



RICHARD J. UMBDENSTOCK

In First Person: An Oral History

American Hospital Association
Center for Hospital and Healthcare Administration History

2020

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

RICHARD J. UMBDENSTOCK

In First Person: An Oral History

**Interviewed by Kim M. Garber
On November 19, 2013
and February 23, 2020**

**Sponsored by
American Hospital Association
Center for Hospital and Healthcare Administration History
Chicago, Illinois
2020**

©2020 by the American Hospital Association
All rights reserved.
Manufactured in the United States of America

Coordinated by
Center for Hospital and Healthcare Administration History
AHA Resource Center
American Hospital Association
155 North Wacker Drive
Chicago, Illinois 60606

Transcription by Chris D'Amico
Photography courtesy of Bill Fitz-Patrick Photography
Note: This oral history was audio recorded only.

The views and opinions expressed in this document are solely those of the participants and do not necessarily reflect or represent the views and opinions of the American Hospital Association. Direct quotations are based on recollection and the entire text has been edited for length and clarity.

EDITED TRANSCRIPT
Interviewed in Chicago (2013) and Tucson (2020)

KIM GARBBER: Today is Sunday, February 23, 2020. My name is Kim Garber and I'll be interviewing Richard J. Umbdenstock, President Emeritus of the American Hospital Association. He served as President and CEO at AHA from 2007 until his retirement in 2015. Prior to that, he was President and CEO at Providence Services in Spokane, Washington, and spent 10 years as a governance consultant. This interview is an update of an earlier conversation conducted on November 19, 2013. Rich, it's great to have the opportunity to speak with you again this afternoon.

RICHARD UMBDENSTOCK: Thank you.

GARBBER: Let's start by talking about your family life and upbringing.

UMBDENSTOCK: My home town is Islip, N.Y., a small town on the south shore of Long Island about 60 miles east of New York City. My parents and two older brothers, Bob and Pete, had moved there from Brooklyn in June, 1950, about four months before I was born. We were very fortunate – dad had a very good job and was able to commute by train to the city, allowing us to enjoy all the benefits of suburban living. The Catholic church and grade school we attended were about a mile away. We had the Great South Bay for swimming and sailing, and just across the Bay was Fire Island and the Atlantic Ocean. We belonged to a small beach and tennis club as well as a small yacht club and we all enjoyed Little League baseball.

We were a close-knit family. Mom and dad were very loving and supportive, excellent role models for their four sons. (Jim was born four years after I arrived.) We were active year round, eventually taking family ski vacations one week each February and maximizing our local resources in the summers. Dad traveled internationally quite a bit in his work so mom was the dominant presence on a day-to-day basis, but there was never a doubt that she and dad were on the same page whether he was home or not. Dad was the strong but silent type while mom was more the social type, but they were both strong personalities, widely respected in the community and terrific role models.

GARBBER: Your father, Robert R. Umbdenstock, held a doctorate in Chemical Engineering. Could you tell us about his influence on you?

UMBDENSTOCK: Dad was born and raised in Queens, NY. His parents came from France before he was born, and he didn't speak English until he went to the first grade. In middle school, he wasn't allowed to take French because he already spoke it. As a result, he said he didn't learn to read and write French very well but he could speak it beautifully. In fact, he was very adept at foreign languages and, given his extensive international travel, he could converse in a handful of them.

Dad went through school, including getting his doctoral degree, on scholarships. He went to college at the Cooper Union in Manhattan which at the time was all scholarship for all students. You got a medal just for being admitted. He then did his master's and doctorate in chemical engineering at The Polytechnic Institute of Brooklyn. He worked for Charles Pfizer and Co. for 25 years, starting at the Pfizer Labs in Brooklyn. The team was charged with devising a process for the mass production of penicillin. It was wartime and they wanted to get it over to the troops. He had worked on a mass production method as part of his doctorate. He said his professors weren't entirely sold on his method but Pfizer apparently said, "We're going to try it. If it works, terrific. If it doesn't, we lived and learned."

