



WILLIAM C. SCHOENHARD
In First Person: An Oral History

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WILLIAM C. SCHOENHARD

In First Person: An Oral History

**Interviewed by Kim M. Garber
On May 24, 2017**

Edited by Kim M. Garber

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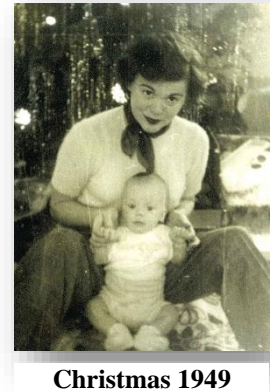
EDITED TRANSCRIPT
Interviewed in Chicago, Illinois

KIM GARBER: Today is Wednesday, May 24, 2017. My name is Kim Garber, and I will be interviewing William Schoenhard, who retired in 2013 after a career in leadership mostly with the SSM Health organization and then with the Department of Veterans Affairs. He has served on the boards of various professional and service organizations, including chairing the American College of Healthcare Executives in 2006. Bill, it's great to have the opportunity to speak with you today.

WILLIAM C. SCHOENHARD: Thank you very much for inviting me, Kim.

GARBER: Could you talk a little bit about your childhood?

SCHOENHARD: I was born in Kansas City and my parents, Bill and Joyce, divorced when I was five years old. My mother married a dental student. When he graduated from dental school in 1959, we moved to Central Missouri. I lived in Eldon, Lake Ozark, Sedalia and Columbia. I went to Sedalia Smith-Cotton High School my freshman and sophomore year and Hickman High School in Columbia for my junior and senior year.



Christmas 1949

While I was from a broken home, I was fortunate in that both my mother and father were supportive and loving. I would see my dad on weekends when I lived in Kansas City, and he would visit me every three or four months when we lived in Central Missouri. We remained close. Both my mom and dad and stepmother, Kathy, gave me a lot of love and support and affirmation.

I was also fortunate that my stepfather, Gale Holsman, was interested in my development and supportive of my upbringing. He had run track at the University of Missouri and encouraged me to go into athletics. He had a lot of interest and spent time with me, which I appreciated very much.

My mother's parents, Gail and Dorothy Thornsberry, had a huge influence. Helen and Bernard Holsman, my step-grandparents, were also influential. The reason my stepfather went to central Missouri after dental school was that his parents owned a cottage camp and beach resort at Lake Ozark, Missouri, and there was no dentist in the area. He set up his first practice at Lake Ozark. Beginning when I was thirteen, I began to work summers for my step-grandparents, lifeguarding and doing many other jobs. They taught me appreciation for hard work and long hours.

My mother and stepfather had three children: Gale, Melissa and Scott Holsman. We remain close to this day.

As far as school experiences – I think of my freshman English Literature teacher, who would have us go around the room and read literature out loud. I would become increasingly nervous as the reading approached my chair. I would stutter. I would stammer. I was flushed and perspiring and really had a difficult time reading out loud. I did not have any trouble speaking in normal conversation, but the idea of having to read out loud to the class frightened me. She automatically enrolled me in Speech class for the next year. I was distressed to hear I was going into a Speech class, but it turned out to be the best thing that she could have done. I appreciate the intervention that she took. I ended

up getting on the debate squad at Smith-Cotton and did a little bit of debating at Hickman. Thanks to her, I overcame a fear of public speaking and I'm grateful for that.

In high school, I was selected to go to Boys State. I learned a lot about government and the Constitution and gained a greater appreciation of American history through that experience. Boys State is sponsored by the American Legion. When you go to Boys State, you're assigned to a city. I ended up being elected mayor of my city. Our city was named the Model City for that Boys State session. There was a city council. You also had the opportunity to have an occupation. I sat through the bar exam in order to become a lawyer at Boys State. This was not a rigorous bar exam, but I had the opportunity to learn a little bit about how that would go. We attended meetings. There is an elected governor for Boys State who goes on to Boys Nation. Bill Clinton met John Kennedy through Boys State when he was Governor of Boys State in Arkansas. It's a tremendous experience. When you come back, you are asked to give a speech at an American Legion meeting about what you learned.

GARBER: Boys State was an educational opportunity that happened during the summer?

SCHOENHARD: Yes, it was between junior and senior year of high school.

GARBER: Was there a Girls State?

SCHOENHARD: Yes. We had a number of women from our high school go to Girls State, and they came back and said they had a tremendous experience as well.

GARBER: Is this a nationwide program?

SCHOENHARD: Yes, I think that it's in all states.

GARBER: You mentioned that your stepfather got you interested in sports. A number of interviewees in this series have mentioned their participation in athletics in high school and how that later tied in to leadership characteristics that they valued. Did you see any kind of lessons learned from your athletic experience along those lines?

SCHOENHARD: When I transferred from Sedalia to Columbia my junior year, I went out for football and separated my shoulder. I had surgery during the off-season. My first memory of health care was having my shoulder repaired during the Christmas break of my junior year. That experience started to interest me in health care and the rehab that went with that. I went to the University of Missouri for rehabilitation.

During our senior year in summer practice, our head football coach, Bob Roark, asked to meet with the seniors one day after practice. He stressed that we seniors were not giving the kind of leadership to our underclassmen that we should give. We were not setting the example as role models or in supporting the underclassmen. We had so much respect for Coach Roark. He was an understated, smart, successful, well-known coach who had been there many years. While we lost our first game by, I think, one point, we won the rest of our games that season and beat our archrival, the Jefferson City Jays. At that time, the Jays, had the longest high school winning streak in the country. We beat them 27-6! I've always thought that while we had some great players, Coach Roark's speech set the tone for expecting leadership. I had not equated being a senior with leadership. As you get older and advance in an organization, you certainly must exhibit leadership as he taught us.

GARBER: That speech obviously made an immediate impact on you, probably being an “aha!” moment.

SCHOENHARD: Yes.

GARBER: Did you then intentionally change your behavior in any way?

SCHOENHARD: All of us seniors took that to heart. I think we played harder. We were more disciplined. We were more supportive of the underclassmen and realized that the underclassmen looked to us for leadership. There were great leaders in that senior class. We had players who have gone on to be very successful.

GARBER: You went on to the University of Missouri-Columbia. What made you decide to go there?

SCHOENHARD: We lived in Columbia during my junior and senior years of high school. I did not have the funds or a scholarship to go to a school out of state. It seemed natural to go to Mizzou, a great university, although a number of my classmates went to other schools.

GARBER: Did you have help with the financing of your education because you joined the Naval ROTC?

SCHOENHARD: I was what they call a contract student. I was not a scholarship student. While I received a stipend, as we all did during our junior and senior year, I was not on scholarship. When I finished, I was going to receive a reserve commission instead of a regular commission in the Navy and my obligation would be less.

I had to think about what I would do about my military obligation. I thought that if I could go in as an officer, I would prefer to do that. My dad had been in the Navy in World War II, and the thought of seeing the world was attractive to me from the way Dad had talked about his service during the war. I went in the contract program. It was four years of ROTC, but I had a three-year obligation when I finished, as opposed to a four-year obligation with the scholarship program, and I received a reserve commission.

GARBER: This was during the Vietnam War, wasn't it?

SCHOENHARD: Yes, it was.

GARBER: Were you part of the draft?

SCHOENHARD: I was registered for the Selective Service and I was in the first lottery. As it turned out, my lottery number was 18, so it was pretty low.

GARBER: Was 18 good or bad?

SCHOENHARD: It was good if you wanted to be drafted! The first lottery was held when I was in my junior year in college. I had already signed the advance contract for ROTC. If you did not complete the ROTC program after signing the advance contract at the beginning of your junior year, you would serve as an enlisted person in the Navy.

GARBER: I'd like to explore the draft lottery a little bit more. Birthdays were drawn out of a hat, as it were, and your birthday came up as #18, which was not good if you didn't want to be drafted.

SCHOENHARD: Right.

GARBER: You mentioned wanting to get out and see the world. Did you actually go to sea?

SCHOENHARD: I did. The summer between my junior and senior year, I took the first class midshipman cruise. They flew me over to the Mediterranean, and I picked up my ship on the Island of Malta. We steamed to Athens and Rhodes before I completed that cycle and came back. The first time I flew on a commercial airplane was going from Kansas City to Philadelphia and then on to pick up my ship.

I served that summer cruise on the USS Laffey, which had undergone a tremendous kamikaze attack at Okinawa and is now a museum ship in Charleston, South Carolina. It won the Presidential Unit Citation and was considered one of the most heroic ships of the war. The honor of being on that ship for four weeks was something that later I appreciated more than I did at the time.

GARBER: Your undergraduate major was public administration. What caused you to choose that and what sort of a career were you thinking about at that time?

SCHOENHARD: I was looking to see if there was a major that would bring the combination of business education as well as political science. I was thinking of a career in law and possibly politics. Public administration at that time was an undergraduate degree at the University of Missouri – now they only offer it as a graduate degree. It suited my interest because I took all the business pre-requisites, then took accounting and other business courses, but it was filled in with Constitutional law and some other aspects of political science.

GARBER: Was it in college that you met your future wife?

SCHOENHARD: Yes. We had both signed up for a campus YMCA tutoring program for disadvantaged children in Columbia. We first met when we took the kids to Jefferson City for a field trip touring the state capital. I didn't have the sense to ask her out until a couple years later, but I would not have asked her if I hadn't met her back then. That was a fortunate trip for me.

GARBER: Is that indicative of your personality that you need to consider new things for a while before plunging in?

SCHOENHARD: No, I thought she was going with somebody else! I would see her on campus and I just assumed. As it turns out, I asked her the last day she was on campus before going to St. Louis for good for student teaching – she was a year ahead of me. I barely asked her out in



time. We started dating once she went to St. Louis.

GARBER: You went to college during a tumultuous time for our country. Did you find yourself involved in political activism in any way?

SCHOENHARD: I was interested in the campus YMCA tutoring program – that’s a form of activism. I had been moved by John Kennedy’s presidency and Martin Luther King, and I thought if there was some way while I was on campus to try to give back to kids who didn’t have resources that I had been blessed with when growing up, I would want to do that.

I was gung-ho in ROTC, though. I was on the drill team for four years and commanded it my senior year. Looking back, I was out of step with a lot of my colleagues in the undergraduate school there, but while we had protests at the university and there was activism on campus there was, for the most part, support for ROTC. I never felt any discrimination or experienced any difficulty.

GARBER: That’s interesting. I was wondering about that, whether you took any flak from the fellow students.

SCHOENHARD: No, not really. In my freshman year, first semester, I took an American History class and had a lab on Wednesday when all ROTC members wore uniforms. The lab instructor was the president of Students for a Democratic Society, which organized most student protests. I always appreciated that he never said anything to me. He was probably one of the best lab instructors I had in college.

GARBER: Did you encounter any situations after leaving school?

SCHOENHARD: One time while I was walking through the airport, I was spit on in the face. During the Vietnam War when you were in uniform, it was not uncommon to have that occur. There was so much angst and opposition regarding the war. There was a tendency to take it out on the person in uniform. Since then, I think we’ve learned our lesson about that. Now, regardless of how people feel about a conflict that we’re engaged in with the Armed Forces, we honor those who bear the battle, or bear the burden of going on deployment. That was not the case during Vietnam.

GARBER: I’m shocked to hear that happened to you.

SCHOENHARD: The only other thing I would like to mention about this time is that the commander in our ROTC unit during my first three years was Captain Earl Johnson. He had graduated from the Naval Academy, I think, in 1942, and was in the Submarine Service during World War II. We looked up to him with awe. He was a great leader and a great supporter of all the midshipmen. He didn’t talk much about his war service, but he was on patrol in the Pacific doing a lot of missions as a junior officer in the Submarine Service.

