LEVERS OF EXCELLENCE IN HOSPITAL LEADERSHIP:
Lessons from the Chief Executives of Pennsylvania’s Best Hospitals

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Across the country, hospitals are under increasing pressure to deliver higher value care – patient-centered service that is attentive, state-of-the-art, error-free, and at a reasonable cost. In part this is due to an insurance industry which is increasingly scaling hospital payments by the actual quality of clinical care delivered, and in part it is due to a rise in consumerism in a better-informed patient base. To service these needs, measurement organizations have emerged to create balanced scorecards that rate hospitals in meaningful and objective ways, ranging from hospital-acquired infections to customer satisfaction. These ratings generate the “Top Hospital” lists that have become so familiar to us all.

But every year we see the same names topping the lists of superior hospitals. What is it about these trendsetters that sets them apart? Our contention is that it is the leadership of these organization that makes the difference, by both empowering their workforces in innovative ways, and by better collaborating with their corporate boards to assure priorities are aligned with the values and needs of the community. At the helm of leadership is the Chief Executive Officer.

The modern hospital CEO faces a daunting challenge in confronting an ever-changing healthcare landscape. Demands for increased transparency, confusing new models of care, declining reimbursement, and mounting regulations mean that the old ways are no longer recipes for corporate success. Effective management requires a more collaborative approach with a much broader array of stakeholders, all of whom must work together seamlessly. The modern hospital CEO is now less like an aircraft carrier commander, more like a symphony conductor.

In this article we have reached out to some of the CEOs of Pennsylvania’s top-performing hospitals, to determine what it is that fuels their successes. All hospitals can obviously not be the best. Our goal is to share the winning strategies openly, so communities – from families to hospital trustees – can better partner with their local hospital leadership in creating health care which is safer, more dignified, more responsive, and less costly.

The PRHI Positive Deviance Project

The positive deviance approach to healthcare quality improvement presumes that the true drivers of success can be found by studying the practices of the highest performing providers or organizations. It implies that new best practice strategies do not need to be invented; they are out there, already pragmatically adjusted to compensate for custom, attitudes, barriers, and human behaviors. They merely await to be revealed.
We at Pittsburgh Regional Health Initiative have been trying to use positive deviance to identify translatable elements of premier healthcare organizations, using newly available “big data” reports published by the Center for Medicare and Medicaid Services (CMS) and other outlets. For example, we have recently shared our analysis of the top regional performer in fall prevention among long-term care facilities, in hopes that the described methods might be adopted by like organizations that aspire to improve1.

In this report, we apply the same approach to hospitals CEOs. We have accessed regional hospital rankings on public websites to identify the best of the best, then conducted structured live interviews with each. The findings are presented below.

How hospitals are rated

Declaring which hospital is “best” is a difficult task. What defines excellence? Is it the facility with the lowest mortality rate, the fewest preventable readmissions, the most compassionate nurses, the highest level of technology, physicians from the most prestigious medical schools, an architecturally splendid physical plant, or the lowest costs of care? Perhaps it is all of the above.

Many entities have attempted to rank America’s hospitals using a blended scorecard approach, relying mainly on publically accessible metrics combined in a way that quantifies quality such that fair comparisons are possible. The most widely recognized compilation is CMS Hospital Compare, an annual online report released by the Center for Medicare and Medicaid Services, which ranks the nation’s 3,700 general acute care hospitals by 70 individual metrics in six different domains: patient experience, timely and effective care, complications, readmissions and deaths, imaging utilization, and payment and value. The size of each category conveys a weighting, with the greatest emphasis being placed on consumer satisfaction with the inpatient experience.

This latter metric, known as the “HCAHPS Score” (for Hospital Consumer Assessment of Healthcare Providers and Systems), is a series of 32 simple questions asked of discharged patients, which is tabulated, benchmarked, and ultimately distilled into a rating from five stars (the most excellent) to one star. (Question #3, for example, is: “During this hospital stay, how often did nurses explain things in a way you could understand?”) The star system proved to be quite attractive to consumers, and in 2016 CMS began making available the entire Hospital Compare summary as a global single five star rating, in addition to the individual reports by categories.