It didn't work but it was a contribution to the larger effort.

Dad was very bright and very accomplished. He was good at all types of engineering and spent a lot of his weekends building onto our house or building cabinetry. I have to admit that I didn't inherit any of his language or engineering skills, but I do think that I share some of his personal qualities – a bit of a dry sense of humor, a degree of seriousness in areas I feel strongly about, and a way of explaining to our own four children how our parenting really isn't fair and they should get over it!

GARBER: I read about your father's patent.

UMBDENSTOCK: I think he had several, each of which became the property of Pfizer.

GARBER: The one that I saw had to do with how to deliver penicillin more effectively by treating it with ultrasound during the manufacturing process.

UMBDENSTOCK: My brother, Jim, found a couple of registrations a few years back. One might be the patent you saw – it was a process that delivered uniform-sized crystals of penicillin so that a proper blood level of the antibiotic could be achieved more rapidly. The other was for sterilizing and inserting pharmaceutical container stoppers under aseptic conditions. One more that I remember him telling us about was a turntable that, through vibration, caused ampules to stand in the correct position so that they could be filled.

GARBER: Your dad had previously worked for another company which was where he met your mother.

UMBDENSTOCK: My mother was born and raised in New Jersey and was a high school graduate who had taken secretarial courses. She went to work for Advanced Solvents in Brooklyn. She told the story that one day she went home and told her mother that two new guys had shown up at work, both single. She said, "I hope the handsome one isn't the one named *Umbdenstock*." I laugh and I cry as I tell that story because that was SO my mother. They went on to have a wonderful married life together and we are all proud of the family and the name.

GARBER: Your parents were married in 1943. This was during World War II, but I've got to guess that your father was considered much more valuable to the nation in what he was doing stateside than he would have been fighting overseas.

UMBDENSTOCK: His older brother, our uncle John, had gone into the Army. My father tried. He went down to volunteer but he was rejected due to poor eyesight. The recruiters asked, "Well, what do you do?" When he told them of his graduate studies, they said, "Holy smokes, that is more important," in a sense. At some point, he got shipped off to a project that I'm not clear about. It must have had something to do with the Army and it was at Princeton. It was classified work that he wasn't allowed to talk about.

GARBER: Your parents were young during the difficult years of the Great Depression and then the war. How did the experience of living through those times influence their values?

UMBDENSTOCK: I heard it more from my mother, probably just because we had more

time with her because of my dad's schedule. She would talk about the challenges of the Depression, not in a negative way, but in a historical or contextual matter-of-fact way. She'd tell stories about making root beer in the basement (pretty sure it was *root* beer!). She also swore she'd never eat rice pudding again. She must have had her fill in those earlier years.

My mother's family came from Ireland. Mom was second generation American Irish. She was Irish on both sides – Shallew and Broderick. They lived in New Jersey. We'd hear about the tough times – about this is who we were and this is how we lived and this is the way we hung together as family.

GARBER: Sometimes when I ask that question of people, they'll say that this experience for their parents made them more frugal, more careful with their money and in their decision-making.

UMBDENSTOCK: I don't think they had much money growing up. My mother's father, Vincent Shallew, was an electrician. Her mom, Helen, did some modeling. They seemed to do okay but the times were tough on everyone. My other grandfather, Jules Umbdenstock, was a chauffeur for one of the Vanderbilts. My father said that he got one day off a year, and it was the day they told him he could take off. It may not have been as harsh as it sounds because the Vanderbilts did so much traveling that they weren't always present, at which point, he'd have free time or be driving the other help to stores or down to the fish docks or wherever. It was a modest but steady job. Overall, my parents shared their family histories, mostly around their respective relatives' lives and family stories, but I recall that they tended to talk much more about who we should be and where we could go than where they had come from. As one example of what I'm trying to say, my father never taught us to speak French. Maybe because my mother didn't speak it, but I suspect it had more to do with us being Americans and his not wanting to live in the past. I really wish he had but I also understand.