GARBER: Then you graduated and went on to serve out your commitment. You were a damage control officer on the USS Samuel Gompers. What does a damage control officer do?

SCHOENHARD: The ship is organized into divisions that are parts of departments of the ship. The damage control officer is what’s called the “R Division” officer – Repair Division. We had 1,000 men – all men at that time – on our ship. We were a floating repair facility for other ships. Half of the ship’s complement – 500 or so – were the Repair Department that serviced all the other ships

that we tended.

I was division officer for the Repair Department of our own ship. My other major responsibility was in the Engineering Department, serving on watch in the engine room, becoming engineering officer of the watch and later on the bridge as a junior officer of the watch. My job was to train the crew about fire, collision, chemical attacks, nuclear attacks – any kind of potential damage control if the ship were to be attacked. I was also in Damage Control Central to assist the chief engineer doing whatever might be needed to keep the ship's firefighting capability going, to keep the ship afloat and to keep it going. It was an interesting experience in that way.

GARBER: Did you like your job?

SCHOENHARD: I did. I came to appreciate teams. There were a variety of different teams on the ship – mobile repair teams, cleaning teams. I became interested in management more so than the law as a result of enjoying working with my chief petty officer, who was very smart, and with the senior enlisted people in my division to try to ensure that we were fulfilling our mission and keeping the ship safe.

One of my first formal mentors in a work situation was Commander Louis Guimond. He was former enlisted, had become commissioned and was the executive officer of our ship. Like a lot of new green ensigns coming out in the fleet, we weren't sure we were up to that much responsibility, because we were given a lot of responsibility early on. He had an uncanny capacity, just by the way he talked to you, of showing confidence in your ability. He was sure to correct or deal with any weakness or issue that involved the ship. He was competent technically, knew the ship inside-out, but he had an extraordinary capacity to display confidence, which I needed at that time.

GARBER: Did you like being at sea?

SCHOENHARD: Yes. We weren't at sea that much because we would go from port to port on deployment, spending most of our time in Subic Bay, the Philippines. Other than getting over initial seasickness, which seemed to happen invariably when we got under way, I enjoyed it.

GARBER: You were also deployed to South Vietnam. Could you talk about that experience?

SCHOENHARD: We were supposed to have a six-month deployment, mostly at Subic Bay, and we were on our way from Taiwan to Japan to be relieved to come home. When en route, we were directed to go to Da Nang, South Vietnam. The Easter Offensive of 1972 was just getting underway. That was the major North Vietnamese invasion through the country that was probably the biggest offensive since the Tet Offensive of '68. We needed ships on the gun line to provide shore bombardment. We had largely pulled out our ground force by that time but we had advisors on the ground. It was through air power and shore bombardment that we were assisting largely South Vietnamese ground forces with U.S. advisors to beat off that offensive.

They needed ships on the line that could not afford the time to go to Subic, which was a several day transit back and forth. We went in to Da Nang to replace gun barrels and do other ship repair. Some of the ships got hit by shore battery as the North Vietnamese were coming down, so we provided some emergency repair, too.

GARBER: How far out is the gun line?

SCHOENHARD: It was pretty close. I was never on the gun line, but I later went back to Vietnam on a veteran's cruise. I was amazed – it was largely a Marine veterans group that I was with, and they said that the precision of that shore bombardment was unbelievable. They would lay the shells in exactly where they were needed. I don't think they were too far off the coast, but I don't know how far.

GARBER: What made you decide against continuing a career in the Navy?

SCHOENHARD: I had never really thought of a career in the Navy. I was thinking of the Navy as being my means to completing my military obligation. I came to like it very much, but I was forced to make a decision earlier than I thought. Between Hawaii and San Diego, I got a message that I was part of a list of reserve officers that were going to receive an early out. Now the only option to an early out was to augment to the regular Navy, which was a competitive process. The captain said, "Why don't you call your wife?" I called ship-to-shore between Pearl Harbor and San Diego when we were returning home. There was only, from receipt of the message, ten days to complete the application and my message had been routed wrong because we were in movement. I had only a few days to decide. We decided to go ahead and take the early out.

GARBER: The next thing that you did was to go to grad school at Washington University. You were back in St. Louis.

SCHOENHARD: Yes.

GARBER: What made you decide on that particular program? There were strong competitors with other hospital administration programs at the time – like Minnesota and Michigan.

SCHOENHARD: Yes, there were those that you mentioned, and others were strong, well-established programs. Part of it was geographic preference. Kate, who was from St. Louis, thought it would be a good idea if I came back to the Midwest, ideally St. Louis. There were programs with long-established traditions at St. Louis University and Washington University. I received an early acceptance, so I took that before waiting to see if any other schools would accept me.

GARBER: At the time did you also consider an MBA? Or were you pretty sure that you wanted to go with an MHA?

SCHOENHARD: I never really thought of an MBA. The Masters in Health Administration program had started at Missouri and was in place when I was still there. A number of upper class public administration majors had gone into that program. I thought if you want to be a health care administrator, the MHA was the best preparation for it.

GARBER: You mentioned earlier an interest in health care because of your injury in high school. Was there some other factor that made you say, "I want to lead a hospital?"

SCHOENHARD: I was interested in giving back to society. My stepfather also had an indirect influence because I was fascinated by his dental practice. I later came to understand oral health as an important part of overall physical health. I was not interested in city administration, which would have been a potential route for a public administration major. Good health care is fundamental to basic human functions and ability to contribute to society. I thought it would be a very enriching career and I thought it would build on what I enjoyed in the Navy, working with teams to accomplish

a mission. The more I read about it, talked to some Navy hospital administrators when I was in the service, talked to some civilian hospital administrators when I got back to San Diego, the more I became sure that's what I wanted to do.

GARBER: Were there any particularly memorable instructors or professors in your program?

SCHOENHARD: Yes, there was an outstanding faculty. Our program director, Dr. Jim Hepner,¹ was very well-known. He later became a chair of the American College of Healthcare Executives and was a silver medal winner from ACHE. It didn't take long when I got on campus to realize that the ACHE was a very important part of the profession, and to become a student associate was very important. Jim Hepner taught a first-semester survey course based on a book that he authored. One of the interesting experiences was that we each had an opportunity to give a speech attended by our spouses based on a paper we would write in that course. The thought of getting up and speaking before your own spouse and others was an interesting part of the class and a good way to begin to prepare for making presentations to committees, boards and communities.

Don Horsh,² who had a law degree, taught Ethics and Health Law. He was an excellent teacher. He ran the residency program, so he was very knowledgeable of the field, contacts in the field, jobs in the field. I remember Don Horsh very favorably as our deputy director.

Harold Hinderer,³ who worked for the Daughters of Charity, taught us health care finance. He gave us a tremendous grounding in health care finance as one of the then most respected finance health care leaders in the nation.

GARBER: Part of your graduate school experience was a hospital residency. This was common at the time. Could you talk about your experience? This was at Deaconess Hospital in St. Louis.

SCHOENHARD: I was fortunate to be offered a residency at Deaconess, which was a well-respected large community hospital in St. Louis. The president, Carl Rasche,⁴ was a long-time highly-regarded hospital executive who chaired the Missouri Hospital Association, was very active in the American Protestant Healthcare Organization and had a great stature. His chief operating officer, Rev. Dick Ellerbrake,⁵ was a Wash U. grad, and I was very fortunate to have Dick as my primary

¹ James O. Hepner, Ph.D. (1933-2013) served as the first full-time director of Washington University's Graduate Program in Health Administration for 33 years beginning in 1967. He was a professor and prolific author. [Washington University Health Administration Program Alumni Association. <https://olinwustl.campusgroups.com/hapaa/history/>]

² Donald J. Horsh (1917-1999) taught a graduate course in health law at Washington University for over 30 years and helped in the placement of students in hospitals for their residency year. [Washington University Health Administration Program Alumni Association. <https://olinwustl.campusgroups.com/hapaa/history/>]

³ Harold W. Hinderer, Jr. (1928-1981) was controller for the Daughters of Charity, St. Louis. [American Hospital Association internal records and www.findagrave.com]

⁴ Carl C. Rasche (1917-2011) was an ordained minister who served as the president and CEO of Deaconess Hospital (St. Louis, MO) from 1948 to 1982. [Rev. Dr. Carl C. Rasche: Obituary. <http://www.legacy.com/obituaries/stltoday/obituary.aspx?pid=154240837>]

⁵ Richard Ellerbrake, an ordained minister, served as president of Deaconess Health System (St. Louis). [Deaconess Nurse Ministry. *Rev. Dick Ellerbrake*. <http://www.faithnurses.org/2016/09/rev-dick-ellerbrake/>]

preceptor.

GARBER: Could you talk a little bit more about Protestant hospitals and this particular one? Who owned and operated Deaconess Hospital when you arrived there for your residency?

SCHOENHARD: Deaconess was part of the United Church of Christ. The Deaconess Sisters were involved in the formation of the hospital. The CEO, at least to my understanding, was always a minister of the United Church of Christ, which had a very outward-looking mission. They were involved in community health, prevention, improvement of healthy communities, righting the injustices of our society. I was fortunate to have my first experience at a faith-filled hospital.

There was still a Deaconess sister on the administrative council – and very strong leadership from the ministers who served there. There were three ministers when I was there – Jerry Schriver was a graduate of Washington University, and he was a minister of the United Church of Christ; Dick Ellerbrake; and then Carl Rasche. I was joining people who were deeply committed to faith-based health care.

GARBER: This was for you the beginning of what was almost your entire career spent in faith-based hospitals.

SCHOENHARD: Yes,

GARBER: I love the expression that you used a few moments ago – “faith-filled hospitals.”

SCHOENHARD: You know it’s a “faith-filled” facility when the people who are serving the patient are showing the values and the charism of the founder. You know that’s when the mission has permeated an institution. I can remember being on the floor of one of the hospitals later in my career when a new resident came on duty in the ICU and the nurse manager said, “Now, doctor, let me tell you what we do and we don’t do here.” He was getting Mission 101 right on the spot.

GARBER: Would you say that’s common, that seasoned staff – like nurses, exactly, tend to have that role with residents?

SCHOENHARD: Yes, that was my experience.

GARBER: John King, who was interviewed for this series, spent much of his career in faith-filled hospitals. He commented that it is challenging for churches to run big hospitals – it is so different from what they normally do – so that over time, there might be this trend for them to get out of the health care business.

SCHOENHARD: Deaconess had long been established and well led by people trained in health care administration, had a community board, a strong medical staff. While I know there was connection with UCC churches in the region and probably through the council – nationwide there was a health council for the United Church of Christ – I did not see or experience anything but competent, dedicated, full-time focused leadership as you would see in any community hospital. Leadership just came with a mission and a religious affiliation that I think really was very important to it. I did not see the churches trying to find an administrator having somebody on an interim basis that was not well-trained. There was none of that while I was there.

GARBER: Maybe another good example would be Intermountain Health Care, where the LDS church felt that it just wasn't their mission to concentrate so many resources there in the Intermountain west while they were a worldwide church, so they eventually decided to get out of the health care business. Before we leave your time at Washington University, I'd like to ask whether you feel that your training there prepared you for the field. Did you feel that there was anything else that you would have liked to have been exposed to before you left school?

