differentiate from is physician-centering, because that's the way we always did it. It was a farmer's market hospital run for the doctors. Now we have to change this around – everyone in the hospital, all the way down to the lowest supposed level of the front lines, has to own it. They have to be not engaged, but owners of it. That's Southwest Airlines, if you want to look at my [inaudible].

Charles Denham: Absolutely. Sharon, you are a trustee at a safety-net hospital. We have a number of them, and most people don't know what a safety-net hospital is. Most people don't know that in about 300 communities across America, the most vulnerable populations are being treated out of almost 6,000 hospitals. They have very unique challenges today that I don't think our nation is rallying behind, because

A) we don't really know the need, and B) we don't know how bad it's getting and how bad it's going to get even further when we have cuts, because when we have cuts, you're already on strands, right? So tell us what a safety-net hospital is and what the unique leadership and government issues are.

Sharon Rossmark: Safety-net hospitals care for our most vulnerable population, as you've indicated. Those are the people who have no insurance or are underinsured. For example, our Sinai Health System, 60% of our population is Medicaid and 20% is Medicare, so as cuts are starting to take place, we're really looking at populations that we're not sure how they're going to continue to receive care if our doors close. In our case, we're one of those few remaining safety nets in the Chicago land area. But to your question about what are some of the challenges, the challenge is talent. The good news for us is that the caregivers [who] are there are people [who] genuinely care and are passionate and easily could go elsewhere and make much more money, but they understand the need and they genuinely care about the population that is served there. So at some point, though, you can only thin your staff so long, so far, to the point where then they're overtaxed and then the caregivers do begin making honest mistakes, not that they're not making honest mistakes otherwise, but then they overtire and then the hours are longer. So the issues begin to just compound themselves. The same thing with the leadership team. You still need the leaders there to help guide the administration, to help guide the [inaudible] system. So at the end of the day, the cuts that are on the table for Medicaid and Medicare are instrumental to keeping the doors open for the vulnerable population; otherwise, where are they going to go for care?

Charles Denham: And the cost of harm could pull you under, whereas a hospital might have enough margin to get away with being inefficient, unreliable, and allow readmissions to occur; that may not be the case.

Sharon Rossmark: Right. Each test will mean the difference between doors staying open and closing.

Charles Denham: So, David, you're sitting next to Bob Chapman. In our session before we went live, he articulated a challenge of a vision statement for us for hospitals and healthcare. Loved ones caring for loved ones. Is that too touchy-feely for doctors? You're out there constantly talking about IT, technical things, clinical things, measurement, and I know you well enough to know that you don't think so. Tell me why.

David Parda: Well, I would say probably because first, it brings us back to why we started into this business of medicine, of caring for people. It gives physicians, caregivers, and clinicians another tool, another resource, because no one wants to ever harm anyone. The devastation that entails with the patient is in some ways also reflected on the caregiver. Having the family involved, having other caregivers involved, actually helps build a larger safety net. It gives physicians another resource that they can rely on, but we've got to be taught to be able to trust these other resources – to be able to listen to the family members [who] come and sit next to the patient in the hospital. We've got to be trained to understand that we can listen from a number of different channels to get all of the information that's needed. But I also wanted to touch on one thing that I mentioned. We talked a little bit about safety-net hospitals and we talked a little bit about cost of care. One thing that isn't frequently discussed is the fact that safety-net hospitals are taking care of, again, our most vulnerable patients. We pay such a tremendous cost, not only in care that is delivered poorly, but in disparate care. That is to say, healthcare disparity may account for up to one-third of the increase in cost that we see every year in healthcare…

Charles Denham: Across the nation.

David Parda: Exactly. So when we talk about being able to deliver care that's better and safer, in part we're also talking about the elimination of disparity in care. Disparity for the minorities, for the underserved, as far as care. That is a safety issue in and of itself also.

John Nance: This is a really important point. We have a nation full of people who do not understand what's going on. They don't understand the equation. There's been a debate in the last number of years about whether there should be universal healthcare. We made that decision decades ago when we said that if you wobble into an emergency room, you're going to be seen, but we're doing this in the most

inefficient and ridiculous way we possibly can. We as a people have got to figure this out, in a way, and I know there's debate about which way you go, but it is not a situation of should we or shouldn't we. We're already there.

Charles Denham: And we're very inefficient. So, Bob, we've heard your vision of loved ones caring for loved ones. Tell us about – what's the snapshot of your leadership model? What is the essence of your leadership model for those who want to know more of what it is.

Robert Chapman: Well, the expression we came to is, "We measure success by the way we touch the lives of people," which applies to healthcare, it applies to manufacturing, it applies to every facet of leadership. If you stop and think about those precious people [who] dedicate their lives – those nurses – when I give a talk on leadership, one of the things people say is, "I got ten things right and I never heard a word, and I made one mistake and I never heard the end of it," and it destroys lives with nurses and doctors. In our leadership model, it's no different than you raising Charlie. Our leadership model is identical to parenting, okay? Our leadership model focuses on holding up the goodness, okay? If the trustees in the boardroom are always talking about metrics and errors, what about all the good things people have done in the hospital. Do you have a balance? If you raise children, and more than 50% of your comments are what they're doing wrong, you are raising a child who lives in an oppressive environment. If we're raising our institutions where we're focused on what we got wrong, the issues we face, and we don't give proper recognition to the good things these nurses and doctors are doing, we are missing the opportunity to engage their hearts and let them go home with a sense of fulfillment. We can talk about that precious child's life who's lost, who we can visualize the parents that we did today, but what about that precious life of that nurse that goes home feeling unappreciated for the gift that she shared that day, because all the focus is on what somebody got wrong or cost of procedure. What we need in this country is to focus on all the people we touch in healthcare, and this came from a service organization, The Ritz Hotel. My wife and I were having breakfast one day and we get exceptional service. I said to the lady giving me service for breakfast, "Why are you treating me so well?" She pulled out a card and it said, "Ladies and gentlemen serving ladies and gentlemen." What does that mean? That she felt as valued as us, and therefore she treated us the way she was treated. Only in healthcare, when we embrace that concept, will we ever deliver safe, compassionate, and efficient care. All of the emphasis is on procedure and it needs to be on those precious caregivers, where if we gave them the opportunity and we gave them the recognition, holding up the goodness in them, not focusing on the brokenness, will we create the kind of healthcare that we want to be a part of that touches our family.