GARBER: Both of your parents were dedicated volunteers.

UMBDENSTOCK: It was a huge part of their lives. It was reflective of who they were and how they felt you should live your life – giving to others. As they became more able to do that, they were able to find the time and were able to make financial contributions as well.

My first memory, from when I was three or four years old, is of a day when my mother took me to the local hospital's nursing school. She and the other lady volunteers stuffed envelopes and I ate doughnuts. I don't know if there were other youngsters there or not. I don't recall that, but I clearly recall her volunteer work that early.

GARBER: What you are talking about – hospital diploma schools of nursing – were important for a long time but are gone now. What were the pros and cons of this model of educating nurses?

UMBDENSTOCK: One of the advantages was that student nurses learned on the job. They were right there close to the front lines. The schools also were a ready source of labor for the sponsoring hospital. Many hospitals saw it as part of their mission and their business model.

These were three-year programs. The hospital schools were the standard. Nursing had not yet gone academic at colleges and universities. Hospital schools began to struggle when people started to question whether it was more appropriate for nursing as a profession to go to a more academic

approach and to include the arts and humanities at institutions of higher learning.

You can see today how nursing has progressed professionally to the point where it now has a terminal degree at the doctorate level. I've always been in favor of nurses going the baccalaureate route because of the added standing in the workforce and the career flexibility it provides. People started to see the value in shifting away from the hospital schools and then they gradually closed and disappeared.

GARBER: You had mentioned your mother's volunteer work and the pleasant memory about doughnuts. Your mother was renowned for having donated thousands of hours of volunteer work during her lifetime.

UMB DENSTOCK: The cornerstone of her volunteer work was at Southside Hospital in Bay Shore, NY, a community-based non-sectarian hospital. Southside is about three miles from Good Samaritan Hospital, in West Islip, NY, a Catholic-sponsored hospital where my dad served on the board. My mother was an auxilian volunteer working in the Southside coffee shop and gift shop and doing anything and everything else. Mom was an extraordinarily hard worker, a popular figure around the hospital and prolific fund raiser. She served many years on Long Island and at the state level doing auxilian organizing work and advocacy for the hospital councils and the state hospital association. Mom finished out her volunteer role at Southside as a member of the hospital board and was recognized for having given over 40,000 hours to that one organization.

Once I started in the hospital field, I would attend the AHA Annual Meeting often alongside my folks as they went in their trustee and volunteer roles. My parents have passed away but I have been proud to keep their recognition awards from the two hospitals – I displayed them and used them as visual reminders in my AHA office.

In health care, my parents also supported Hospice of the South Shore, a volunteer-based hospice service. Dad helped to construct Consolation Manor, a Catholic-sponsored skilled nursing facility on the property adjacent to Good Samaritan that they supported over the years. In fact, that's where Mom was cared for in her final years until she passed away in 2009.

GARBER: By the end of his career your father had extensive responsibility at Pfizer.

UMB DENSTOCK: He was manager of international and foreign production for Pfizer Pharmaceuticals. He travelled the world developing new manufacturing plants. This was the day of prop planes and then prop jets. When you went out, you stayed out. He would go to Europe often and he'd stay two to four weeks. Colleagues would take him home with them on the weekends or he'd go sightseeing or, if he was in France, he'd investigate our family name. We would follow him on a map on the kitchen wall. Consequently, I'm not too bad at world geography. He'd come home and we'd have nights of photo slideshows and they'd entertain friends with fettuccini fresh from Alfredo's in Rome.

Pfizer got big and aggressive, and dad decided to part ways on his 25th anniversary. He bought a small company that supplied machines to the pharmaceutical industry as well as to the cosmetic industry and the beer sector. They represented for European manufacturers machines that were sold and distributed in the United States. One company, Code Edge, had a product which was a vise and sawblade that could be used to notch production information like plant number and lot number onto the edge of product labels. Another labelling line was a specialty printing machine for vials and

ampules and things like that. Dad moved the company from Scarsdale, NY, down to Islip. Mom was the bookkeeper and he had a secretary and that was it.