SCHOENHARD: No, I felt very fortunate to have the combination of a strong 60-hour didactic experience – four semesters – summer/fall/spring/summer – followed by a nine-month administrative residency. Having not experienced a hospital setting other than as a patient before graduating, I think that practical work experience was extremely important. The first day of my residency, Rev. Ellerbrake gave me the housekeeping and security departments to supervise. Right away, I was getting department head administrative experience. Looking back, I feel that we had the comprehensiveness of the core curriculum coupled with the practical experience, plus a number of outside lecturers who came in from the community to speak on different subjects that prepared us extremely well.

GARBER: Today the educational model has moved a little bit more towards an MBA-like MHA.

SCHOENHARD: Yes.

GARBER: Do you feel that that's appropriate, moving along with how times have changed? Or do you feel that something's been lost?

SCHOENHARD: The practical experience was a tremendous opportunity, although I understand that it's probably difficult now to keep going with the traditional two-year master's degree, four semester, fall/spring/fall/spring. But I think the idea of a summer internship or some experience during that summer would be beneficial.

I think the MBA emphasis has brought a strength of rigor of finance and quantitative methods, statistical control, quality control that is good in our field. We were fortunate at Washington University to have Dr. Stuart Boxerman⁶ teach us quantitative methods. He was on campus only a short time before we arrived. With Harold Hinderer's health care finance class – some of us took a finance elective on the MBA side over on the Hilltop at Wash U. – and the quantitative methods, we had a pretty good grounding in the quantitative aspect of this field, in addition to accounting and other courses we took.

The MBA focus has been a good one, but I guess I will sound like a traditionalist in that a hospital is a much different enterprise than a business corporation like a bank or an investment institution. It's important to understand the dynamics of a hospital, the complexity of a hospital, the role of the medical staff, the voluntary community board that serves most hospitals. That's a very different experience than running a business corporation. I think it's important that those who get MBAs have the health care background to succeed in that very complex environment.

⁶ Stuart Boxerman, D.Sc. served as the program director of the Washington University Health Administration Program from 2000 to 2007. [Washington University Health Administration Program Alumni Association. <https://olinwustl.campusgroups.com/hapaa/history/>]

GARBER: Another advantage of the administrative residency is that it often leads to a job offer. It did for you.

SCHOENHARD: Yes.

GARBER: Deaconess made you an offer and your entry level job was as a vice president?

SCHOENHARD: Yes.

GARBER: Excellent.

SCHOENHARD: I was very fortunate. I was vice president of general services, which was a mix of clinical and support departments. I was very grateful to the administration to offer me my first opportunity.

GARBER: It's a wonderful tryout. With the administrative residency you get a long time to look at the institution. They get a long time to look at you and oftentimes a match is made. You were vice president in charge of general services. As you had mentioned, this was a big hospital, and it doesn't exist anymore.

SCHOENHARD: No.

GARBER: The building actually has been razed. I think that the St. Louis Zoo wanted the grounds.

SCHOENHARD: Yes, that's correct.

GARBER: This happened long after you left, but do you have a sense as to why the hospital is not there anymore?

SCHOENHARD: It's important to take stock of the entire St. Louis health care scene prior to what happened to some hospitals in St. Louis, including Deaconess. At the time when I was going through graduate school and working at Deaconess, we were under cost reimbursement. There was zero managed care at that time. Most of the work was inpatient. Outpatient care wasn't a major focus of our work.

With DRGs coming in in '86, there was a strong business coalition formed in St. Louis of major employers who wanted to lower the rate of increase of their health care premiums. They invited a number of major insurers like UnitedHealthcare and Coventry and others to come in the market.

Over time, what was clearly an over-bedded hospital situation in St. Louis began to rationalize and wring its way through a really major shift in hospital deployment. Lengths of stay dropped with DRGs. More and more work was shifted from inpatient to outpatient – not admitted at all – thanks in part to cost pressures but most often to technology advances. Deaconess had a difficult time when networks were being formed in St. Louis, becoming part of a strong must-have managed care network in St. Louis. Networks like BJC particularly, with Barnes and Jewish and Children's, along with Christian, Missouri Baptist, and other facilities that joined BJC, were geographically dispersed, and academically related in a way that was indispensable to marketing a managed care plan in St. Louis.

I think the same was true in St. Louis University's case. There were two medical schools in St. Louis – Washington University and St. Louis University. SSM, which had a number of hospitals throughout metropolitan St. Louis, had various affiliations with St. Louis U. Deaconess had an affiliation, but not as strong as St. Mary's, which had OB/GYN services with the university at St. Mary's.

Over time, the occupancy level dropped in nearly all the hospitals. That coupled with a sense of where do people think the future of hospitals is with regard to medical staff dynamics – I think the physicians began to align and associate themselves with those who were going to survive the shakeout of networks in St. Louis. Deaconess, while a tremendous hospital, did not survive that evolution.

GARBER: The prospective payment system had a hand in right-sizing the market in St. Louis.

SCHOENHARD: It's interesting. I certainly think that which can reduce the time a patient needs to be in the hospital is beneficial, not only from a cost standpoint, but from a quality and safety standpoint. To show you how much things have changed during my career – when I was at Deaconess, Dick Ellerbrake was very interested in cost management. He was ahead of his time concerning the cost of care, not just the cost at Deaconess, but the cost to the community. He thought that was part of the quality of care, which it is.

He approached one of the major insurers in the market, but they were reluctant to undertake a thought that he had had about pre-admission testing. When I was at Deaconess, at least in the early years, you had to be admitted for your EKG or blood tests and the rest, so you would be admitted the day before to get all your pre-surgical tests. He said, why don't we do that as outpatient? You pay for the outpatient lab – the EKG or whatever is needed – and we admit the patient on the day of the surgery and save a whole day of care. There was strong opposition to doing that. It was so new that people didn't know how to handle it.

In my own philosophy of health care, we should work more toward the value of health care, the value equation of cost, quality and outcome – and patient experience – patient satisfaction as opposed to unfettered fee for service that reimburses on a click-click-click basis.

GARBER: You mentioned that a strong business coalition was formed. What was the name?

SCHOENHARD: St. Louis Business Health Coalition.

GARBER: Was the coalition effective as a catalyst?

SCHOENHARD: Yes, very effective.

GARBER: You received an offer from St. Mary's in St. Louis. How did that opportunity come about?

SCHOENHARD: It was my first lesson in networking. It came through a Washington

University classmate, Chuck Sardegna,⁷ who called one Friday night and said he'd been promoted to run the rehabilitation hospital for SSM,⁸ and would I have an interest in applying for his position? I said yes. He got back to Sr. Betty Brucker,⁹ who was the executive director of the hospital at that time. We interviewed and she offered me Chuck's position.

GARBER: What was the position?

SCHOENHARD: Assistant executive director. We had not undertaken the corporate titles at SSM as early as Deaconess had.

GARBER: What was the assistant executive director in charge of?

SCHOENHARD: It was essentially what I was doing at Deaconess, with a few minor differences in departments. It was a mix of clinical and support departments like laboratory, radiology, dietary, security, library, and I was the assistant administrator for a few other departments.

GARBER: At that time, this hospital was owned and operated by the Franciscan Sisters of Mary?

SCHOENHARD: Yes.

GARBER: This was before SSM came into existence.

SCHOENHARD: At that time, it was owned by the Sisters of St. Mary. Maybe I should mention a little bit about the change in name of the congregation. The Sisters of St. Mary owned and operated St. Mary's at the time I went there in 1978, as well as hospitals in a number of different states. In 1987, while I was still at SSM, they reunited with the Sisters of St. Francis of Maryville. This was a congregation that had been part of the original Sisters of St. Mary and went a different direction in the late 1800s. A really happy and affirming experience was having those two congregations come together, reunite and become known as the Franciscan Sisters of Mary. That's why now it's sponsored by the Franciscan Sisters of Mary, but at the time, it was part of the original group. The Maryville Sisters brought hospitals from Northwest Missouri and Oklahoma as part of the reunification in '87.

GARBER: Thank you for that coherent explanation, although I'm not sure I have it straight.

SCHOENHARD: It's complicated.

GARBER: At any rate, you interviewed with and then were hired by Sr. Betty Brucker, who had graduate degrees in nursing and health administration. She sounds like she was admirably qualified

⁷ Charles J. Sardegna served as assistant executive director at St. Mary's Health Center (Richmond Heights, MO) from 1975 to 1978 and then as executive director at SSM Rehabilitation Institute (St. Louis) from 1978 to 1984. [American College of Healthcare Executives. (2000). *2000 directory*. Chicago: ACHE.]

⁸ SSM Health traces its roots back to Mother M. Odilia Berger (1823-1880), who immigrated to St. Louis from Europe and founded the Sisters of St. Mary. The first hospital was St. Mary's Infirmary, dedicated in 1877. [*SSM heritage tour: Appreciating our history*. <http://ssmheritagetour.ssmhc.com/PDFs/SSMheritageguide.pdf>]

⁹ Sister Betty Brucker (1925-2015), Franciscan Sisters of Mary, served as president of St. Mary's Health Center from 1975 to 1991. [Barr, D. (2015, July 2). Sister Betty Brucker dies: Former head of St. Mary's Health Center. *St. Louis Business Journal*. <https://www.bizjournals.com/stlouis/news/2015/07/02/sister-betty-brucker-dies-former-head-of-st-mary-s.html>]

for that job. Was that a common model for administrators of Catholic hospitals at that time?

SCHOENHARD: I think so. I don't know a lot about the other Catholic congregations, but certainly St. Louis University had a strong MHA program for years. A number of sisters went back to get MHAs in Catholic health care from a variety of different congregations through the years, as well did lay people. The Sisters of St. Mary were far-sighted in ensuring that their hospital CEOs were well-prepared for that work. While they might already have had a masters in nursing, for example, there was an emphasis on going back and getting an MHA degree. That was certainly the case with Sr. Betty, who was a graduate of St. Louis University.

GARBER: Sr. Betty Brucker, Sr. Mary Roch Rocklage of the Mercy organization, Sr. Mary Jean Ryan – are all examples of leaders who had a background in nursing, and I think they all had MHAs.

SCHOENHARD: Yes.

GARBER: It seems like that was a best practice for leadership of Catholic hospitals.

SCHOENHARD: Yes.

GARBER: Then something happened and that had to change. The thing that happened was there weren't so many sisters left any more in health care. The congregations needed to transfer over to a lay leadership model.

SCHOENHARD: Yes.

GARBER: Could you talk about Sr. Betty's leadership style?

SCHOENHARD: She had an uncanny capacity to connect with everyone in the organization. She had strong interpersonal skills and genuine interest in and caring about everybody that was in that hospital. She would make early morning rounds and talk to housekeepers and nurse aides and others who were providing the primary care of our patients. She would know about their families. She would know about someone who was sick. She would pray for those who were in need. She would assist them in every way that she could. She was visible and much loved. She was also responsive to physicians and was interested in ensuring that they had the resources and the capabilities they needed to provide high quality care at St. Mary's.

She had a strong network of friends and colleagues throughout the industry. She was a chair of the Missouri Hospital Association and was well thought of and affectionately respected by her colleagues in St. Louis, throughout the State of Missouri and throughout the nation. She taught me that being visible and really truly connecting, not just walking through and having your mind on something else, but really taking the time to stop and connect and be present with a patient or a staff member was powerful. I think she motivated people to want to do very good things at St. Mary's.

GARBER: I can see that would be a powerful leadership model. You stayed in your work at St. Mary's in St. Louis for about three or four years.

SCHOENHARD: Three years.

GARBER: Then you had your first opportunity to actually lead a hospital at Arcadia Valley Hospital, an SSM hospital in Pilot Knob, Missouri. How did that opportunity come about?