PRHI’s survey of the healthcare marketplace revealed that there are also a myriad of other hospital rankings available on public websites. Some of these repackage HCAHPS and other CMS Hospital Compare ratings into unique combinations, occasionally merged with other-source data. Some are new reports developed to support federal pay-for-performance programs, such as the CMS Hospital Acquired Condition Score or the CMS Value Based Purchasing Score. In addition, there are private initiatives,

including The Leapfrog Group (which combines multiple patient safety metrics) and the U.S. News and World Report Best Hospital Rankings (based largely on reputation surveys). A summary of ratings consulted for this report is shown in Table 1.

Our experience is that no single ranking prevails, and there is substantial variability among the organizations that top each “Best Hospitals” list – a fact that may confuse consumers. Taken as a whole the rankings group enables entities to be viewed through multiple lenses, and can actually impart advantages.

Pennsylvania’s best hospital CEOs, and what we learned from them

In preparing a short list of “positive deviants” from the sources listed in Table 1, the PRHI Research Team emphasized two factors: hospitals that exhibited high rankings simultaneously on multiple publically-available lists, and hospitals that were repeatedly top-tier over multiple years. Insofar as we were ultimately seeking to profile leadership, we also considered the personal opinions of unbiased thought leaders in the healthcare community. Lastly, we limited the field to CEOs of organizations within the Commonwealth of Pennsylvania.

Our analysis was not scientific, but attempted to be both objective and illuminating. We relied upon data that was in the public domain in December 2015, and we specifically sought those CEOs who were in office in the years during which the data was collected. Lastly, interviews were performed separately, and the executives were unaware of each other’s responses.

Four individuals repeatedly came to our attention, and served as profiles in this report:

- **James Collins**, CEO of St. Clair Hospital, a 328-bed independent general acute care facility near Pittsburgh
- **Tom Beeman**, then-CEO of Lancaster General Hospital, a 630-bed organization located near the state capital of Harrisburg
- **Jack Lynch**, CEO of the 5-hospital Main Line Health System in suburban Philadelphia
- **David Feinberg, MD**, CEO of the 12-hospital Geisinger Health System based in central and northeast Pennsylvania, and in New Jersey

During identical structured live interviews conducted by the co-authors, the four CEOs distinguished themselves by their energetic, charismatic approach to health care in general, and their intense commitment to their individual communities and organizations. Questions were open-ended, and the interviews were paced to allow ample time for them to expand on areas of their choosing.

In short, we found that the CEOs were remarkably similar in their basic management styles, however each exhibited a unique personalized theme which defined their leadership. It is those “levers” that differentiated them from each other, and revealed a deep awareness of their community, the nuances of their marketplaces, and their strategic position. We felt that the selective use of these levers powered their successes, and is our focus below.
Without question, the most common shared value was a complete investment in measurement and transparency. It was not an ethereal admiration of data; it was a relentless, gritty focus on embedding measurement into every aspect of work. “We’re a metric-driven organization”, explained Collins. “You can’t manage what you can’t measure.” All four organizations relied heavily on dashboards with key corporate targets – many of which were adapted from Hospital Compare – that were regularly circulated to staff, physicians, and even board members. Surprisingly, internal pay-for-performance was common, with three of the four systems tying scorecard outcomes to compensation, for staff, managers, and occasionally employed physicians.

Another common shared value was presence – the act of being visible, involved, and attentive in the day-to-day operations of the organization. Lynch explained that he is known as “Jack” to most employees as he roams the halls at Main Line Health. Beeman was a regular participant in Safety and Leadership Rounds at Lancaster General, covering the 120 acre clinical campus. Collins hosted Town Halls at St. Clair, and introduced the frequent training classes. Feinberg capped his in-office time at the Geisinger corporate office in Danville at two days per week so he could focus on patients at the geographically diverse clinical sites. Feinberg also famously sent his personal cell phone number to the home of every employee, and freely gives it to patients. Even though all of the CEOs embraced virtual technology in management, it was regarded as an adjunct and never a substitute for just showing up and being there.