GARBER: This was Griffin-Rutgers?

UMBDENSTOCK: Yes. He bought it from Mr. Rutgers. It's still called Griffin-Rutgers. My brothers, Jim and Pete, took it over after Dad passed away in 1986 and today Jim is the last one working it.

GARBER: It's remarkable to circle back and note that despite your father being away on business so much and with four sons to raise, your mother was committed to her volunteer work.

Let's move on to high school years – all of you boys went to La Salle Military Academy in Oakdale, NY. Why LSMA instead of public school?

UMBDENSTOCK: My mother's uncle, who was a Christian Brother, taught at a school in the Bronx called Clason Point Military Academy. The Christian Brothers decided to transfer that school to a campus on Long Island – a large beautiful campus on the Great South Bay which had been owned by Frederick Gilbert Bourne, president of the Singer Sewing Machine Company and Commodore of the NY Yacht Club. When my parents moved to Islip, within six miles of the school, the Christian Brothers said that we'd always be welcome there.

La Salle was a Catholic military boarding school. The four of us were allowed to attend as day students as a family courtesy. We had certain restrictions as day students. My oldest brother Bob was one of the first day students and was not allowed to hold a military rank. Other students, by the time they got to their senior year, had become at least corporal or sergeant, but he went through as a private. This was later changed and by the time my older brother Peter got there it was possible to become a non-commissioned officer in the Cadet Corps. Peter and I were both Master Sergeants. When our youngest brother Jim went through there, he was able to become an officer in his senior year.

Later, because of the Vietnam War, the appeal of military academies was sinking. LSMA was looking at whether the school needed to attract more day students or more international students or if they should accept women. Eventually, the military aspect got dropped and then later the school sold the property to St. John's University. Mom was on the board at that time, in the '80s, which was long after we had graduated.

GARBER: Did that bother you as a young student that you had that restriction on rank that made you different from other people?

UMBDENSTOCK: No. We had the advantage of a much more flexible schedule. We had to be there by the time they got out of breakfast, in time for military inspection every morning, and we had to stay through sports and activities every afternoon. We would arrive at about eight o'clock and we'd leave at six o'clock. We got to go home every night and we ate mom's cooking, which was much better than the school's mess hall. On weekends, other students weren't allowed to leave campus until noon on Saturday, and they had to be back at six on Sunday. We would typically have practice on Saturday morning anyway – basketball or whatever. The other students accepted us. Many of them came home with us on weekends or, if nothing else, they were envious and razzed us.

GARBER: Did you play basketball in high school?

UMBDENSTOCK: Yes. I played basketball and tennis for four years. Tennis was particularly my sport. I started when I was four years old at the Bayberry Beach and Tennis Club that we belonged to for the summers. I played varsity in college at Fairfield University. I also played high school football for a couple of years but I was too slow. I was a target.

GARBER: What did you learn from your participation in sports?

UMBDENSTOCK: In the formative teen years, coaches are important. Brother James Sullivan was our tennis coach. Although Brother James was not an outstanding tennis player, he was a great supporter and a very positive influence on us as young men. It was his mission after school to lead the tennis team and drive the station wagon.

We did have a tremendous tennis team because we had a fellow from Nassau County, in close to the city, who had grown up playing a lot of tennis, as much as I did. =About a third of the school was from Central and South America. Some fellows from Puerto Rico and Central America had played a lot of tennis. I believe that in my four years, our team went 54-2 playing other Catholic and private schools around the Island. As good as I was as a local tennis player, I played number three behind two guys that were a year ahead of me who were terrific tennis players.

Brother James Bonilla¹ was an exceptional tennis player. He would play with us in the afternoons even though he wasn't our coach. He was a terrific individual. My basketball coach, Charlie Davidson, was a great guy, a great leader, really a team-focused person. We were a small school, and we played against schools that were a lot larger than we were.

La Salle was a terrific experience – a good school and experience. It wasn't a New England prep school but it was a very good school and certainly the military influence resulted in a lot of life lessons – discipline and attention to detail.