SCHOENHARD: The position was posted. Sr. Grace Marie Vehige,¹⁰ who had been the administrator there for several years, was leaving. I wasn't sure Kate would want to live in such a rural area. It's a very rural part of Missouri. We went down before I applied for the position, and she said that she was willing to give this a shot, which I was very grateful for. I think I was the only candidate.



The Schoenhard family in 1986

GARBER: Did you have children at that point?

SCHOENHARD: We had Sarah, who was just going into kindergarten, and our son, Tom, was one.

GARBER: It was a good time to make a move then, in that your children would start school in a new place and not have to leave friends behind.

SCHOENHARD: That's true.

GARBER: Did your family adjust to living in a rural area?

SCHOENHARD: They did.

GARBER: Oh, wait, you weren't there that long. I just looked at your resume.

SCHOENHARD: Probably the hardest adjustment was moving again in such a short time for the family.

GARBER: This was a one-year or two-year assignment?

SCHOENHARD: One year.

GARBER: It turned out to be one year but that was not the intention going in.

SCHOENHARD: No, no. I had expected that I would be there three to five years.

GARBER: What happened?

SCHOENHARD: An opening for administrator became available at St. Joseph Health

¹⁰ Sr. Grace Marie Vehige (later known as Sr. Margaret Mary Vehige), FSM (1931-2004) served in leadership in a number of SSM health facilities. [Margaret Mary Vehige, FSM. (2004, Fall). *FSM magazine*. <https://427e6xzz6uq4ee63k4cen1fy-wpengine.netdna-ssl.com/wp-content/uploads/2017/02/2004fall.pdf>]

Center in St. Charles. I was reluctant to leave Arcadia Valley because I had only been there, at the time this opportunity came up, ten or eleven months, and felt that I should stay there and complete some of what we were trying to complete. The sisters thought it would be better for me to go to St. Charles, so I did.

GARBER: That's an interesting case study because, on the one hand, you don't want to look like you're just hopping around – that you're not willing to commit to staying in one place for a while. On the other hand, nowadays this is supposed to be the model for young people – that careers are project-based and that you should be thinking about the fact that you're going to make these moves every three or four years. You were ahead of your time.

SCHOENHARD: I was in the right place at the right time.

GARBER: Plus, you were staying within the same larger organization. The Sisters were helping to guide you.

SCHOENHARD: Oh, absolutely. I had a lot of resources from the central office at that time that assisted me at Arcadia Valley. It was certainly a strong Sisters of St. Mary commitment to that ministry that supported me when I was there.

GARBER: The Sisters have, themselves, the mindset of obedience.

SCHOENHARD: That's true.

GARBER: You were complying with that idea that if the order says I should do this, then that's what I should do.

SCHOENHARD: It was that, plus, I must say that a 400-bed hospital was attractive as well. I was hoping to complete some of what we were getting underway there before I would leave.

GARBER: St. Joseph Health Center in St. Charles was a large hospital. It was not a teaching hospital. Which hospitals were competitors?

SCHOENHARD: The primary competitors were DePaul Health Center, which was just across the Missouri River from us in northwest St. Louis County. DePaul was a new hospital that had been built in the '70s and was an all-private room facility. There was St. Luke's, in West County, which had built an ambulatory care center in western St. Charles County. Finally, there was St. Peters Hospital, owned by HCA, that was a for-profit hospital just six miles west of St. Joseph.¹¹

GARBER: When you came on board in 1982, what were the challenges facing the hospital?

SCHOENHARD: We were in the middle of a building program, and that was a much-needed new E wing – for operating suites, ICUs and the rest. We had a tremendous amount of rain that year, so we had a big lake that we kept trying to pump out in order to finally get the construction

¹¹ The hospitals mentioned were DePaul Health Center (Bridgeton, MO), St. Luke's Hospitals (St. Louis) and St. Peters Community Hospital (St. Peters, MO). [American Hospital Association (1983). *American Hospital Association guide to the health care field* (1983 ed.). Chicago: American Hospital Association.]

completed. There were also plans to build a parking garage, which dealt with a severe parking problem.

Probably the biggest concern was with our location in downtown St. Charles, that the market was moving west of us and that we weren't well-positioned geographically. We were between St. Peters and DePaul and major competition from both of those. There was a good deal of charity care. There was no county or city hospital in St. Charles County. St. Joseph was the primary provider of indigent care. We were concerned with being in a position that we would remain a strong and attractive hospital as managed care developed.

GARBER: A solution was found to the perception that the market was moving west, which was that you decided to build a satellite hospital.

SCHOENHARD: We did.

GARBER: It was called St. Joseph Hospital West – and that was in Lake St. Louis. Where was Lake St. Louis in relation to St. Charles?

SCHOENHARD: Seventeen miles west along Interstate 70.

GARBER: Did that new hospital open after you left leadership?

SCHOENHARD: I was involved in the dedication of the hospital in December of 1986. I was appointed to the corporate office position as chief operating officer in November, but I didn't start there until January. So I was seeing the way through for the hospital being dedicated and initially occupied.

GARBER: That's a very exciting type of a project, to build a brand new hospital. Could you talk a little bit about that experience?

SCHOENHARD: It was a tremendous opportunity to create a facility where we would try to position it to serve outpatients as well as inpatients. The entire design of the hospital was with an outpatient focus and with visibility and proximity to the interstate so that it would be accessible to patients in western St. Charles County.

We decided to transfer 60 of our 402 beds to that 100-bed facility so we weren't just adding 100 beds, but really only 40 beds net, so that we would try to keep the over-bedding situation down. St. Charles County was one of the fastest-growing counties in the United States at that time. Of course, it was working off of a relatively small base, so the percentages were probably higher.

We were applying for that hospital at the same time that St. Peters was trying to expand to become full service – to add OB and additional beds. Another hospital in Wentzville was also receiving consideration for a certificate of need. We had a certificate of need law in Missouri at that time and still do. Health planning approval was needed in order to have any of those plans approved.

GARBER: What is a satellite hospital?

SCHOENHARD: The concept at that time was that the administration at St. Joseph St. Charles would operate two campuses, each led by a chief operating officer, one at the main campus

in St. Charles and another who was the chief operating officer/executive director at St. Joe West. The health center would provide as much support services to that facility to lower cost and eliminate duplication as we could. That was the initial concept of it being part of the mother house, if you will, or the mother ship.

GARBER: That sounds like a good, reasonable, logical model.

SCHOENHARD: I think so because we had members of our medical staff who were interested in moving more of their practice to the western facility. Some had no interest at all, but with those who did, we would have the opportunity to work with them. The entire ambulatory care facility creation in St. Charles County could be coordinated from one viewpoint so that you weren't ending up competing with each other.

GARBER: There was one united medical staff?

SCHOENHARD: There was in the beginning but that has certainly changed over the years.

GARBER: How did the board structure operate?

SCHOENHARD: We had an advisory board at St. Charles and an advisory board at St. Joe West. The main governing board at that time was still before what would eventually become the system board, but was initially the congregational board. Everything that had to do with St. Joe West would come through the St. Joseph Health Center administration to the board. That was before regional boards were developed and there are different markets of SSM.

GARBER: You also mentioned that there was a 60-bed transfer. What does that mean exactly?

SCHOENHARD: With the licensure with the state, you voluntarily give up 60 beds so that your overall licensure is reduced. Technically you're not authorized to operate at anything higher than your licensed capacity.

GARBER: What actually happens with those 60 beds? You just turn the lights off?

SCHOENHARD: We were taking the opportunity every place we could to convert what we could to private room capacity. In truth, our occupancy was well under 402 beds so we weren't, of course, turning patients away.

GARBER: What you're saying is that there were some double-occupancy rooms which were converted to private patient rooms.

SCHOENHARD: It took a while to get to that but we were trying to convert as much private room capacity as we could, especially for isolation and special needs patients. We were not approaching the 400 census, so it really didn't have a material effect on daily operation. But it did mean we would forego a 60-bed expansion later if we had to. If we had wanted to expand our licensed capacity again later, we would have had to go back and receive approval for that.

GARBER: Why was St. Charles County growing so fast?

SCHOENHARD: It was a market that was seeing significant housing creation, a housing boom. General Motors built a plant in Wentzville. That was a major anchor. A number of major corporations were looking to put in facilities – there’s now a MasterCard facility in St. Charles County. It was seen as the next suburb of bedroom community progression moving out of St. Louis County and out to St. Charles County, particularly where people might want more housing for their money than they could get in many St. Louis suburbs or in the City of St. Louis.

GARBER: At the new hospital, St. Joseph Hospital West, did you have a medical office building on the grounds?

SCHOENHARD: We did.

GARBER: Do you consider that to be a best practice for a community hospital?

SCHOENHARD: Oh, yes. I think it’s very important to have medical office capacity for physicians who particularly have a lot of their practice in the hospital.

GARBER: The new hospital – St. Joe West – really struggled for a long time. There was a very low occupancy. Under a quarter of the beds were occupied. Could you talk about the reasons why and how that was eventually overcome?

SCHOENHARD: The primary reason was all of the expansion programs that I mentioned earlier – the St. Peters program was eventually approved and OB was added at St. Peters. Probably the most material effect that we had not factored in was that there would be another hospital in Wentzville, which was about six miles west of Lake St. Louis, that would be approved also – another 100-bed hospital. That added startup impacted the early growth of St. Joe West.

GARBER: The Wentzville hospital was owned by whom?

SCHOENHARD: HEI, a for-profit osteopathic hospital.

GARBER: St. Joseph West was also a 100-bed hospital. Eventually you dropped to a lower licensed capacity, it looks like.

SCHOENHARD: I don’t recall.

GARBER: That was after you went to corporate. It looks like it, from my reading of the *AHA Guide* over the years. That did help bring the occupancy up. As we’ve been talking about the development of hospitals and transferring beds from one license to another, we’ve mentioned certificate of need in Missouri. What’s your opinion about certificate of need? Is it a program that has been a good idea?

SCHOENHARD: I think so. It can be a barrier of entry for an out-of-state, out-of-city new developer who may want to look twice at adding duplication of services to a community where they’re likely to receive opposition from existing providers. Having some rational basis on which approval is given for major capital expenditures and establishment of new facilities is good, and I think Missouri has benefited from certificate of need.

GARBER: Yet in this case, where we have St. Joe West competing with the Wentzville

hospital, it appears not to have worked.

SCHOENHARD: No. I think that the osteopathic take on that became very powerful.

GARBER: Before we move on to creation of SSM, is there anything else you would like to talk about? We haven't mentioned many of the people that you might have worked with.

SCHOENHARD: I was fortunate to have a wonderful administrative staff who were supportive and talented. We had a challenge of promoting growth in the western St. Charles County area and of preparing for DRGs and cost containment and all of what you would need to do to get costs in line at St. Joseph Health Center. The staff there was marvelous in addressing that.

We had the normal questions, as you would expect. Why are we cutting here when we're adding out in Lake St. Louis? It took a great amount of effort to communicate the importance of that and the vision for that. The staff who were there did a tremendous job of carrying that kind of a challenge forward and helping to plan the new hospital. Corporate actually undertook the construction of the hospital, but we had all the programmatic and service delivery initial deployment to that facility when it opened, and all of it came from St. Joe resources. The staff up and down the line worked hard.

We were fortunate to have strong community leaders on our advisory board. Two people that come to mind particularly are Henry Elmendorf¹² and Jim Fitz. Henry led the development council, and Jim was the president of the advisory board during those crucial years. I reported to a vice president who very courageously took the recommendation of the hospital to the full governing board for approval and support – and that was Sr. Mary Jean Ryan.¹³ Sr. Mary Jean was an instrumental person in taking what was a difficult position to take because people were saying hospital beds needed to be reduced and eliminated. We were moving from inpatient to outpatient. The thought of proposing a new facility was counter to many people's thinking of how health care should be delivered in the future.