There was only one area where the CEOs split into camps, and it was in response to the question: “Did culture-change precede system-thinking, or did system-thinking lead culture?” Perhaps not surprisingly, the division occurred by organizational size. The two single-hospital CEOs, Collins and Beeman, advocated investment in skill-building to break down the traditional intramural barriers within their organizations, and sought to begin with a common culture of quality. Alternatively, Feinberg and Lynch stressed the primacy of carefully-designed systems to streamline their multi-facility organizations. “You need a roadmap first”, responded Lynch. Added Feinberg, comparing his current position to his earlier career in a prestigious academic health center: “Before, the doctor was the star. Here at Geisinger, the system is.”

Indeed, the leaders we profiled were cut from the same cloth. But where their similarities ended marked the point where we appreciated their highly individualized approaches. Each CEO displayed a core theme which defined their management style. These “levers of excellence” – Culture, Stability, Preparedness, and Community – were what we were seeking in identifying the drivers of executive positive deviance in hospital leaders.

CULTURE: How Jim Collins created a place where ordinary people accomplish the extraordinary

When Jim Collins arrived as the new CEO of St. Clair Hospital in suburban Pittsburgh, it was with an agenda for change. The hospital was posting unimpressive scores on public quality and patient satisfaction reports, and the board wanted to see the organization perform better. Collins hence began his tenure by delivering a reality check.
“The first step for an organization that wants to get better is to candidly assess where you are,” he shared. “(The data was) less than mediocre, which was jarring to the organization. The urban legend that the hospital created for itself was that St. Clair is great, and every complimentary letter we received was shared throughout the land. But the surveys were discounted.” He added: “The organization had been telling itself to ignore the reports.”

Collins began by changing the entire organization’s attitudes about data – from the medical staff to the frontline employees. He first directed his leadership team to put the public reports under the microscope, and separate fact from fiction. The internal perception was that St. Clair drew upscale, hard-to-please patients from affluent suburban neighborhoods, and mediocre ratings were inevitable. But when the team re-ran satisfaction numbers by zip code, they found no correlation between patient satisfaction and socioeconomic factors. The organization was forced to admit that the problems that led to low scores on public reports were real and ran deep.

Next, he made measurement part of everyday work, and raised the bar. “We set for ourselves the goal of being in the top 10% of the nation in everything. At one point in time we were the prisoner of low expectations. We said things like ‘we’re good for a community hospital’. We then changed our philosophy and said we’d have no qualifiers on our performance”. Whether internal Press Ganey scores or online Hospital Compare rankings, all reports and all measures would become institutional priorities.

At this juncture Collins made his most important decision. Rather than overload his management team with a multitude of quality improvement initiatives, he focused on a single aspect of his organization: its culture. Collins had a vision of converting his entire workforce – every employee – into an army of
trained and empowered problem-solvers which could address every flaw at the point-of-care and in real time. “In the right culture, ordinary people can do extraordinary things”, he explained. “That is the essence of leadership. The answer to that is culture.”

Early on, St. Clair adopted the Lean Toyota Production System as a core quality improvement methodology, and hired a small team to act not as Lean quality improvement managers, but as Lean educators. Every St. Clair employee was subsequently trained in both Lean engineering and guest relations. In addition, employees in cohorts of 20 participated in a rolling Toyota Champions program to encourage independent quality improvement projects. St. Clair has even tied activity in quality improvement initiatives to compensation.

But to really get buy-in from his entire medical community, he needed a watershed quality improvement initiative – something that would disrupt his organization’s preconceptions and ignite change. He decided to start with one of its most vexing issues: wait times in the emergency department. Patient satisfaction surveys placed St. Clair at the 14th percentile nationally in this performance metric, and over 100 patients per month were leaving the ED without being seen. It was the flagship issue he needed.