GARBER: Do you consider yourself to be disciplined?

UMBDENSTOCK: I am pretty disciplined when I need to be, I guess. My folks had high expectations for us and I suspect all four Umbdenstock boys have a degree of discipline that started at home and got reinforced throughout our Catholic education. I have two quick stories where some of the military high school experience apparently came through.

First, I was in Canada one day doing a seminar in my consulting days. A guy in the front row came up to me at the coffee break and he said, "You've been in the military." I said, "Actually, I've never been in the military." He said, "How come your gig line is so straight?" (The gig line is the alignment from your top shirt button to your belt buckle to the fly on your trousers.) I said, "Military high school."

¹ Brother James Bonilla (1937-1997) was a Christian Brother and educator who served as headmaster at the La Salle Military Academy (Oakdale, New York) and later as principal at Bishop Loughlin Memorial High School (Brooklyn, NY). [Saxon, W. (1997, October 22). Brother James Bonilla dies at 60; headed Bishop Loughlin High. *The New York Times*. <https://www.nytimes.com/1997/10/22/nyregion/brother-james-bonilla-dies-at-60-headed-bishop-loughlin-high.html>]

The other happened when I was in Chicago, working at AHA in the '70s, and I was walking down the hall with (retired Colonel) Bill Robinson,² who I was working for at the time. He said, "You were in the military." I said, "No, I was never in the military. I went to a military high school, but I don't consider that the military." He said, "Well, you dig that right heel in when you walk." That's exactly what you were taught to do when marching. I apparently acquired some of the traits.

GARBER: Is there anything else you'd like to add before we move on to your college years?

UMBDENSTOCK: I was thinking about the tennis experience. I got to play all over Long Island. The thing about tennis – it is an individual sport. That seemed to work well for me. I played more singles than doubles. I was good for my age, so I always played up in the age groups. By my early teens, I was playing against the men at our club.

That was a good experience because they were successful people who took an interest in me. There were lawyers and utility execs and Wall Street leaders from New York City who would summer in our hometown on the water. They provided me good role modeling and confidence building.

I'd also like to mention my grade school, St. Mary's in East Islip. It was a typical Catholic school experience. From an early time, there was a context of discipline and expectation, service and faith and the common good. Those are strong principles. It's hard to get anyone to talk about the common good these days. When I left AHA and they gave me the Distinguished Service Award, I said in my remarks that when I came to AHA as CEO nine years prior, I talked about something that might have even seemed a little old-fashioned at the time – the common good. I said, "That's where I want to go out. Hospitals are a cornerstone of the common good; everybody else is thinking about themselves." Again, with the example of my parents volunteering – we learned that you gave back. You tried to make it better for everybody. That started at St. Mary's.

GARBER: What did you do after graduating from high school?

UMBDENSTOCK: I went to college at Fairfield University in Fairfield, Conn., an all-male Jesuit-sponsored school before going co-ed in my junior year, and I have a Bachelor of Arts in Politics. Following that, I immediately went to graduate school at the State University of New York at Stony Brook on Long Island, now known as Stony Brook University. I have a Master of Science degree in Health Services Administration.

I went to Fairfield, which was the only college I got into – I applied to four colleges and got into only one, so I guess I overshot my resume coming out of high school. I probably finished 10th or 12th in a class of 60 or 65. My SATs were not good. I did okay in school, but didn't always test well. A couple of guys from La Salle had gone to Fairfield, and I got in.

A quick story about my Providence Services days – I was being interviewed to be the CEO by

² William T. Robinson worked for a number of hospital associations, serving as president of the Massachusetts Hospital Association and later as a senior vice president of the American Hospital Association. His oral history, Garber, K.M. [Ed.], (2011). *William T. Robinson in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from www.aha.org/chhah <https://www.aha.org/oral-history-project/2018-04-03-william-t-robinson-first-person-oral-history>

some very close friends on the board. It was the first case where I had been on a board, came off the board and became the president. With AHA, I've done that twice now. Anyway, Providence sponsored several hospitals, a small liberal arts college and a large early childhood development center. They said, "Well, we know you know a lot about hospitals. What do you know about colleges?" I said, "Well, I have a C-transcript from one in Connecticut. That's what I know."