GARBER: There was a report that the State of Missouri issued right about the time when the new hospital was set to open that the St. Louis metro area was over-bedded by 2,500 hospital beds. That's a lot.

SCHOENHARD: Yes.

GARBER: You mentioned Sr. Mary Jean Ryan. This seems like a good time to talk about SSM and 1986. Could you tell that story, how SSM Health Care came about?

¹² Henry J. Elmendorf (1922-2013), manager of an automobile dealership in St. Charles, MO, was considered to be a remarkable civic leader with lifelong commitment to the success of local public projects. [Korando, R. (2013, January 7). Longtime St. Charles civic leader Henry Elmendorf dies. *St. Louis Post-Dispatch*.
http://www.stltoday.com/suburban-journals/stcharles/news/longtime-st-charles-civic-leader-henry-elmendorf-dies/article_4f6421cc-bcf6-52c7-8c1a-96343171b3f2.html]

¹³ Sr. Mary Jean Ryan, FSM, served as the founding CEO of SSM Health from 1986 until her retirement in 2011, after which she continued in leadership as board chair until 2015. [Liss, S. (2014, December 10). Sister Mary Jean Ryan stepping down as SSM Health board chair. *St. Louis Post Dispatch*.
http://www.stltoday.com/business/local/sister-mary-jean-ryan-stepping-down-as-ssm-health-board/article_2e75723d-ad78-538b-a288-d7d31d134ada.html]

SCHOENHARD: Before it became known as SSM Health Care, there was the infrastructure to create a system. It was far-sighted in having a central information center that served all facilities prior to 1986, a strong central office with a variety of different services that offered management, engineering and other resources to the facilities. As executive directors of our hospitals, we'd come in and meet with the congregational board. We had basically a member of the board who was viewed as the hospital lead president for the governing board, and the mother superior was on there along with other people like Sr. Mary Jean, who was the vice president appointed to the board. There was a basic infrastructure in place to have a reporting mechanism to one board supported by central office services that served the entire system.

It became apparent that we needed to do a number of things to restructure in order to not wear out the congregational board. They would meet with every hospital individually. They might meet with three or four hospitals a day, going through individual hospital governance structure. The concept of restructuring was to become more regionalized, to create regional hubs as managed care and as competition were increasing. We would take a system approach to the entire system but have a regional infrastructure to be able to effectively compete in our various larger markets where we had critical mass. With that also was the thought that we should create regional boards to attract community leadership to that cause and to finalize and review corporate services that were really needed in the field.

It was restructured in 1986 to SSM Health Care with Sr. Mary Jean Ryan as the first president and CEO. There was a concept at that time that we would look for economies of scale and look for opportunities to not have our own facilities compete with each other in markets where we had critical mass and to create some system-ness so that we had less variability around the deployment of such things as quality improvement and so forth with support from Corporate.

GARBER: The quality improvement subject is going to become huge a little later on in this conversation. You mentioned that one of the objectives was to reduce or eliminate competition with others in the same system. Did you do that by saying – we're going to have pediatrics here, but not there? We're going to have OB here, but not there?

SCHOENHARD: To the credit of the earlier leaders before the system was structured, that was already in place, particularly in St. Louis. Cardinal Glennon Children's Hospital was the pediatric service for the St. Louis market and it had beds also in St. Charles. When I was there, we developed the Glennon unit at St. Charles because we had a growing pediatric community to serve. There was OBGYN at a variety of different facilities. We didn't have a lot of direct competition because our hospitals had grown out of different geographic markets in the city that were distinct from each other. We didn't have the problem of rationalizing two facilities that were in head-to-head competition with each other. It wasn't anything like that.

When we acquired DePaul, for example, in the 1990s, which I mentioned earlier was a competitor of St. Joseph, we were careful to try to ensure that DePaul was faithfully serving its North County population while not duplicating the services of St. Charles County that it might have been inclined to do under another ownership.

GARBER: How many regional boards were there?

SCHOENHARD: There were regional boards in Wisconsin, Southern Illinois, Oklahoma

and St. Louis – in time. That was not the case initially but as the system grew in the ‘90s. We had hospitals in Blue Island, Illinois, which we ultimately divested. In Maryville, Missouri, they had individual hospital boards.

GARBER: Who served on those four regional boards?

SCHOENHARD: I served, as well as did Sr. Mary Jean – so we had a connection from the system office. We would have community leaders and physicians who would serve those regional boards that were from those markets.

GARBER: Did anyone give pushback as far as changing to this new corporate structure?

SCHOENHARD: No, I don’t think so. It was recognized with the advent of DRGs and with increasing competition that we needed to restructure in order to be more competitive, to develop economies of scale, to have a regional strategy that did not rely on the governance of the old congregational board but that had full-time executive talent and governance devoted to helping to ensure each market was healthy. There was not that much pushback.

We had a long tradition of standardization which was unlike some congregations in Catholic health care – a standard management information system. The information system was the data center that served the facilities for many years. There can be a lot of pushback, when you’re changing information systems in a facility. We had common pension, labor, personnel practices and the rest that came out of central offices. It’s not that big a change, but it was one that I think was generally welcomed by the field.

GARBER: Were there individuals who were champions for this idea?

SCHOENHARD: Certainly the members of the congregation leadership – Sr. Mary Ellen Sloan,¹⁴ Sr. Francine Burkert,¹⁵ Sr. Connie Fahey,¹⁶ Sr. Mary Jean Ryan, Sr. Mary Ellen Lewis,¹⁷ Sr. Irene Radtke¹⁸ – I’m sure I’m not naming everybody I should – but they were among the major congregational leaders who saw the vision to create this system and have Sr. Mary Jean as the CEO.

¹⁴ Sr. Mary Ellen Sloan, FSM (1927-2011) served as vicar general and then superior general of the Sisters of St. Mary from 1969 to 1985 and was instrumental in the establishment of SSM Health Care in St. Louis. [Sr. Mary Ellen Sloan. (2011, Fall). *FSM magazine*. <https://427e6xzz6uq4ee63k4cen1fy-wpengine.netdna-ssl.com/wp-content/uploads/2017/02/2011fall.pdf>]

¹⁵ Sr. M. Francine Burkert, FSM (1923-2010) served as superior general of the Franciscan Sisters of Mary from 1969 to 1977 and was later involved in governance in the SSM Health organization. [Sister M. Francine Burkert dies: Led Franciscan Sisters of Mary. (2010, July 20). *St. Louis Post-Dispatch*. http://www.stltoday.com/news/local/obituaries/sister-m-francine-burkert-dies-led-franciscan-sisters-of-mary/article_9ef0b718-e0f1-54c5-b7d8-8d1aebc16f0a.html]

¹⁶ Sr. Connie Fahey, FSM, has served in a variety of ministries in the U.S. and Africa. [Connie Fahey. *Global Sisters Report*. <http://globalsistersreport.org/authors/connie-fahey>]

¹⁷ Sr. Mary Ellen Lewis, FSM, served as general superior of the leadership team that worked on the reunification of the order during the late ‘80s. [Sister Mary Ellen Lewis. (2015, May 19). *St. Louis Review*. <http://stlouisreview.com/jubilarian/franciscan-sisters-mary-1>]

¹⁸ Sr. Irene A. Radtke, FSM (1928-2014) served in leadership positions at SSM hospitals and founded the Almost Home transitional housing program for adolescent homeless mothers in St. Louis. [Radtke, Irene A., FSM. (2014, February 21). *Madison.com*. http://host.madison.com/news/local/obituaries/radtke-irene-a-fsm/article_46804e35-918a-5bce-b90f-5669fbeatd6b4.html]

Gayle Capozzalo¹⁹ was the vice president of planning and marketing, later a senior vice president of strategic planning. Gayle was instrumental in helping develop the various documents, the actual implementation and the operating of the new structure.

GARBER: Then the Sisters said, Bill, we've got a new opportunity for you, too!

SCHOENHARD: We were just opening St. Joe West and I felt, once again, that I should stay where I was because I felt a duty to see it through, and I knew it would be tough with the Wentzville approval. I called Sr. Mary Jean and I said, "I think I should stay here in St. Charles, don't you?" hoping she would agree. She said, "Let me think about it for a week." A week later she called and said, "I think you should apply." There was a formal process. We answered a number of questions in writing and she decided to select me.

GARBER: Could you talk a little bit more about Sr. Mary Jean Ryan? What is her leadership style? Is she still active?

SCHOENHARD: Yes. She is speaking at quality forums internationally and she remains a mentor to many people in the system and a good friend.

The best way to describe Sister's leadership at SSM is that it was focused and inspirational. She was focused on making us better, that saying we were good was not good enough. Remember that we came from a time when we used to do nursing audits and medical audits, and you would only address those problems that fell out of the norm, like a nosocomial infection rate of three percent. Then you would develop an improvement plan. Back in the early days of quality assurance, as we called it, nobody thought, "Why should we be willing to tolerate a three percent nosocomial infection rate? Why not lower it? Why can't we get to zero defect in terms of patient harm? One hundred percent satisfaction of our patients?"

She had the leadership capacity to motivate people – she's an inspiring public speaker. Most of all, she had the persistence, the rigor and the discipline to stay with the message that, "We can always be better," that ultimately led to being the first health care recipient of the Malcolm Baldrige National Quality Award.

Sister had worked as an operating room nurse and she probably had, from her experience in the operating room, a keen appreciation for process, or the lack of process. The operating room, the necessary marking of surgical site and all the rest, had fueled this passion. She is a determined leader who feels that health care can be much better than it is.

GARBER: I read Sr. Mary Jean's book, *On Becoming Exceptional*,²⁰ which is a captivating account of this journey that I was surprised to note took four years? Four application cycles?

SCHOENHARD: At least four.

¹⁹ Gayle L. Capozzalo served in leadership positions with SSM Health during the '80s and '90s. [Women leaders in healthcare: Gayle Capozzalo, FACHE. (2012, April 12). *Modern Healthcare*. <http://www.modernhealthcare.com/article/20120412/INFO/304129950>]

²⁰ Ryan, M.J. (2007). *On becoming exceptional: SSM Health Care's journey to Baldrige and beyond*. Milwaukee: ASQ Quality Press.

GARBER: There was a dry run before SSM was even eligible because at that time they were not accepting health care organizations as applicants.

SCHOENHARD: Yes, that's true.

GARBER: Sister said, "Well, let's give it a go, anyway." Then, the next year and the next year – she notes in the book that before the last cycle, she felt that people were exhausted. They just couldn't go through this application process one more time. She gave it a careful, and I'm sure, a prayerful consideration and said, "Yes, we're going to do it." This has been nicely recorded in her book, but could you give your personal take on what the process was like?

SCHOENHARD: As I mentioned, we were trying to find our way to a business model, a framework, around which we could improve quality and outcomes and employee/patient/physician satisfaction. The Baldrige criteria was one model that some of our early pioneers supporting Sr. Mary Jean, like Bill Thompson,²¹ Gayle Capozzalo, Paula Friedman²² and others had become familiar with. As you mentioned, it was not initially available to health care, but was being used to create recognition for those companies that were seeing major leaps in quality improvement and customer satisfaction.

It's important to recognize that this was not about the award. It was not about receiving recognition. That's nice and reinforcing, but the award was secondary to finding a business framework around which there were criteria that were comprehensive and systemic that would drive improvement. What had occurred was that some states – and Missouri was one of them – started creating state quality awards that were based on the Baldrige criteria. A facility would make an application to the state. Also, we were seeing people in health care who were applying to become Baldrige examiners even before health care was eligible to apply for the award.

