RICHARD J. UMBDENSTOCK

Past President & CEO
American Hospital Association

EDUCATION

Bachelor of Arts, Politics, Fairfield University

Master of Science, Health Services Administration, State University of New York at Stony Brook

CAREER

American Hospital Association
President & Chief Executive Officer (2007–2015)
Chief Operating Office & President-Elect (2006)

Providence Health and Services, Seattle, Washington
Executive Vice President, Advocacy, Governance & External Affairs (2006)

Providence Services, Spokane, Washington
President & CEO (1993–2005)

Umbdenstock-Hageman
Independent Governance Consultants (1983–1993)

Sacred Heart Medical Center (1980–1983)

American Hospital Association (1975–1979)

Hospital Association of New York State (1974–1975)

AWARDS & RECOGNITIONS

Honorary Member Award
Association of Nurse Executives, 2015

Gold Medal Award
American College of Healthcare Executives, 2015

Health Care Leadership Award (Inaugural)
Federation of American Hospitals, 2015

B'nai B'rith International National Healthcare Award, 2014

Honorary Doctor of Laws Degree, Gonzaga University, 2003

BOARDS & AFFILIATIONS

Vice Chair, National Quality Forum, 2013–2015

Board of Directors, National Quality Forum, 2007–2015

Member, National Priorities Partnership, National Quality Forum, 2007–2015

Board of Directors, Enroll America, 2010–2015

Co-Chairman, CAQH Provider Council, 2011–2015

Chairman, Hospital Quality Alliance, 2006–2011

The National Center for Healthcare Leadership is honored to present the 2015 Gail L. Warden Leadership Excellence Award to Richard J. Umbdenstock for his tireless work to transform and improve healthcare and unparalleled leadership in breaking through the divisive debate on health reform to help drive change in the nation's healthcare system.

LEADING THROUGH TUMULT: THE VALUE OF LISTENING, BRINGING PEOPLE TOGETHER, AND FINDING COMMON GROUND

Richard J. Umbdenstock
Gail L. Warden Leadership Excellence Award Recipient

Rich Umbdenstock's healthcare career finished where it started. The immediate past president and CEO of the American Hospital Association (AHA) began working at the AHA in 1975—one year after receiving his master's degree in health services administration—as a special assistant to the president. And then, step-by-step, he carefully moved through his next series of roles as if he knew all along he was preparing to return to lead the AHA through one of the most crucial and conflicted eras of its 116-year history. His consulting career, his focus on governance, and his experience enabling collaboration, building consensus, and navigating healthcare's complexity all came together as the tumult of the Affordable Care Act unfolded into headline news—and stayed headline news—for the entire eight years that Rich headed the organization.

Q. What has inspired you as a leader throughout your career?

A. It's fair to say that my parents inspired me. My parents were both hospital volunteers; they always made time for others. So I think about them when I think about leadership and mentoring. Rather than trying to figure out how to develop leadership skills, I have tried to be open and accessible to others, just like my parents. I don't think so much about formal mentoring, but I have never been shy to offer my advice and I am always willing to continue the conversation. Mostly it's a matter of liking people and liking to stay in touch and being available. When you have a big job people automatically assume you don't have time to be accessible. That has not been true for me.

Q. Did your parents influence your choice of healthcare for a career?

A. I grew up around a lot of hospital talk and events, so I always had the interest. Medicare was exploding—and there was tremendous concern about access for seniors and cost for the nation. Initially, I was focused on the business side but I came to realize the importance of the social good. In my first job I organized and conducted seminars for the member hospitals, including educational sessions for hospital board members to help them understand their role, even though many hospital administrators did not always want them more involved. Over time, I developed a specialty of interpreting the business of healthcare to community leaders so they could better understand the field, and importantly, understand why they were in a business that competes for non-paying customers.

Q. What have you learned about your leadership style and how did that equip you to lead the AHA?

A. My big learning is that I am always better at moving large blocks of a puzzle than the small, finer ones; I am good at taking the broader view, seeing the interplay between things in a dynamic situation, and bringing diverse opinions together towards a common goal. Fundamentally, I am a facilitator, which is why I think I did well in consulting. I know my strength—it's listening to different sides of the conversation and bringing people together to reach consensus. I have used that skill throughout my professional life.