Despite putting in the time and effort, I wasn't strong in academics until I got to grad school, then it all clicked. At Fairfield, I was pretty active in the student body, co-chairing homecoming my junior and senior years. We booked concerts – we had Sha Na Na one year and the Beach Boys the next year. That was a little heady, getting into contracts with talent agencies, with help, of course, from administrators at the school. I also ran a dorm my senior year. I played varsity tennis for three years and was number one on the team each year. Freshmen were not allowed to play a varsity sport under NCAA rules, even a non-contact sport like tennis, so I practiced with the team as a freshman. That's my Fairfield highlight.

GARBER: You were at Fairfield 1968 through 1972.

UMBDENSTOCK: Correct.

GARBER: That was a time of unrest in the country. What was it like at Fairfield?

UMBDENSTOCK: Fairfield was probably as unrestful, unsteady, simmering as most campuses. By the time I got there in '68, the students were starting to rebel about internal rules. You couldn't wear blue jeans to class, then yes, you could wear them to class, but you still couldn't wear them in the dining hall. Students started to push back on what they viewed as paternalistic things. These weren't things that bothered me especially. I had come out of a military school. I knew what rules and regs were, and this place was more open in a lot of ways than what I was used to.

By the second year, the war issue heated up and there were campus sit-ins although that was not something that I participated in. By then my oldest brother, Bob, was becoming a salvage officer in the Navy. By sophomore year, I knew that I wasn't going. I was in the first draft lottery in '69. We were huddled around the radio as numbers were coming up with people keeping track on a piece of paper. My birthday got called and it was number 202. I had no idea whether 202 was a good number or a bad number at that point. You didn't know how far down the list they'd go. My local draft board wound up that year going to 195. They said that if you give up your student deferment for any portion of the year and we don't take you, we will have considered you to have done your duty and we'd like to close your file. All of us handed in our deferments for the last week of the year. The draft board lived up to its word and I never went.

Peter, the second oldest in the family, got a very high number in the lottery so he never would have had to go, but he had already signed up for Navy flight. He had always wanted to be a pilot and fly off aircraft carriers, and after college that's what he wound up doing. I had two brothers in the Navy. Coming out of a military school, I wasn't anti-military. The war was a problem, but it was not something that I dove deeply into or led protests against. I was more concerned with: Was the draft treating people fairly? Was recruiting on campus an appropriate thing or not? Also, since we were a Catholic institution, what was the Church's stance on all of this?

GARBER: After you graduated from Fairfield, you went right on to grad school. Why did

you decide on Stony Brook?

UMB DENSTOCK: If nothing, I'm consistent. I went to the one that accepted me – I got in to Stony Brook and didn't get accepted at Michigan. I didn't have the type of business course background that most of the traditional grad schools wanted to see. Stony Brook had just started a program and it was about 20 miles from my folks' house. I was able to move back to Long Island and commute to school. I had in-state tuition, so it was pretty reasonable compared to the private tuitions we attended and for which our parents had paid. And, yes, they did cover our tuition for as far as we wanted to go academically. We were very lucky guys.

Stony Brook wasn't a strict management or finance program. It was really the beginning of my public policy exposure. I had a couple of instructors who had served at what was then HEW³ and other Washington-based agencies. They were interested in the creation of Medicare, which had happened in '65, and in areawide health planning. Medicare was expanding rapidly, if not already starting to indicate that it would be exceeding all growth and cost targets.

We got a dose of public health and a dose of health policy. I also had computer courses and finance courses and other things. It fit well with my undergraduate degree in politics, where the curriculum I chose tilted more toward political philosophy and public policy. I never thought about this until after the fact, when I got to HANYS, my first trade association. That's where my two degrees meshed.