Charles Denham: For those [who] have logged on globally or are on our webinar who have not seen our documentary, *Surfing the Healthcare Tsunami*, Bob Chapman is the Chairman and CEO of Barry-Wehmiller companies. By any metric, for those of us [who] have a background in business and other areas, by any metric, over 50 acquisitions, almost 60 acquisitions, almost all successful, over $1.3 billion in revenue, an incredible financial growth; and yet we're hearing about the heart and about the care and personal empowerment, and I think this is what we want to hear. We just have a hard time believing that the byproduct of having that kind of focus could actually translate into the typical business metrics. But we also heard Clay Christensen, the much-beloved professor at Harvard Business School, when I asked him – and those [who] are logging on will get to see it tomorrow if they watch the Discovery movie, and I asked more of Clay, which is not in the movie. I said, "Do you think it's possible that there could be a Collins level six leader?" Jim Collins was also in the film and wrote the book, *Good to Great*. I asked Clay Christensen, "Do you think there's a level six leader?" He said, "What do you mean?" I said, "Do you think there's a leader who can create an environment where joy can be the focus, that can have a byproduct of the kind of performance at Harvard Business School that they would believe is great?" and he said, "Absolutely," but he hadn't met Bob yet.

Mary Foley: So, Chuck, I can see why Bob's on your list of influential people, and that's a message that I hope permeates healthcare, a really important message. I've been in my quest of doing my studies, looking at healthcare-worker injury, risk of harm from needle sticks, back injury, violence, chemical exposures, and I see an incredible alignment. I'd say for the trustees here and those of you in training, "Why aren't those metrics looked at side by side with the patient safety metrics?" I think, if you would align the two sets of strategies, you'd see incredible similarity – safety climate, safety culture, we even call it

different things but I think it's one thing – it's the right climate in which the caregiver is cared for and then empowered and feels safe to give the best care they possibly can, because their focus can then shift to what they want to do, which is to be the best professional they can be. So I think it's a wonderful conversation. I'm glad you raised it. I think these kinds of decision leaders and folks who are leading the way will make a difference in leadership, and I'm glad to be part of that journey.

Charles Denham: Great, Mary. Next question – I'll give you a second question, and that is care of the caregiver, because it builds on what Bob is telling us that we need to do. If we exhibit – as you told me, Bob, in casual conversations – the same kind of unconditional love and think of an employee the way we would think of our own child, and even when they're not behaving the way that we would want them to behave, but have that unconditional love that we have for a child, rather than discard them. We're discarding a lot of nurses, a lot of pharmacists. We put that in our film – for those [who] haven't watched it yet – we addressed the pharmacist [who] was indicted for actually signing a piece of paper and signing off on a clear IV bag of fluid that he couldn't possibly measure to determine whether it was properly prepared or not. Because of the state that he was in, it's a felony if you sign a piece of paper with your signature that leads to a death – it's a felony. I know Chris Jerry is here; and it was joyful to see true forgiveness, but we were excited to be able to tell the story about forgiveness, but that forgiveness is not happening in America today. We have nurses who are committing suicide, leaving the practice, and it is very easy and convenient when you have a system failure to point out a bad apple, because they're defenseless and they're vulnerable. In the case of one of them that we've seen, the records of the interview after an event are released so that the indictment really happened, and we see that as an active thing. I'm ashamed to say that's in our industry. Address this issue of where are nurses' heads today? At the front line, where are they today? The AHRQ study said two-thirds believe that they can't trust their leaders.

Mary Foley: Yeah, and I think that's really sad, because they really do want to be part of a team. Healthcare is a team sport. It is not an individual activity. It isn't just doctors, just nurses, or the CFO, who we think sometimes they think they do run it. It is really a team and a just culture is what we're really talking about here. An environment in which the leaders follow, the followers feel very instructed in the care that's being given, and the leader will stand there and say, how could I remove the barriers for you so that you can do the best you can. What's the barrier today for you giving that medication as safely as possible. What is the barrier? And then systematically take a look at the structures, the support, the resources, the equipment, the computer, whatever it takes to then guide that setting so that it's safer. When a staff person is asked to file a report, A) they're either suspicious that it is going in their file, more importantly, they don't think it makes a bit of difference. They don't feel that there's anything different tomorrow than what happened the day before, as a result of reporting a near-miss or perhaps an actual error. That's really sad, because there has been a pattern of nothing changing, and you show up again on Tuesday and it's just like it was on Monday, and you wonder, when are they going to get the message. How many people have to be hurt. How bad to the headlines have to be before there's actually a response. So it is leadership. It definitely is leadership helping the folks giving the care to do the best they can.

Charles Denham: Well, I'd like to thank this panel. A terrific panel. We're going to keep moving forward with our groups, but thank you very much. I know that our audience here at the National Press Club and other panelists and staff, and I know there will be an opportunity to cross-pollinate as we shuffle the deck of our panels; but all of you, all of you are great leaders and great role models and we're so grateful to have this much talent up on the stage. We could make a whole day of it. Thank you very much.