CHRISTINE K. CASSEL, MD
Planning Dean
Kaiser Permanente School of Medicine

EDUCATION

Bachelor of Arts, Philosophy, University of Chicago

Boston University (pre-med)

MD, University of Massachusetts Medical School

Internal Medicine Residency, Children's Hospital of San Francisco and UCSF

Geriatrics Fellowship, Veterans Administration Medical Center

Bioethics Health Policy Fellowship Program, University of California, San Francisco

CAREER

Planning Dean, Kaiser Permanente School of Medicine, April 2016–current

National Quality Forum, President and Chief Executive Officer, July 2013–April 2016

American Board of Internal Medicine & ABIM Foundation, President and Chief Executive Officer, July 2003–July 2013

Oregon Health & Science University, Dean, School of Medicine and Vice President for Medical Affairs, 2002–2003

Mount Sinai School of Medicine, Chairman, Brookdale Department of Geriatrics & Adult Development, Professor, Geriatrics and Internal Medicine, 1995–2002

University of Chicago, Chief, General Internal Medicine and Director, Health Policy, 1985–1995

Mount Sinai Medical Center, 1983–1985

AWARDS & RECOGNITIONS

American Society of Health-System Pharmacists, Boards of Director's Award of Honor, 2015

European Federation of Internal Medicine, Honorary Fellowship, 2005

Royal College of Physicians of London, Honorary Fellowship, 2005

Honorary Doctorates, Medical College for Women, Northeast Ohio College of Medicine,Thomas Jefferson University College of Medicine, New York Institute of Technology

Ignaz Nascher Award for Excellence in Geriatrics, 3rd Viennese International Congress, 2000

(numerous others)

CURRENT BOARDS & AFFILIATIONS

Institute of Medicine
Greenwall Foundation
Institute for Healthcare Improvement Leadership Alliance
Kaiser Permanente Regional Executive Advisory Board
Modern Healthcare CEO Power Panel National Quality Forum
President's Council of Advisors on Science and Technology
Stanford University Clinical Excellence Research Center

CURRENT EDITORIAL BOARDS

Healthcare: The Journal of Delivery Science and Innovation, 2013–present

Journal of Delivery Science and Innovation, 2012–present

Journal of the American Medical Association, Editorial Board, Contributing Writer, 2007–present

The National Center for Healthcare Leadership is honored to present the 2016 Gail L. Warden Leadership Excellence Award to Christine K. Cassel, MD for her pioneering work in geriatrics and bioethics, and her leadership at the National Quality Forum and other national organizations. Now, as Planning Dean at the new Kaiser Permanente School of Medicine, Dr. Cassel is helping to build something from the ground up with an innovative approach to medical school education that immediately immerses students into clinical work with a focus on patient-centered care.

DR. CHRISTINE CASSEL'S QUEST FOR QUALITY IMPROVEMENT, SHATTERING SILOS AND PRACTICING MEDICINE THROUGH A DIFFERENT LENS

Christine K. Cassel , MD
Gail L. Warden Leadership Excellence Award Recipient

It was a broken arm and a magnanimous doctor that set Dr. Christine Cassel on the path of medicine. A fall while hiking through the Pacific North West left her with a badly broken arm and rejection from the local emergency room because she was uninsured. Ever so resourceful, she found care from a nearby Navy Base doctor who treated her gratis, calling it a humanitarian act. From that encounter Dr. Cassel knew that she, too, wanted to do something humanitarian. And that is how it began.

Q. What about that experience set you on a career in medicine?

A. The way that Navy doctor treated me was a case of moral philosophy in action. His willingness to provide care without pay just melted me and I wondered if I could do something similar. After my arm healed, I took a year of pre-med classes and never looked back. Although my background was in philosophy and I had intended to get a PhD, I decided to pursue medicine in a way that continued to explore the philosophy of ethics.