The ED staff members were trained to conduct their own observations, workflow analyses, tests of change, and plan-do-study-act cycles. Patient flow was radically restructured, and the door-to-room time gradually fell from 54 minutes to 4 minutes over the course of one year. Patient satisfaction rose to the 99th percentile, and St. Clair was recognized as being the top performer in the United States among emergency departments with over 50,000 visits per year.

As the organization realized what it could accomplish, its perceptions about itself were reshaped. Collins leveraged this in adapting his leadership approach.

“The deal between workforce and management has changed”, explained Collins. “The old model was: Who is the best employee? It used to mean the employee who noticed a problem, suffered in silence, and developed a work-around. The way we are going to evaluate you now is that if you can’t find a single opportunity for improvement, you can’t possibly be a great employee. There are opportunities everywhere you look. To be a great employee you can’t just complain about things. We’re not looking for reporters. We’re looking for people who can help us improve.”

The commitment to culture has paid indirect dividends. “What is not commonly known is that we have the lowest staff vacancy rate in the region, and our turnover rate is exceptionally low, too. The secret is to get the right people and have them stay. If you aren’t constantly retraining, you’ll have fewer mistakes”, he added. “People come here because they want to be part of this culture”.

Collins feels strongly that the primacy of culture over strategy would work in most healthcare settings. An avid reader of healthcare organizational history, he notes that the American hospital evolved as a collection of trades under one roof – a concept that has been surprisingly durable to this day. The key to improving hospital care is to not repair each department or unit, but rather to facilitate a common culture of self-repair. The strategy was the right choice at the right time for St. Clair Hospital and Jim Collins.
PREPAREDNESS: Tom Beeman doubled-down on scenario planning and medical staff development to prepare Lancaster General Hospital for the future

When Tom Beeman became CEO of Lancaster General Hospital in 2005, he brought with him the sensibility of a military tactician. Perhaps his background as a Navy flag officer had something to do with that.

Although the central Pennsylvania health marketplace may have been less tumultuous than the environments in Pittsburgh and Philadelphia, all that meant was that the distractions were different. Beeman was still charged with navigating Lancaster General, a pillar of the community, through the uncharted waters of the coming decade. Strategically, Beeman invested in a critical commodity: exquisite preparation.

The approach LGH used was a traditional military technique called scenario planning. Rather than rely on a linear strategic plan to chart the path ahead, Beeman held a retreat with his leadership team, medical staff, and board members, and invited them to conceptually leap into future scenarios and gauge LGH’s capacity to succeed. For example, one scenario envisioned a future customer base composed of millennials demanding digital communications to support their healthcare needs. Did LGH have the IT infrastructure to support such a shift in traditional communications? What investments needed to be made? Another scenario was an aggressive move of a for-profit urgent care provider into their market. How would LGH compete with a Wal-Mart? Would it want to?
Scenario planning is an edgy alternative to typical health system strategy sessions. The method levels the playing field across leadership teams, gives voice to the contrarians, and allows participants to take risks. Not only does this create a forum for truly innovative ideas to come to light, but it also enables controlled disruption of the hospital hierarchy. In this way emerging leaders may be revealed.

In most cases, scenario planning translated into real course corrections as LGH plotted its path forward. But the most important scenario was in anticipating the organization’s ability to manage financial risk as it prepared for a future increasingly defined by accountable care organizations and other alternate payment models. Did it have the financial reserves to withstand a catastrophic clinical error? Would it be able to attract and assemble the quaternary resources required to offer the next generation continuum of care to residents of central Pennsylvania? As a freestanding $1 billion organization, were they strong enough for the future? This introspective approach led Lancaster to ultimately pursue a strategic relationship with the University of Pennsylvania Health System, which evolved into a successful full integration in 2015.