There are a couple of little-known facts about Stony Brook. I was in the second class in a short-lived program. Three years later, it got written out of the New York state budget. There were 15 students in each class, and we were there for two years, so we overlapped with the class ahead of us, then the class behind us. In my class, there were two people who would become AHA presidents – first, Carol McCarthy⁴ and then me. Carol and I met on my first day of school at the coffee truck.

GARBER: Do you recall the name of the program director?

UMB DENSTOCK: Yes, the program director was Mike Enright.⁵ He had a prior affiliation with Georgetown University Hospital. Tom Dunaye⁶ taught there and went on to teach in Florida.

³ The U.S. Department of Health, Education, and Welfare (HEW) was a Cabinet-level department created in 1953. It later became the Department of Health and Human Services (HHS). [U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (1972, July 1). *A Common thread of service: A history of the Department of Health, Education, and Welfare*. <https://aspe.hhs.gov/report/common-thread-service/history-department-health-education-and-welfare>]

⁴ Carol M. McCarthy, Ph.D., an attorney, was CEO of the Massachusetts Hospital Association and later the first woman to serve as president of the American Hospital Association from 1986 to 1991. [Bellandi, D. (1998, January 26). AHA 100th anniversary: The view from the top, McCarthy broke ground. *Modern Healthcare*. <https://www.modernhealthcare.com/article/19980126/NEWS/801260307/aha-100th-anniversary-the-view-from-the-top-mccarthy-broke-ground>]

⁵ Michael Enright served as director of the Graduate Program in Health Services Administration at the Health Sciences Center of the State University of New York at Stony Brook. [SUNY. (1972). *Health Science Center 72-73 bulletin*. <https://ir.stonybrook.edu/jspui/bitstream/11401/58236/1/1972-73%20HSC%20Bulletin.pdf>]

⁶ Thomas M. Dunaye, Dr.P.H., was associate professor of health sciences at the State University of New York at Stony Brook in the '70s. [SUNY. (1972). *Health Science Center 72-73 bulletin*. <https://ir.stonybrook.edu/jspui/bitstream/11401/58236/1/1972-73%20HSC%20Bulletin.pdf>]

Dr. Ed McTernan⁷ ran the Health Sciences Center, which at that time included mostly nursing, and a physician assistant program. We were the smallest of its programs. Steve Allen was a famous TV personality at the time, and Steve Allen, Jr., who looked just like his dad, taught in the P.A. program.⁸ We were a half-step removed from somebody famous.

GARBER: Is there anything else you want to stay about Stony Brook?

UMBDENSTOCK: It served me very well and I had a residency at Good Samaritan Hospital. Each member of the class at Stony Brook had to do a residency that was about six months long. Our family had a long-standing connection to Good Sam. My dad was among the group asked to build the hospital by the Catholic bishop for Long Island, and then he served on the board for many years. Because the master's program at Stony Brook was new, there weren't as many residency slots as were needed. I was able to let Stony Brook know that Ed Peterson,⁹ the administrator, had agreed to be the preceptor. I think that part of the reason that they took me at Stony Brook is that I was able to bring a residency with me. Stony Brook didn't have to help me find one.

This residency was a terrific experience because I had gone right to graduate school after college. I had known of the health care field because of my parents' volunteer work, and had thought about it as a career, but really, as a college student, I didn't know. The hospital mission appealed to me but until I got into the field and did my residency, I had no idea as to how I was going to take to this field or what I'd learn about it. Good Samaritan was my first exposure to real day-to-day life in health care. In addition to making sure I had a complete rotation through the hospital, Ed Peterson taught me about leading and managing the organization and its stakeholders, especially when it came to the different interests and agendas that often needed to be called out and harmonized.

GARBER: After you earned your master's degree, you went on to your first job at the Hospital Association of New York State, now known as the Healthcare Association of New York State (HANYS). How did you get that job?