After medical school I focused on bioethics, which was just emerging in those days, and I did a fellowship in geriatric medicine, which was quite unique at the time. I was attracted to it because of the complexity, need, and obvious challenge of caring for older people, especially around patient safety and complications related to hospitalizations. From there I sought out

opportunities to study ways to make hospitals safer. In my career, I have always had a penchant for problem solving and the desire to try new things, so I have been drawn to work in policy areas with ethics and values serving as a backdrop to whatever I was doing.

Q. So your interest in quality improvement grew from your study of philosophy?

A. Yes, you can see the thread connecting everything I have done. A significant event was when I was elected to the Institute of Medicine in 1991. Everyone came to that experience with a different perspective and mine was a focus on setting clearer standards for physicians. I was really concerned about how doctors felt that every mistake was their fault; I wanted to see how to change that to an understanding of how systems—rather than an individual—can help support quality improvement.

Q. How did you react to your work on the IOM's reports on the status of healthcare in the US?

A. IOM's two seminal reports—*To Err is Human* in 1999 and *Crossing the Quality Chasm* in 2001—while harsh, gave me hope. I actually came away from that experience optimistic, perhaps naively so, that once the gaps were exposed, healthcare professionals would be motivated to improve and get better. We have made a lot of progress toward quality improvement, especially along the lines of ensuring that we have the right patient, the right procedure, and all the boxes are checked. That progress continues and is now moving towards providing physicians with immediate feedback from patients to inspire more focus on recording patient outcomes. Even though this is more expensive and difficult to measure, the digital world is really pushing us to make this approach the new standard. So in the future patients may see a survey that pops up on your phone the minute you finish a medical appointment and then two weeks later you get another phone survey seeking feedback on outcomes.

Q. How does emphasis on survey information translate into meaningful change?

A. Transparency of data and information across an organization is transformative. When you show people the data and they can share ownership of that information and identify how to fix it, dramatic change can occur because clinicians and healthcare professionals really care about doing the right thing. We are scientists and empirical people and we can be motivated to make things better when we can see the supportive data.

Q. It was your work on the IOM that set the stage for you to assume the leadership role at the National Quality Forum in 2013. What was your initial focus at NQF?

A. The NQF grew out of the IOM reports that said two things: first the nation needed ongoing oversight and guidance to monitor the quality of care, and second, that public and private institutions would need to work together to develop quality measures that would become standard. One of the reasons this award is so meaningful to me is because Gail Warden was the first chair of the NQF. Gail was the force behind it and he really understood the need for a national entity to oversee quality measurement while recognizing it would be difficult and politically complex to get this started. I was appointed to the initial strategic framework to create the design of what NQF would become. And because my focus on quality is seen through an ethical lens, I brought that to the NQF. For all of us engaged in this endeavor of healthcare, we recognize the importance of improving quality and transparency.

Q. You are credited with reinvigorating NQF. How would you describe your influence over the organization and what focus will it have in the future?

A. One of my mandates from the board was to make NQF more nimble and creative so that it could work more easily with technology and with the private sector. That meant more transparency, more accountability. In some ways that was something younger doctors could embrace more easily than more experienced doctors who couldn't quite see the need for change.

When I left NQF earlier in 2016, we were "ranking the rankings." With the Internet has come a proliferation of reviews and rankings and listings that provide tons of information to people, but not necessarily information that is presented in a way that is useful or helpful.

Q. How can those rankings be made meaningful to the public?

A. You can't stop these rankings; people are hungry for information. But we need a way for consumers to evaluate the reliability of the healthcare information that is being provided. The federal government has done a good job with nursing home information, but hospital and doctor information isn't good enough yet. This really should be something the private sector also does, but it can't be a black box. The technology has to be transparent so people can determine the most reliable source of

information. However, there is a limit to patient empowerment; we can't ignore our own responsibility and just say "caveat emptor." Furthermore, we have to be sensitive to cultural issues around patient empowerment as this concept may not resonate the same way in all cultures. We need to think about the range of patients that are under our care.