Beeman made one other early investment that paid compelling dividends, especially as the organization prepared to tackle big issues that had huge impact on the medical staff; he developed a cohort of management-savvy physician champions to be a virtual part of his leadership team. Beeman had begun experimenting with a Physician Leadership Academy soon after arriving at Lancaster General, but he felt that training people one-by-one was insufficient. He needed a group that had an inherent cohesion, so three years ago he created an entire leadership cohort to pursue MBA training together at the Haub Business School at St. Joseph’s University. Sixteen physicians and five non-physician leaders completed the two year training together. He produced a critical mass willing to carry the ball. “This was a cohort I wanted to run together”, explained Beeman. “I knew I had at least 16 physicians who would talk the talk and walk the walk. They started to grow, and to this day provide significant leadership as clinical chairs, or senior executives leading major initiatives, like the population health director, chief quality officer, president of medical group, and chief physician executive. These are the type of people to move the needle in a value-oriented world.”

The original cohort of sixteen had an age range of 30 to 60 years. There will be a critical mass of physicians available for the next 20 years, “but my intent was to make this on a rotating basis every 3 years or so”, Beeman explained. “You are always refreshing your leadership”.

(Note: After the merger with the University of Pennsylvania Health System, Dr. Beeman assumed the position of Chief Operating Officer for Regional Operations with the parent organization. Because he was CEO at Lancaster General Hospital during the public reporting period featured in this report, the authors chose to conduct the interview with Dr. Beeman.)

**STABILITY: Displaying a steady hand was how Jack Lynch vaulted Main Line Health to the top of the rankings in a challenging Philadelphia marketplace**

Decades in healthcare leadership roles in health systems had made Jack Lynch, President and CEO of Main Line Health, quite aware of the disruptive impact of corporate instability. In a Philadelphia marketplace characterized by mergers and acquisitions, the indelible picture of suitors walking the halls
doing due diligence was a concern, especially with an recent influx of for-profit hospital chains reshaping the local healthcare marketplace. “This impacts staff attitudes,” said Lynch.

He countered by putting four words at the center of his organization’s new strategic plan: “We’re not for sale”.

Under Lynch’s leadership, Main Line Health’s five hospitals have typically appeared on many “Best of” lists. Although he admits that Main Line is the beneficiary of an enviable suburban footprint with a financially favorable demographic, it is not an upscale and health-conscious clientele that powers the organization’s success on public surveys. Lynch believes that the system’s strategic reinvestments in its workforce and physical plant that keep it at the top. The system deliberately maintains employee staffing ratios at the high end of industry standards to create a more responsive and welcoming environment for patients. “Patients positively respond to the extra attentiveness”, said Lynch. The organization’s strong balance sheet also allows it to provide the best tools to its workers, from recent decisions to replace aging hospital beds and infusion pumps, to a sweeping system-wide upgrade to a costly but comprehensive electronic health record.

Although important, the culture-first approach adopted by St. Clair was not the right fit for Main Line Health. Lynch had a different challenge; how to juggle situations in five different communities at five different hospitals. “We are the sum of our parts. System must precede culture,” noted Lynch.
Main Line Health also made a strategic decision to invest heavily in building a strong and resilient workforce, with everyone’s focus on the patient. All employees – including employed physicians – attend a mandatory six-hour “I Am the Patient Experience” workshop. Exceptional performances are openly acknowledged in two different award programs, one for Patient Care, another for Culture of Safety. The employee group as a whole is rewarded with an annual cash bonus based on a blend of corporate financials and patient satisfaction scores. All employees feel they have skin in the game. They are directly connected to the public measures of success.

But creating an environment of extraordinary workforce stability goes beyond recognition and incentives. Main Line Health invests substantially in the dignity of the employee experience. The issue was brought to light when Lynch received an anonymous email from a staff member dismayed by a racially insensitive remark by a co-worker. With a multicultural workforce drawn largely from metropolitan Philadelphia, such behavior directly threatened the high morale that Main Line Health leadership tried so hard to maintain. Lynch and his team responded by implementing a “Diversity, Respect, and Inclusion” two-day workshop for executives and managers, during which probing discussions of race, gender, sexual orientation, and education were held. The experience has been transformative, and will soon roll out to all employees.