Probably the best advance for us, beyond Sister's passionate leadership, was having some of our people go for Baldrige training and be able to come back and translate these seven criteria sets in real terms so we could understand what a leadership system was, or what it meant to really identify the needs of our customers, for example.

What was most beneficial in this journey was not the award itself although that is nice recognition. It gave us a framework within which we could, at the state level initially and then when we could apply for the national award, see the gaps as you fill out the application. You fill out a 50-page application. As you answer certain questions as to how your organization meets these requirements, the gaps in the improvement, leadership, strategy, human resources, process improvement, information systems and the rest would become apparent.

Some of the best consulting engagements we ever had were the site teams that would come visit us from the state quality award, and then later, the Baldrige award, who would further point out where our gaps were in order to ensure that we had a systemic approach to quality improvement. I can't over-emphasize – people think of the award and say, "Isn't that great?" But, the framework within which we broke into teams and addressed different sets of the criteria and came together as a

²¹ Thompson, William P. served as president/CEO of SSM Health from 2011 until his retirement in 2017. [SSM Health president and CEO William P. Thompson announces intent to retire in 2017. (2016, June 8). *Press Release*. <https://www.ssmhealth.com/newsroom/2016/6/ssm-health-president-and-ceo-william-p-thompson-a>]

²² Paula J. Friedman serves as chief strategy officer at SSM Health. [Paula J. Friedman: Chief strategy officer. *SSM Health*. <https://www.ssmhealth.com/about/management/paula-friedman>]

leadership group to try to deploy those system-wide was the greatest value of the Baldrige journey.

GARBER: The sets of criteria are difficult to grasp?

SCHOENHARD: They are, definitely.

GARBER: Did you have any sense when you first applied that because the Baldrige was now available for the first time to health care organizations that maybe there were gaps and that the set of criteria doesn't really fit well with a health care provider?

SCHOENHARD: No, I think that it was more a lack of really understanding deeply what the criteria meant. I don't know that it was so much "not applicable" as it was not completely understood. When we would have experts, both in health care and outside of health care, come in and point out what Baldrige meant by this and that, buttressed by our own Baldrige examiners who went for training and did site visits elsewhere, and brought back their learnings from other organizations, that's where we can see more of what would be occurring.

There was some resistance to this in the early days because as the system was developing there was a feeling as we would look for that framework, there might be the Management-Fad-of-the-Year that we kept going through. "This, too, will pass." The Baldrige provided the anchor for Sister's commitment, and it soon became clear that this was not just a fad.

Like many organizations before they become customer-focused, health care organizations tend to create policies and procedures and operate in a way that is good for the system. How we think we are best serving our patients? What best works for us? Maybe not what works best for the internal customer and the ultimate customer – the patient – in terms of breakthrough improvement going forward. There was inertia built into health care that, "We're going to wake you up in the morning to do your blood pressure and disturb your sleep because it's a convenient time for us to get that charted before we go off." Now, I don't mean to minimize the need for early morning patient rounds – that's probably a poor example. There are so many examples, particularly in support services, where we were geared toward what we thought was best for us as opposed to what was best for the internal customer, and that took a lot of resistance to overcome in the initial years.

We had a hard time initially thinking of our patients as customers. Our patients are our patients. We know best what's needed for our patients. "We've been trained and through experience, we know. We would tend to put the patient in a subservient role of receiving our expertise, because, after all, we had the training, experience, education to know best." That was totally flipped – or at least was attempted to be flipped – in the early years as we would look to what really drives patient loyalty and seeing our patients as true customers. That was another cultural barrier to break through.

GARBER: Was that a physician talking there?

SCHOENHARD: No.

GARBER: It sounded like it.

SCHOENHARD: No, it could be some. You can't stereotype, because we had great physician leaders who saw this and were pushing the system before we were on it. There were some physician leaders, but there were nurse leaders and other clinicians and staff who felt that our patients

are our responsibility and we know best how to take care of them. If you read the Baldrige criteria, it puts the patient as the ultimate end user of all those customer/supplier relationships.

GARBER: Who were your champions in this process?

SCHOENHARD: Bill Thompson was an early champion with Sr. Mary Jean. Gayle Capozzalo was an early champion. She went on to become very active in Baldrige even after she left SSM. Paula Friedman. Barbara Spreadbury²³ was the first director of our Quality Resource Center. I had the responsibility of staffing up the Quality Resource Center to provide the education and the resources for quality improvement education throughout the system and led the CQI implementation team. We had a plan developed for this implementation of continuous improvement.

There were many champions in the field who took this up and were early adopters and led the way, and facilities that were winning the state quality award before we applied. Tom Langston,²⁴ who directed our Information Center – I think the Information Center, along with being a Baldrige winner, because the entire system was recognized, won the Missouri Quality Award several times. People may not think of the Information Center as a place that is providing excellent care but that was certainly the case under his leadership.

Were it not for Sr. Mary Jean's tenacity, commitment and perseverance, your earlier point of getting survey-application-weary may have taken hold. Actually, the multiple applications were always an opportunity for new learnings, new breakthroughs, new improvements that ultimately benefited our patients.

GARBER: How does SSM continue the process today?

SCHOENHARD: I've been gone since 2009. I think the way an organization most faithfully continues the Baldrige process is to continue to use the Baldrige framework. To the extent that any organization after winning the award continues to use the rigor of that business model for its improvement, it can certainly have life after Baldrige. I don't know what the current requirement is, but after a certain number of years, you can apply again for the Baldrige and get another review.

GARBER: Is there anything else you'd like to say about the Baldrige?

SCHOENHARD: It changed a lot of my thinking about health care. I can remember at Deaconess, we would always worry about hot-food-hot, cold-food-cold being delivered to the patient. In the old days, I had a great relationship with Ruth Triefenbach, the director of nursing. One of my departments was dietary, and we would go through this cycle about every three to six months where there would be complaints from patients that the hot food wasn't hot and the cold food wasn't cold. I would huddle with my staff. Ruth would huddle with hers. We would come to a meeting prepared to tell the other party exactly what they needed to do to correct the problem. Maybe we would reach some compromise and agree, "Well, yeah, we could probably do that better." We never put in place, at least at that time, a systemic process improvement – hardwiring the process, relying on the process,

²³ Barbara Spreadbury served as corporate vice president of the SSM Quality Resource Center from 1990 to 2001. [LinkedIn. <https://www.linkedin.com/in/barbara-spreadbury-a356233/>]

²⁴ Thomas Langston served as the chief information officer of SSM Health. [Feldt, B. (2014, December 10). SSM Health names new CIO. *St. Louis Business Journal*. <https://www.bizjournals.com/stlouis/blog/biznext/2014/12/ssm-health-names-new-cio.html>]

with good people implementing the process, to make a breakthrough so we wouldn't have to keep revisiting this problem every three to six months.

GARBER: In 2009, you left SSM and took a different kind of a job. You left working in faith-filled organizations and went to work for the federal government. Could you talk about how this opportunity came about?

SCHOENHARD: I began to more appreciate that all the blessings, freedoms, privileges and rights we have in this country are a direct result of those who have gone before us. When my dad died, I thought a lot about his service and the service of others of the Greatest Generation, as Tom Brokaw would say. They fought against genocide, bigotry and prejudice. They fought for justice and dignity of all persons. As our grandkids started to come along, I got sentimental about what the veterans have given for this country. When you are building your career, you care about getting everything done and moving on. Later in life, you start to reflect on all the blessings we have in this country due to those who have gone before us.

An experience that stuck with me was that Kate and I visited Normandy and talked to a number of French citizens. All these years later, they thanked us as Americans for liberating them, for taking away that dark shadow of Nazism and the terrible suffering and genocide. That experience and 9/11 and the wars in Afghanistan and Iraq – I felt like there are so many people who are sacrificing right now, families that are being separated, people who are being injured and killed in the line of duty to defend us.

I started to explore with friends like General David Rubenstein,²⁵ Tom Dolan,²⁶ Rich Umbdenstock,²⁷ Marc Smith²⁸ and others if there was some way in which my experience would be transferrable to the care of veterans. I wasn't sure because I came from the private sector. I'd had a brief military experience but that was many years ago. They put me in touch with a variety of people at the VA who talked to me about making some application, and that led eventually in 2009 to applying for the Undersecretary for Health position. A commission was set up to review candidates and I was one of the four finalists. The Undersecretary for Health was offered to another candidate who was much more qualified than I was to serve. I was offered another position, the Deputy Undersecretary for Health for Operations and Management position that I accepted.

²⁵ Major General David A. Rubenstein (retired) served in various command positions during this 35 year career in the U.S. Army, including as the Deputy Surgeon General and as the Chief of the Medical Service Corps. [Texas State. *MG (ret.) David Rubenstein, FACHE, MMAS, MHA*. <http://www.health.txstate.edu/ha/fac-staff/fac/d-rubenstein.html>]

²⁶ Thomas C. Dolan, Ph.D., served as President/CEO of the American College of Healthcare Executives from 1991 to 2013. His oral history: Garber, K.M. (Ed.). (2014). *Thomas C. Dolan in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <https://www.aha.org/2006-01-13-hospital-administration-oral-history-collection>]

²⁷ Richard J. Umbdenstock served as president and CEO of the American Hospital Association from 2007 until his retirement in 2015. [AHA president Rich Umbdenstock to retire at end of 2015. (2014, Nov. 21). *H&HN. Hospitals & Health Networks*. <http://www.hhnmag.com/articles/3833-aha-president-rich-umbdenstock-to-retire-at-end-of-2015>]

²⁸ Marc Smith served as president and CEO of the Missouri Hospital Association from 1998 to 2010. [Galloro, V. (2009, February 20). Smith announces plans to retire from Missouri Hospital Association. *Modern Healthcare*. <http://www.modernhealthcare.com/article/20090220/NEWS/30220966>]

GARBER: What were your responsibilities?

SCHOENHARD: I had responsibility for the 21 Veteran Integrated Service Networks directors. The United States is divided into 21 VISNs, regions that are led by VISN directors, all of whom reported to me, along with a variety of administrative programs that also reported to the Deputy Undersecretary for Operations and Management.

GARBER: These 21 VISNs are geographic regions that have a certain number of VA hospitals and other facilities?

SCHOENHARD:
That's correct.

GARBER: Are there any sorts of governing boards?

SCHOENHARD: No, there are various advisory councils and organizations that help medical center directors in the field – veterans groups that they're consulting with. There are no governing boards as we know in the non-governmental sector.

GARBER: Is there an advisory council for each hospital or for each VISN?

SCHOENHARD: We were always looking for opportunities to receive veteran input. This would vary from facility to facility. VISNs would get that input. We certainly at the central office would meet with leaders of veterans' groups. That was extremely beneficial, because they would give us the feedback from their membership.

GARBER: Were you constantly travelling, visiting the VISNs? Or did they come to D.C.?

SCHOENHARD: They came to D.C. periodically for meetings but I tried to get out to them. I wish I had gotten out more than I did. I would go to ceremonial events like ribbon cuttings or dedications of new facilities if the Undersecretary or the Principal Deputy were not available. Sometimes I went on congressional visits and went with members of Congress to see their state or their district for various needs. I spent more of my time in Washington than I did on the road, but I was always refreshed and inspired by the opportunity to actually see the care being provided.

GARBER: You mentioned ribbon-cutting and new facilities – it makes me wonder whether the VA has enough. Does the VA have enough money? Does the VA have enough people?