Q. Passage of the ACA was a major event during your tenure. How did you work with your members, especially with all the opposing views?

A. During healthcare reform, I had to carefully listen to and engage with our 5,000 AHA members. We did a lot of work tracking what our members were thinking as the debate progressed: 70 percent favored our actions, about 20 percent were neutral, and the final 10 percent were opposed, so we felt we had strong support. Opinions were varied, even after the ACA passed. Some in that final 30 percent against it were vocal; some threatened and a few did drop their membership. But as the AHA leadership, both board and staff, we were clear—change was needed and this was our best opportunity to lead and do what was best for patients and communities. We could see that mergers and acquisitions would create integrated delivery systems that would be better for patients; hospitals would need to prepare for more financial risk because the fee-for-service payment system would not last indefinitely; providers would be dinged for readmissions and other complications; and there would be more accountability as patients and their families would insist on more public reporting of outcomes, satisfaction ratings, and costs in order to make better decisions.

Q. When did you begin to see that change was afoot?

A. As early as 2006 we understood that healthcare would be part of the 2008 presidential race and that cost would be the big driver. We sought input from our members; we were constantly talking, discussing, refining, and looking for ways to get buy-in as we moved forward with a plan for change. We understood this would be enormous, that it would be a huge campaign issue, and we knew it could be a political firestorm. Everyone would be challenged—pharma, providers, insurance—everyone would have to change the way they did business if we were to achieve real reform. By 2008, we were ready. Our platform was "Health for Life—Better Health, Better Health Care," the AHA's five-point system was designed to be a balanced and comprehensive framework for health reform.

Q. What surprised you the most about the ACA conflict?

A. ACA created such a political schism that after it was passed no one tried to fix the problems in the bill to make it better. So we had to focus on ACA's real purpose: rise above the politics and go about the hard work of improving access and creating better healthcare. But we always struggled with the fact that our members didn't have a uniformity of views.

Q. How would you sum up the battle?

A. It's been amazing in a bunch of different ways. First, it's remarkable that we were able to extend healthcare coverage to so many people so quickly, which hopefully improves access and then improves health, which is the goal of just about everybody in the healthcare sector. We continue to move in the right direction on that goal. Then there is the substantial restructuring of the healthcare system on both the insurance side and the provider side. I would say from the provider side we are closer to getting it right than ever before—we are working on the right things to make healthcare more connected, more user friendly, and more accountable for quality, outcomes, and safety. And the financing side is moving in substantive ways as well. However, it's also incredible—a different kind of incredible—that after five years of implementing ACA, some people are still trying to repeal ACA. They think we can wind back the clock and start all over based on their

ideology. And, most surprising, there even are citizens who have benefited directly from the ACA who feel this way.

Q. You have talked about finding common ground and leading to consensus. How do you get there?

A. Transparency with reality. I learned some important lessons from Alex McMahon (AHA's president from 1972-1986) who said when you are faced with difficult choices, lay all the cards out face up and then challenge people to pick the ace of spades. Amazingly, they always get it right! So the huge leadership lesson is to give everybody all the viable options. Don't try to tell them your right option; even more important, don't let them pick a bad one. As a leader, you will likely have your preferred "best choice." Yet, when you lay it out with full transparency, and people can compare the choices, they will usually pick the right one.

The corollary part is that the primary leadership principle is to be able to assess the choices in the first place; the reality factor is the key thing. As a leader you have to be knowledgeable and clear and help people see how issues, the practical and political, fit within the vision of the larger puzzle. And, as the leader, you also have to be judicious and transparent if you take a stand to try to direct the decision—as opposed to facilitating the decision—to get buy in.

Q. What's an example of how your role as a facilitator played out?

A. Just think about how each state faces different issues with regard to healthcare—different kinds of hospitals and different constituencies—from payers to providers and consumer representation, to say nothing of politics and cultural norms. So we facilitated conversations among our state association colleagues and acted as the translator allowing the group to find common themes that everyone could agree on. I would like to think that is my hallmark—the ability to find common themes and consensus while also being transparent about our own challenges and our need to improve.