The emphasis on creating a great work environment resonates with Main Line Health’s nursing and medical staffs. All five Main Line Health hospitals have been recognized as “Magnet” facilities by the American Nurses Credentialing Center, the ultimate achievement in high-quality patient care, and a badge of the country’s finest workplaces for nurses. At the time of the designation, only 22 health systems in the United States had attained this system-wide distinction. Such recognition has been a boon to physician recruitment, with Main Line Healthcare – the system’s employed physician practice - growing by 20-30 young physicians per year.

Lynch prides himself on the high morale he has maintained across the system. The organization has remarkably low staff turnover rates, and has attained “World Class” status in Gallup and Advisory Board satisfaction surveys. Patients experience concierge-level care while the hospital posts top-decile quality scores.

The spirit that Lynch was trying to build across Main Line Health’s five campuses was summed up in his closing words: “This is a fun place to work”.

**COMMUNITY: Sustaining a health system without walls allowed Geisinger’s Dr. David Feinberg to lead the nation in population health**

When Dr. David Feinberg came to the Geisinger Health System in May 2015 after 25 years in leadership positions at the University of California at Los Angeles, he was confronted with a curious management challenge. Unlike the other leaders we have profiled, Feinberg did not have to implement a new system, build a corporate culture, disrupt, or re-invent. Geisinger was thriving. His charge was to protect the
gains of the organization, and prepare it for the future. But to do so, he had to fully understand what allowed Geisinger to repeatedly appear atop rankings of best hospitals. What he learned astonished him.

He found was that the health system and the community were inseparable. “I didn’t get this until I moved out here. I don’t want to get too psychodynamic, but there is a love between the community and the organization that is bi-directional. In California, if Kaiser left, everyone would find a new doctor and new hospital. In Danville, if Geisinger failed, communities would literally collapse.”

“We are the community”, Feinberg added. “Multigenerational people work for us, are engaged with us, and we care for them. In some of the communities where we have our 12 hospital campuses and 250 offices, the only restaurant in town is the cafeteria. It is a unique relationship of a thriving medical business in a part of the country that has seen better times. That relationship, the stability of the people, interacting with Geisinger, has allowed us to do things that other places can’t.”

This special synergy resulted in Geisinger assertively moving toward population health well ahead of much of the country. An early bet to deploy the Epic electronic health record system-wide over 20 years ago allowed the organization to use data to first identify, then painstakingly fill gaps in care, both within the hospital and in the community. Medical offices were reconfigured into team-based medical homes, with care managers, embedded behavioral health specialists, and disease-management pharmacists, all provided by Geisinger.

The ability to better control post-acute care allowed the organization to roll out its ProvenCare® initiative ten years ago, in which Geisinger “guarantees” its outcomes by refusing to accept payment for
unplanned readmissions or complications. First successfully offered to its open heart surgery patients, the hospital now attaches it to 15 services and procedures. The New York Times called it “the first warranty in healthcare.”

Since arriving, Feinberg has expanded the concept to all patient relations offered by the health system through a new program called ProvenExperience®, and included something even more controversial – a money-back guarantee. “We’ll answer the phone when you call. We’ll treat you as if we were expecting you, so when you show up it won’t be like a surprise. We’ll offer same-day appointments for every specialty, regardless of acuity. If you need a well-woman check-up when you happen to have a day off of work, we will see you then. The care will be high quality and low cost, but also compassionate, kind, dignified, culturally sensitive. And we’ll even send you a bill that you completely understand. It will look like a restaurant bill or one you’d get at the supermarket,” he explained. The initiative has accelerated a system-driven change in culture.

“After 6 months of our no-questions-asked money back guarantee, we gave back just over $100,000. I asked my CFO how much we gave back in the same period last year (before the guarantee) – this was interesting – he said we actually gave back a little more.”

Like the other CEOs profiled above, Feinberg does invest in universal training for his 30,000 employees. But the skill-set he felt was most valuable to the organization fell more into the category of concierge care than quality improvement. To date, 98% of employees completed coursework in CICARE (“Connect with compassion, Introduce with integrity, Communicate with teamwork, Ask with discovery, Respond with respect, and Exit with excellence”), a method he previously used to boost patient satisfaction scores at UCLA.