Q. You have also talked about how silos frustrate quality improvement. Why are they hard to breakdown?

A. Silos are cultural and organizational. It's not that people are resistant to needed change; however, it has do with the culture of an organization that says this is how we have always done it. So resistance is not active, it's just a culture of passive resistance to collaboration. But we know medicine can't work like that anymore. The culture has to change so that healthcare professionals understand the incentives and value of learning to do things differently. And we know the way to do this is to involve and engage your team and, importantly, identify leaders inside your organizations who you can be advocates for change.

Q. How have you broken down silos?

A. My clinical work in geriatric medicine is a great example of how leadership that walks the talk can make change. We would treat geriatric patients who had many different specialists; in effect the patient was the general contractor. Not surprisingly we would see many mistakes: medications that interacted or test results that were lost. We created an interdisciplinary team that worked together. This was long before workable electronic medical records. Technology has made it much easier now.

Looking to the future, new payment models are also breaking down walls, especially as it relates to the need for hospitals to reduce readmissions. Until recently, most hospital leaders probably had never been in their local nursing homes. There was no working crossover, creating opportunity for lots of errors and miscommunication. We know now that hospitals can reduce readmissions of high-risk older people if they have good communications with the nursing homes and home healthcare agencies. So this is an excellent example of how a single payment policy is driving change to benefit the hospital, the nursing home, or home healthcare agency, but most importantly to benefit the patient.

Q. You have held just about every kind of healthcare leadership position available from academic medical center chairs to president and CEO of the American Board of Internal Medicine and NQF. Now you are returning to medical school education as the planning dean at the new Kaiser Permanente School of Medicine. How did that come about?

A. Well, I was not planning to leave NQF. But I am drawn to new ideas and problems that need to be solved and this struck me as a once in a lifetime opportunity. This medical school is different because it is not being created at a university, it is being started inside a healthcare system. Context, culture, and innovation are driving it. Even though the first students don't come on board until 2019, we have a group of physicians and other professionals at the KP system who have working on this for six or seven years. They were able to convince the Board to fund the new medical school through the community benefit part of KP, which as an institution is well recognized for the way it measures quality and uses data for decision making. With 18,000 physicians and 36 hospitals, it has a culture of transparency. Early on it invested in electronic health records to share data about its 10.5 million members in 13 states. They have the ability to look at and understand the data.

Q. And the new medical school will teach medicine in a different way, correct?

A. We are going to give students the opportunity to be part of a medical team that will be involved in quality improvement as well as patient care.. Starting on day one the students will be embedded with the clinical reality. Whatever they do will have a lasting contribution within that unit. So when they leave, they will know that they made something happened and learned how to work with nurses and staff and pharmacists to solve problems and care for patients. Our program is attracting a certain kind of student; one who is interested in clinical immersion and understanding healthcare delivery science..

Q. As head of a medical school, what advice would you give to aspiring healthcare professionals?

A. Learn how to be a change agent. One of the reasons doctors are so frustrated and experiencing burn out at rapid rate is that everything in healthcare is changing so rapidly. We are not typically trained in change management. When doctors come out of medical school, they know they have to keep up with changes in medical science, but they expected the healthcare system to be stable. That just isn't the case any longer. One of our goals at Kaiser Permanente School of Medicine is for our students to be energized rather than traumatized by changing environments.

Q. How would you describe your management style?

A. I am a collaborative person and I like to get input from multiple sources. I also like to have people disagree freely. I like to come into a room and get all the ideas on a table and then have those ideas challenged. The keystone in that kind of setting is to keep the environment safe so everyone can contribute and disagree freely; however, there also has to be a level of trust so that when everyone leaves the room they are on board and supportive of the decisions that have been made and what we are doing. That level of trust comes from having personal relationships with your team.

Q. How do you see your role as a mentor?

A. It's not a formal program. It's just the way it is. People come to me for advice and I try to be available, especially to young people who are just starting their careers. Even though when I came up in medicine there were not many women I could turn to for guidance, I was fortunate to have mentors who did guide me. I didn't always take their advice, however. I had one mentor tell me that I was throwing away my career by studying geriatrics. It's important for young people to know that if you ask for advice and then don't take it, you have to find a way to respectfully communicate that information back. Thank them, let them know what you are doing. Don't ever burn bridges.