SCHOENHARD: It's important to put this in the context of veteran care. One of the major



**Ribbon cutting ceremony at the Anchorage (AK)
VA outpatient clinic**

issues that we dealt with when I was at the VA was the increasing number of female veterans. Having facilities and programming for women, either in the facility or in the community, was an important emphasis.

Another major focus has been mental health. When we look at veteran suicides – there is actually a lower number of suicides by veterans who are being served by the VA than there is among veterans as a whole. The efforts to identify suicidal conditions and to intervene and provide mental health in the medical home and all that has been done to try to address homelessness and addiction and pain management were other major initiatives.

The VA is a vast system. A great effort was made in the 1980s to shift, as the private sector did, from an inpatient to an outpatient focus. I went to a number of large outpatient clinics and facilities that were around the hub of the hospital, but were in fast-growing areas of veteran growth.

Over time, the challenge was ensuring that we were bringing needed facilities online in time, particularly in fast-growing veteran markets like the southeast and the southwest, to meet that need. A big part of that effort, of course, was ensuring that we had strong physician and executive recruitment and retention efforts to have the caregivers there to serve veterans.

One thing that made me admire the career executives who serve at the VA is that they are paid at a much lower rate than they could earn in the private sector. The pay for nurses and physicians was better, more competitive, but executive pay was a concern.

When I would go out into the facilities, I would often ask a housekeeper or a nurse or a social worker, “Why do you work at the VA?” Every one of them had a story. They were veterans themselves, or their dads had served, or their children were veterans, or they felt like this was their way of serving. There was always some connection to serving this special, distinguished, honored group of Americans.

GARBER: Are the veterans who are cared for within the system paying any fees?

SCHOENHARD: Yes, in certain instances. There are eight categories of classification for veterans. What is not well understood is that not all veterans are eligible for VA health care. I should mention that the VHA – the Veterans Health Administration where I worked – is one of three administrations in the VA. The second is the Veterans Benefit Administration which administers the G.I. Bill, life insurance, home mortgages and other benefits that veterans can apply for. Many more veterans can apply for those kinds of benefits than may be eligible for VHA care. The third administration is the National Cemetery Administration.

At the time I was there, we had about 21 million living veterans, of whom about seven to eight million were actually enrolled in VHA because many veterans would not be eligible, given the criteria. In the eight classifications of care, there were different co-pays and payments that would be needed, depending on what category a veteran was in. For service-connected disability, that care would be provided.

GARBER: Are there any hospitals in the VA system that are stars or well known for some reason?

SCHOENHARD: The polytrauma centers always gain a lot of recognition because they

have tremendous capacity and services available to help those who have been severely injured. San Antonio, Palo Alto and others are part of that category. I would not minimize having the opportunity to go to some of the medical centers in our rural facilities. Many of them are stars as well because they serve a rural population of veterans and a lot of veterans live in rural areas. A lot of the Guard and Reserve come from rural areas. There are smaller rural facilities that are providing wonderful care for those veterans. They may not have all the high tertiary-level services of a polytrauma center, but they are reaching veterans in a way that is meaningful to them.

GARBER: That's a great point. I also wanted to ask when you were talking about physicians and nurses before, are the VA physicians employed?

SCHOENHARD: They are. One of the great benefits of the VA all through the years is that besides the patient care mission of VHA, there's the research mission and there's the teaching mission. A vast number of physicians and other clinicians have received training from the VA.

GARBER: There were some difficult events that happened at the VA after you left.

SCHOENHARD: I'm hesitant to speak because that occurred after I left. I don't want to say or do anything that would in any way hinder the ongoing improvement. I will say that a lot has been done with improving access. That's important. When I was at the VA, billions of dollars of care was provided in the community. While I am not in favor of privatization of the VA, I think that Congress and the administration have done a lot to ensure that funds are available and are being extended, from what I read, to ensure that where there are shortages or difficulties having patients referred for specialty services or for other services, that they're referred in a good way to the community.

It's important to understand that the VA is a true integrated health care delivery system. It has a continuum of care that is unmatched in the private sector – everything from home care to polytrauma care to prosthetics to outpatient care to mental health services to domiciliary care to long-term care. The whole integration is driven out of medical home of a primary care physician who owns that patient and refers the patient for a lifetime of care.

One of the great advances has been the focus on patient-centered care, which is not unique to the VA. This involves really understanding what the veterans want to accomplish in life. What are their goals? What are their individual needs and desires beyond just getting a shoulder fixed or a traumatic head injury treated? What is it they want to do with their lives? With the whole wraparound of the services of VA, it is ensuring that the veteran's life is as fulfilling and rewarding as it can be.

While we need to be able to refer patients to the community, the community may not have the infrastructure to be able to organize that full delivery of service. I think that Congress really believes they must accept the financial obligation to care for those, as Lincoln said, who have borne the battle, and that the investment in their care and well-being is a decision that comes concomitant with the decision to appropriate the funds to deploy troops in the first place.

GARBER: You mentioned domiciliary care. Does that mean long-term housing?

SCHOENHARD: Yes.

GARBER: Is there a time limit on how long veterans can stay?

SCHOENHARD: Until their condition improves and then there's a number of home services that can benefit them going forward.

GARBER: The last thing I wanted to ask about your time with VHA is how you adjusted to an environment that was political.

SCHOENHARD: Congress has a very important oversight role across the Executive branch of ensuring that the funds that they appropriate are well spent for the needs of the mission of that Executive branch department. I'm a believer in oversight and in the role of the Congress. I had some preparation for a political environment as Chairman of the Missouri Hospital Association, through SSM, before that, and in my Chair year, we would lead Congressional visits to the Hill. I had met with a number of senators and members of the House of Representatives over the years regarding health care issues. That wasn't entirely foreign to me.

I had great appreciation for the role that Congress plays because they are involved with ensuring that veterans in their districts and in their states are well served. It was not as big a leap for me as it might have been without any prior military service or with no Congressional experience. We were always well supported there in the central office also in our interaction with the various political aspects of it. I think that leads to greater transparency, to more accountability, all of which is good for the care of the veteran.

GARBER: Something made me think about mission statements or vision statements. Do you still remember SSM's statement?

SCHOENHARD: Through our exceptional health care, we will reveal the healing presence of God.

GARBER: Does VHA have a mission statement?

SCHOENHARD: There is a mission statement for the Department and a set of values. Secretary Shinseki,²⁹ when I was there, went through a robust process of refocusing the mission statement and values. What it comes down to, and the thing that always inspired us, is what you see as you enter the VA Central Office, a quote from Lincoln's Second Inaugural Address – "To care for him who shall have borne the battle." We drew a lot of inspiration from that admonition from President Lincoln.

GARBER: Let's move along to some concepts. What are the characteristics of a good board member, a good board chair?

SCHOENHARD: The board chair has the responsibility for setting the agenda for board meetings. With the members of the board, the chair has the responsibility of deciding what is going to be the process of governance. Are we just going to have a lot of committee reports that we rubber stamp, get through the meeting, publish the minutes and go do it again the next time?

²⁹ Erik K. Shinseki served as Secretary of Veterans Affairs from 2009 until 2014. [Jaffe, G., and O'Keefe, E. (2014, May 30). Obama accepts resignation of VA Secretary Shinseki. *The Washington Post*. https://www.washingtonpost.com/politics/shinseki-apologizes-for-va-health-care-scandal/2014/05/30/e605885a-e7f0-11e3-8f90-73e071f3d637_story.html?utm_term=.b67f40fa8a6c]

My bias is more toward, through a consent agenda or other means, informing the board of the important developments but leaving time for the board chair to lead strategic discussions around matters that face that organization. The relationship that the board chair has with the CEO is crucial. The most important decision that any board makes about any organization is the recruitment, selection, retention or replacement, if needed, of the CEO. That falls to the board chair and leadership to ultimately ensure.

The board chair as well as other board members must be careful that they come with their organizational hat on, that they're not there to serve themselves, to advance their own careers, to ensure that their company gets some kind of entrée to the organization. They need to be careful to avoid conflict of interest and to have the courage to bring up a subject that they feel needs to be discussed. When board members go to a meeting and don't talk, or they talk in the parking lot about what they should have been talking about in the board meeting, that's not representing the best governance for an organization.

The best boards are well-prepared. They're well-educated. They're dedicated to the mission of the organization they serve. They really care about it, and they recognize the legal and fiduciary responsibility they have for ensuring that mission continues to be viable. They are most of all there to ensure that they are serving the organization's best needs with a good understanding that they're not managers. They're not operating the facility. They are there for governance. It's inappropriate for them to dive in deep into management issues that they really don't have any time for, expertise about, and which may disrupt the organization.

GARBER: What are your thoughts about the concept of expert leadership – that physicians make the best hospital administrators?

SCHOENHARD: All of us admire bosses who are technically competent, who have the expertise and the experience. That would be true in my experience in health care as well as in the Navy. When somebody is technically competent, it gives them credibility and an understanding of what it is that they're leading or managing that is very important. That certainly speaks to physician leadership. It's a great trend over the years that more and more physicians are leading organizations and leading hospitals and the rest.

I do have one caveat, though – remember what it is that the physician is doing. If you're director of cardiology, for example, it's important to be a top-notch cardiologist and to work with other cardiologists who respect your expertise. If you're a hospital CEO, you're not practicing cardiology. You're practicing health care administration, leading what Peter Drucker described as the most complex organization in the U.S. economy.

Can clinicians like dietitians, nurses, physicians, physical therapists, respiratory therapists and others can advance in health care and be great CEOs? Absolutely, yes. I know great nurse CEOs who have gone back to get their degrees and have cut their administrative records with brilliance – they had a step up over those of us who were coming out of grad school in understanding clinical care. There's always credibility and appreciation when the top person is a clinician. The staff appreciates that they demonstrated earlier in their career a commitment to the healing professions. They're not switching from some non-health care industry to another, hoping to see what this is like. I would say it depends on whether they have really, truly had the set of experiences that prepared them for that given position.

GARBER: How would you describe your own leadership style? Has it changed over the years?

SCHOENHARD: I don't know that I really had a style early on. I think what I evolved into, through the mentoring of Sr. Betty, Carl Rasche, Dick Ellerbrake, Sr. Mary Jean and others through the years is what you referenced earlier in Sister's book – servant leadership.

The greatest leaders are those who demonstrate a commitment to something bigger than themselves. They care about a cause that is larger than themselves, like Lincoln preserving the Union and abolishing slavery, Martin Luther King ensuring civil rights. Followers quickly pick up if a leader is there all about himself or herself. Invariably, there's going to be a time when a leader is going to have to make a difficult decision that is painful and hard to make, that will either be made or not made for the benefit of the mission but may not be for the benefit of the individual.

The other part of leadership is making sure that everybody has an understanding of what they do every day to contribute on a direct line of sight to the mission statement. Leadership has the important responsibility of providing the culture and the framework within which people can see that when they provide exceptional health care, they really truly do reveal the healing presence of God. Caregivers know when that happens and when it doesn't happen. Finally, a leader provides the infrastructure to make that happen.

You also have to have physical and moral courage. You have to have the physical courage to get through the day in a demanding and stressful environment and have the ability to keep your cool, treat people with dignity, not fly off the handle and do dumb things. Secondly, you need the moral courage to ensure that you're getting the facts, that you really understand the problem, that you're not coming in with your own preconceived notions. You need to make sure that you have all the stakeholders in the room because there are diverse interests in a tough decision. Ultimately, you need to be willing to make the moral decision that you feel best executes the mission going forward. That sometimes can cost you your job but that's part of leadership.