Is this training why Geisinger posts such excellent HCAHPS scores? There Feinberg counters that high scores are unimpressive when the bar is actually set so low. “To get 98th percentile, you have to get 85 out of 100 people to say ‘great’. That means that we failed the last 15 out of 100 people who came to us. We didn’t communicate or coordinate for 15% of people who came to the hospital at this vulnerable time. In any other industry you’d be out of business.”

Feinberg sees the rise of consumerism in healthcare as a good thing, especially when combined with disruptive innovation. “High patient satisfaction scores compared to other hospitals is the wrong benchmark. You need to be as satisfied when you come to see me as you are using Amazon or going to the Apple store. As health care moves more and more toward retail, some dropout from Stanford will completely disrupt our industry, and we’re going to be Kodak or the taxi companies instead of Uber.”

With such a strategic focus on community, could the Geisinger model work outside of rural Pennsylvania? The idea is being tested as the system expands throughout the state and beyond – and the early results are interesting. “The secret sauce can be exported – if you want it”, Feinberg assured.

An October 2015 merger with AtlantiCare, a Baldrige-winning New Jersey health system, proved the point. After implementing corporate systems through Geisinger’s XG Health Solutions spin-off, the hospital saw dramatic declines in readmission rates and length of stay within 9 months. Alternatively, an urban Pennsylvania acquisition has not gone quite as smoothly. “It depends upon whether organizations believe, in their core, that population health is what they want to do – to go from volume to value. If you believe it, we can come in and make it happen.”
Feinberg was a newcomer to the Geisinger community, but rapidly recognized that the challenges of providing care to rural and underserved parts of Pennsylvania could be turned into a strategic advantage. “Because the community is poor, we have to innovate to keep costs low as well as quality high”, he explained. “If we get it right with our patients, are authentic and doing our very best, communicate and coordinate, I’m positive nothing can stop us. The community won’t let anything bad happen”.

**In summary**

We have found that excellence in hospital leadership is built around many common themes, including humility, visibility, attention-to-detail, tact, respectfulness, collaboration, constancy, and discipline. Autocracy was eschewed. Importantly, all of the CEOs to whom we spoke regarded their leadership as a team effort, but struggled to define the boundaries of their teams. All regarded their employees, board members, and medical staffs to be as intimate and vital to them as their colleagues in the C-suite.

In this overview, however, we found the differences between the leaders to be far more compelling than their similarities. Each CEO displayed uncanny adaptiveness to their unique situation. Like a quarterback “reading the defense” before the play and adjusting his team’s formation, each leader took the time to deeply understand the unique strengths, weaknesses, opportunities, and threats of their world, and build a management plan that aligned with those drivers while leveraging their own personal style.

All took different paths. Collins found organizational excellence by asking his team to look inward, while Feinberg realized it by looking outside the hospital. Lynch paid exquisite attention to the realities of the present, while Beeman had his eye focused on the future. As diverse as these approaches were, they demonstrated the singular willingness to listen and adapt. Perhaps that is the path for any American hospitals to ascend to the top of the lists.
Biographies of the CEOs

James Collins
President and Chief Executive Officer
St. Clair Hospital
Pittsburgh, Pennsylvania

James M. Collins came to St. Clair in April 2006 as only the third President and Chief Executive Officer in the Hospital’s 60 year history. Prior to joining St. Clair, Mr. Collins was President and Chief Executive Officer of The Western Pennsylvania Hospital from 1999 to 2006. He had previously served in progressively responsible positions since 1986, earning the Regent’s award from the American College of Healthcare Executives for Early Career Achievement in 1992. Mr. Collins earned a master’s degree in health administration in 1987 from the University of Pittsburgh, where he was a fellow at the Health Policy Institute. He also earned a bachelor’s degree from the University of Pittsburgh in 1981. Mr. Collins is a member of several professional organizations, including the American College of Healthcare Executives, and currently serves as treasurer of the board of directors of the Hospital & Healthsystem Association of Pennsylvania (HAP). Mr. Collins and his wife Lori reside in Mt. Lebanon, Pennsylvania, and have two adult children.