Q. Now, as we move forward, what must providers do to improve the way they work with their patients?

A. Healthcare customers think about healthcare the way they think about other things in their lives, so they want some kind of continuing personal connection; the mobile world makes that personalized connection possible and hospitals need to be part of that. Providers have to earn their customers' trust and loyalty every day, and relate to them in the way they want to relate to you. Social media demands ease of access and pushing out of information in a way where everything is integrated and easily accessed. Providers need to bring a new type of service to their customers.

Q. Is that being done anywhere?

A. A few years ago when CVS, Walmart, and Rite-Aid all decided they wanted to get into healthcare delivery, some established providers dismissed them. But truthfully, people go to the pharmacy more regularly than they go to the hospital or the doctor's office. And when they do go, the parking is right there, not down the block in a parking garage. And usually it's free. So that's a good example of how the pharmacy companies are meeting people where they are—connecting with them as part of an ongoing relationship.

Q. What do you think is healthcare's biggest obstacle?

A. It's a fiercely independent profession. And while independence is a great strength, complete independence in the provision of care is no longer affordable. The financial pressures can be a great benefit that force tough decisions. Boards and executives are now assessing the cost of independence versus joining a larger system; of siloes of care versus coordinated systems and processes of care; of independent clinical practice versus evidence-based care. This is where we hope real change and improvement can occur.

Q. And next?

A. We have a way to go to get our integrated networks to be coordinated, adequate, and transparent. If you are part of an integrated and closed system, like a Kaiser or parts of a Geisinger, there is no question what is in or out of network. In the non-integrated, fee-for-service world, it's very hard to standardize and coordinate across entities, much less be able to tell the patient what is or is not in network. With the array of products and the level of quality across these products, hospitals, and insurance plans look more like shopping malls rather than a single coordinated store.

Q. What competencies will the next generation of leaders need to keep moving healthcare forward?

A. First, systems thinking and management. All of healthcare, including clinical processes, will be organized and managed in systems of care. Once the low hanging fruit is gone, continued improvement will only come through systems engineering and improvement. Second, risk management. Assuming risk turns the compass around from a revenue orientation to a cost orientation;

growth will move from facilities and overhead to membership (the risk pool) and strategic investments in care management and member satisfaction. Lastly, healthcare leaders will need to be entrepreneurial and the ability to collaborate will be essential. Being a skilled and effective business partner will be highly valued.

Q. How well is healthcare addressing diversity?

A. The healthcare system is representative of the broader culture. Biases and barriers have not been eradicated across society and the same is true for healthcare. In a pay-for-performance world, if different groups of people relate to the healthcare system differently and have different outcomes, you have to determine why. Is it cultural or something else? Everyone should get the same standard of care, but the way consumers interact with the system, such as following through on protocols, could be cultural and could affect outcomes. If we are going to succeed in delivering affordable accessible healthcare, providers will need to understand how care inside the formal system combines with what happens in the external world of different cultures.

Q. How would you sum up your outlook for healthcare in America?

A. I am more optimistic now than ever because we are working on more of the right things than we have in the past. We are still trying to figure it out, but we are connecting parts to more of a system with greater accountability, both financially and with respect to quality of care. We are making decisions that will help the system be more accessible and responsive, utilizing mobile technology and providing care through digital portals, and increasing access. I think that is terrific. But then we have to determine what do we really need in terms of physical infrastructure?

Q. And how would you answer that question?

A. Your home has to become your medical home, which underscores the importance of working in the community and across social service agencies. For instance, you want to make sure that people even have homes; housing is more important earlier on than things they get in the hospital. Secondly, using the number of beds to describe hospital size and, presumably success, is an outdated measure. It doesn't tell the story anymore. Hospitals may like their buildings but can they successfully be in real estate and patient care and food service and everything else? I would say hospitals should look ahead and focus on doing something unique to better understand how to keep people well and how to standardize the delivery of medicine using the lowest overhead model possible. I think it is coming.