GARBER: Your comment about the physical aspect of the job is interesting. The CEO's job involves early morning meetings and late evening meetings because you have to accommodate people who are not available in the normal work day. This leads me to thoughts about work/life balance. How did you manage that in your family?

SCHOENHARD: Not very well, especially early on. I remember at St. Joseph when I would come home after a busy day and I would think, "Well, I'll be with the family while they're watching TV after dinner." I would open up my briefcase and start reading the mail. I was present. I was there, but I wasn't there. I wasn't engaging with the kids. I wasn't engaging with Kate.

The truth is, I loved the work so much, I didn't want to stop and that is wrong. The thing that I find so encouraging in my son-in-law, Rob, and the way he's raising our grandchildren, is that he's engaged as a father in a way that I should have been and wish I had been. I may be overstating it. Maybe I wasn't as bad as I think I was, but I did not handle the family/work balance well. I came to do that better but never achieved it in a way that I wish I had.

As far as the stress of the day, I tried to work out every day, but the truth of the matter is, I liked it so much, I thrived on it. It wasn't a burden. It did get stressful at times but that comes with

the job.

GARBER: You've had a stellar career with your professional organization, the American College of Healthcare Executives. I wonder if you might talk a little bit more about ACHE and the importance of networking.

SCHOENHARD: It's important for a health care executive to be affiliated with ACHE from a number of standpoints. Particularly for the newer wave of clinicians who are advancing into the C-suite, ACHE offers the tremendous benefit of helping to ensure that the transition goes well. Through the credentialing program they can become board-certified in health care management by passing a comprehensive exam. This credential gives them credibility, whether they're in their current position or looking to the next position, with search firms and with others that they are really committed to executive leadership. The credentialing aspect of ACHE is extremely important.

Add to that the ongoing continuing education. There is tremendous educational content available at the Congress on Administration in Chicago and at the chapter level, where a variety of educational programs are provided locally. There is a need for us to become lifelong learners in this work, because things change so quickly. Through ACHE, you're able to hear from the experts in the country and the organizations that have really advanced themselves.

There are a variety of different networks. There's a fellows' reception at the ACHE Congress. There's chapter-level networking. The formation of chapters has advanced the networking capacity of ACHE by a quantum leap through the ability to provide local programming and opportunities for local health care leaders to come together with continuing education, service projects and other activities that provide tremendous networking.

There are other affinity groups – the consultants have their group. The search firms get together. What is most basic to the networking aspect of ACHE is that we are part of a professional group of executives who learn from each other, respect each other and are guided by a code of ethics.



Family celebrates Bill's installation as ACHE's chairman in 2006

GARBER:

What were your responsibilities during the year that you were board chair at ACHE?

SCHOENHARD: You also serve as chair elect and later as past chair, but as board chair, that's the year you actually chair the board of governors. You preside over the ACHE Congress, along with the other chair officers. There are different functions. You give a keynote speech. All three years that you're a chair officer, you visit various sites and facilities. But your chair year is typically the

heaviest year, where you'll meet with search firms when they come to Chicago to meet with ACHE and to work with other organizations. That's the year when you're the top elected leader and carry all the duties and responsibilities for the ACHE, with the gifted staff at ACHE. Tom Dolan and Deborah Bowen³⁰ and that entire staff were a joy to work with.

GARBER: What year was that?

SCHOENHARD: It was March 2006 to March 2007 that I was chair.

GARBER: You were still with SSM at the time.

SCHOENHARD: I was, yes.

GARBER: How did the organization get along without you?

SCHOENHARD: Better! With Sr. Mary Jean's support, I had the opportunity to do these things, but my job was different in that I could work virtually. I was not a hospital CEO. I did not have a local constituency. I didn't have "the medical staff meeting tomorrow that I had better be at." When the hospital presidents or regional presidents would call in to me they didn't care if they were talking to me while I was in Chicago or Salt Lake City or St. Louis. The nature of my work becoming more virtual through email and through the advances of technology during that time enabled me to do this in a way that was easier than a hospital CEO would have. That's why I have so much appreciation and respect for those who do that at the hospital level.

GARBER: I'd like to give you the opportunity to speak more about significant people, and particularly if there were any mentors that you have not mentioned that you would like to and also to speak about your wife, Kate.

SCHOENHARD: I've mentioned a number of the mentors who influenced me. I think that Carl Rasche, the president of Deaconess, taught me how to make fair and fast decisions. He was unbelievably rigorous when it came to a difficult decision in ensuring that he got all the stakeholders' input, that he got all the information and that he made the right ethical decision for the patient, the ultimate person we're serving. He went through a process and was disciplined about it. He was probably one of the most just people I've ever known.

Dick Ellerbrake, my preceptor at Deaconess, taught me administrative routine, how to organize yourself to be productive and also to have a good appreciation for cost containment. I've talked a little bit about Sr. Betty already and Sr. Mary Jean. Another significant person was Carol Rose,³¹ who served as my executive assistant from 1987 to 2009. She was a great informal leader and interfaced with a number of internal and external constituencies with effectiveness and grace.

There is one other story I would share. When we came back to San Diego from deployment

³⁰ Deborah J. Bowen has served as president and CEO of the American College of Healthcare Executives since 2013. [American College of Healthcare Executives. (2013, January 2). Deborah J. Bowen, FACHE, CAE, named new ACHE president/CEO. *Press Release*. <https://www.ache.org/pubs/Releases/2013/deborah-bowen-named-ache-president-ceo.cfm>]

³¹ Carol Rose also served as alderman and mayor of the town of Foristell, MO. [Various online news reports from the *St. Louis Post-Dispatch*.

to the Philippines and Vietnam in '72, Admiral Zumwalt,³² the Chief of Naval Operations, came to San Diego to give a speech. I was a green ensign still – probably not as green as when I started, but still pretty green. A couple of us junior officers decided to go see him. He gave a fine speech. He opened it up for questions.

A young Navy commander stood up in the back of this huge auditorium. He said something like, “Admiral, I have a young junior officer on my ship who is getting an early out.” My ears perked up, because I thought, “That’s like me!” He was on the list – same list, I guess, that I was on. He had the same ten-day requirement. My message had gotten to me in time to call Kate and talk about it, but he did not get his message in time. By the time he got back in port, the time had lapsed, and the commander had tried to get an extension to consider this young officer’s application for a regular commission. He apparently had not been successful. I remember him asking the Admiral right there in front of all these admirals and captains and everybody else something like, “Admiral, is there anything you can do about that?”

You could hear a pin drop. The chain of command was maybe more respected in the Navy than in any other service. Admiral Zumwalt had these great, big bushy eyebrows. I remember him looking down at his podium, and we saw those eyebrows moving, and I thought, “Oh, boy, now what’s going to happen?” He looked up and I recall what he said was like this, “Commander, I’ve been in this man’s Navy for a long time. I’ve never seen such loyalty from superior to subordinate as I’ve seen today. You tell that young officer that he has verbal authority from CNO to extend the application as long as it takes to be considered, and would you drop me a message when you hear the outcome?”

The place went quiet again. Then the standing ovation started.

That commander mentored me in a way that I didn’t appreciate at the time, but I would always remember. He cared enough about a mission larger than himself, the future of the United States Navy and Navy leadership, to take on what he thought was probably his last resort and could have jeopardized his career. Hopefully it didn’t. I don’t think it did. To go to bat for somebody he believed in because he believed in the mission and was willing to do that to ensure one of his officers would at least have the opportunity to stay in the Navy. That’s a mentor who never knew he mentored anybody. I don’t even know his name. I don’t know if he’s still living, but I can still see his face.

As it relates to Kate – the best thing ever happened in my life was going on that field trip to Jeff City. She is smart – smarter than me. She is a good read of people – not that she’s always offering her opinion of that in a way that’s inappropriate. She has a good sense of what’s going on. She’s been my ballast through the years, in addition to being a great wife and a great mother and grandmother to our kids and grandkids. I can get carried away. I can get pretty excited or pretty down. I can swing. She would always bring ballast – it’s not as bad as you think. It’s probably not as good as you think right now, either! She would keep me grounded in a way that’s hard to describe. It’s just her presence. She has been a wonderful partner in life. She’s been indispensable to all that I’ve done, and I could not have done it without her. I really could not have done it without her.

³² Admiral Elmo R. Zumwalt (1920-2000), a four-star admiral, was named Chief of Naval Operations by President Nixon in 1970, a position in which he served until his retirement in 1974. [Smith, J.Y. (2000, January 3). *The Washington Post*. <http://www.washingtonpost.com/wp-srv/WPcap/2000-01/03/036r-010300-idx.html>]

GARBER: Thank you for your time today.

SCHOENHARD: Thank you.

CHRONOLOGY

- 1949 Born September 26 in Kansas City, Missouri
- 1971 University of Missouri - Columbia
Bachelor's, Public Administration
- 1971-1972 United States Navy
Damage control officer, *USS Samuel Gompers*
- 1972 Married to Kathleen Klosterman of St. Louis, Missouri
Children: Sarah, Thomas
- 1974-1978 Deaconess Hospital (St. Louis, Missouri)
1974-1975 Administrative Resident
1975-1978 Vice President & Director of General Services
- 1975 Washington University (St. Louis, Missouri)
Master of Health Administration with honors
- 1978-1981 SSM St. Mary's Health Center (St. Louis, Missouri)
1978-1979 Assistant Executive Director
1979-1981 Associate Executive Director
- 1981-1982 SSM Arcadia Valley Hospital (Pilot Knob, Missouri)
Executive Director
- 1982-1986 SSM St. Joseph Health Center (St. Charles, Missouri) and St. Joseph Hospital West
(Lake St. Louis, Missouri)
Executive Director
- 1986-2009 SSM Health Care (St. Louis, Missouri)
Executive VP/Chief Operating Officer
- 2009-2013 United States Department of Veterans Affairs (Washington, DC)
Deputy Under Secretary for Health for Operations and Management

SELECTED MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives
Chairman, board
Chairman, Credentialing Task Force
Governor
Life Fellow

Member, Healthcare Executive-Supplier Relationship Task Force
Regent

American Hospital Association
Alternative Delegate
Delegate
Member, board
Member, Executive Committee

Catholic Health Association of the United States
Member, Finance committee

Deaconess Nurse Ministry (St. Louis, Missouri)
Chair, board

Gene Slay's Girls and Boys Club of St. Louis
Secretary, board

Greater St. Louis Area Boy Scouts of America
Member, board

Lindenwood University (St. Charles, Missouri)
Member, board

Mary Queen of Peace Catholic Church (Webster Groves, Missouri)
Member, finance council

Mid-America Transplant Services
Vice Chairman, board

Missouri Commission on Patient Safety
Member

Missouri Hospital Association
Chair, board
Member, board

Mizzou Alumni Association
Member, board

Organ Donation and Transplantation Alliance
Member, board

University of Missouri – Columbia, College of Business
Member, Management Advisory Board

AWARDS AND HONORS

- 1971 Naval ROTC Curators Gold Medal
- 2002 Regent's Award, American College of Healthcare Executives
- 2002 William P. Spurgeon, III, Award, Greater St. Louis Area Boy Scouts of America
- 2003 Distinguished Alumnus Award, Washington University Graduate Program in Healthcare Administration
- 2007 Distinguished Service Award, Missouri Hospital Association
- 2008 Exemplary Service Award, American College of Healthcare Executives
- 2009 Exemplary Service Award, St. Louis University, School of Public Health
- 2010 Gold Medal Award, American College of Healthcare Executives
- 2013 Award of Excellence, American Legion
- 2013 Distinguished Career Award, U.S. Department of Veterans Affairs
- 2017 Marquis Who's Who Lifetime Achievement Award

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The Schoenhard family
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