Thomas Beeman, Ph.D., FACHE
Chief Operating Officer, Regional Operations
University of Pennsylvania Health System
Philadelphia, Pennsylvania

Dr. Beeman has more than 40 years of experience in the healthcare field and is responsible for the regional operations of the University of Pennsylvania Health System. Prior to joining Penn, he served as President and Chief Executive Officer for Lancaster General Health. He is a fellow of the College of Physicians of Philadelphia, a Fellow of the American College of Health Care Executives and a member of the Association of Military Surgeons of the United States. A Rear Admiral in the United States Navy Reserve, he is currently serving as the Assistant Deputy Surgeon General for Reserve Affairs. He holds a Ph.D. from Vanderbilt University; a master’s degree in Hospital Administration from Widener University; a master’s degree in Health Education and a bachelor’s degree in Community Health Studies from St. Joseph’s University. He is the author of “Leading from Within” and has published myriad of academic articles.

Jack Lynch, FACHE
President and Chief Executive Officer
Main Line Health
Philadelphia, Pennsylvania
John J. (Jack) Lynch III has served as president and CEO of Main Line Health since 2005. Main Line Health is comprised of four acute care hospitals: Lankenau Medical Center, Bryn Mawr Hospital, Paoli Hospital and Riddle Hospital, as well as Bryn Mawr Rehab Hospital, Mirmont Treatment Center (addiction treatment programs), the Lankenau Institute for Medical Research and the Home Care Network. Prior to joining Main Line Health, Lynch served nearly 20 years as an executive with the St. Luke’s Episcopal Health System in Houston, Texas, where he advanced to the position of Executive Vice President and Chief Operating Officer for the system, as well as CEO of the system’s flagship facility, St. Luke’s Episcopal Hospital. Lynch received his undergraduate degree from the University of Scranton in Pennsylvania and his Master of Health Administration degree from the Washington University School of Medicine in St. Louis, Missouri.

David T. Feinberg, MD, MBA
President and Chief Executive Officer
Geisinger Health System
Danville, Pennsylvania

David T. Feinberg, MD, MBA is president and chief executive officer of Geisinger Health System. Dr. Feinberg received his undergraduate degree from University of California, Berkeley, graduated with distinction from the University of Health Sciences/Chicago Medical School, and earned a Master of Business Administration from Pepperdine University. He is triple-board certified in child, adolescent and addiction psychiatry by the American Board of Psychiatry and Neurology. Awards include Alpha Omega Alpha Medical Honor Society; Medical Center CEO of the Year Healthcare Leadership Award; Distinguished Fellow of the American Psychiatric Association; and the Cancro Academic Leadership Award from the American Academy of Child & Adolescent Psychiatry. Dr. Feinberg previously served as CEO of UCLA’s hospitals, associate vice chancellor UCLA Health Sciences, and president of UCLA Health System.
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Lastly, we are indebted to Mr. Collins, Dr. Beeman, Mr. Lynch, and Dr. Feinberg for their time and candor in sharing their approaches to hospital leadership. In a healthcare sector that is more competitive than collaborative, such openness is a glimmer of light.

About Pittsburgh Regional Health Initiative

Founded in 1997 as an operating arm of the Jewish Healthcare Foundation, the Pittsburgh Regional Health Initiative (PRHI) is one of the nation's first regional collaboratives of medical, business, and civic leaders organized to address healthcare safety and quality improvement as a social and business imperative. PRHI has guided efforts to drastically reduce hospital-acquired infections, bolster the healthcare workforce, and transform care delivery and payment through demonstration projects that smooth the transition for patients between medical and community settings and integrate physical and behavioral health care. PRHI is a founding member and plays a leadership role in the Network for Regional Healthcare Improvement (NRHI), a consortium of over 30 multi-stakeholder organizations across the U.S. that serves as a key resource for healthcare policy decisions.

About the Authors

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Table 1: Selected Publically Available Ratings of General Acute Care Hospitals in the Commonwealth of Pennsylvania

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