UMBDENSTOCK: When I graduated in 1974, it was not a good employment market. I did not receive any offers from hospitals. There were few jobs. A lot of my classmates got their first job by continuing on at the hospital where they had done their residencies, but Good Sam didn't have a position available. Ed Peterson spotted an advertisement in the weekly HANYS newsletter for the position of institute coordinator. This was a person who would work with the professional staff to run their seminars. If there was to be a seminar on finance, you'd work with the reimbursement and finance specialist. If it was on long term planning, you'd work with the planning specialist. I got to work with the different experts on the HANYS staff, putting together seminars for the members. Then we would promote them, get the registrations in, and I would travel the state and do the logistical

⁷ Edmund J. McTernan (1930-1993), D.Ed. served as a professor and dean of the School of Allied Health Professionals at the State University of New York at Stony Brook beginning in 1969. [Edmund Joseph McTernan. *Prabook*. <https://prabook.com/web/edmund.mcternan/84711>]

⁸ Steve Allen, Jr., M.D., a family physician, became a stress management speaker who incorporated humor and juggling into his presentations. [Perrone, J. (1990, September 11). Doctor tickles funny bones as a way to ease stress. *The Baltimore Sun*. <http://www.baltimoresun.com/news/bs-xpm-1990-09-11-1990254056-story.html>]

⁹ Edward J. Peterson (1926-2009) served as administrator of Good Samaritan Hospital Medical Center in West Islip, New York, from 1967 until 1982. [Edward J. Peterson, Good Samaritan Hospital administrator. (2009, March 25). *Massapequa Post*. <https://www.massapequapost.com/articles/edward-j-peterson-good-samaritan-hospital-administrator/>]

support onsite on the day of the institute.

This was a fortuitous development in my career. When I got to HANYS and learned what a trade association did, I realized that my undergraduate in politics and my master's in health administration would combine nicely. I got intrigued with associations. I liked the exposure to the various members. I liked the exposure to all of the topics. The notion of being involved in public policy was appealing. I had the opportunity to work with two leaders in the field – George Allen¹⁰ the HANYS CEO and Msgr. James Fitzpatrick,¹¹ our lobbyist, who taught me a lot about leading a diverse membership and working with public officials. This job was my first lucky break.

Best of all, it's also the job through which I met Barb because she came from Chicago as faculty of one of the seminars we hosted for nursing leaders.

GARBER: Another lucky break came along about a year later when a great opportunity opened up in Chicago.

UMBDENSTOCK: That's right. About halfway through my first year, I asked George Allen for more work because my institute coordinator job was organized and functioning easily. I wanted to branch out. He didn't have a broader position at the time, but he came back from one of the SHAEF meetings,¹² where he had seen Alex McMahon.¹³ Alex had told him that his special assistant was leaving, and he was checking around with people to see if they knew of any young graduates. George told him about me and apparently gave him reason to believe that he should interview me. I sent a resume and a week later flew to Chicago during the May AHA Board meeting. I met with Alex and with Bill Robinson. The next morning, I got a call from Alex and a job offer. This was my second and undoubtedly biggest break professionally. I was one year out of graduate school and I had a front row seat to the entire health care field and all of its leaders. Best of all, as I said, I had met Barb when she came to New York as a faculty member for a Joint Commission seminar on quality assurance in nursing. Barb and I dated after I relocated to Chicago in 1975 and were married in 1977.

GARBER: Did you report directly to Alex McMahon?

UMBDENSTOCK: Yes, the title was special assistant to the president. His executive assistant, Vicki Osterman, our receptionist, Ollie Williams, and I teamed up to support him in his work as president. I had an office just a couple doors away from him. I talked to him and worked with him every day, drafted things for him, interfaced with people on his behalf when he was out of the office, and supported the board officers and others as they would come through the organization.

¹⁰ George B. Allen (1932-1993) served as CEO from 1971 and later as president of the Hospital Association of New York State (HANYS) until his retirement in 1986. [George B. Allen, 60, a retired executive at a hospital group. (1993, February 13). *New York Times*. <https://www.nytimes.com/1993/02/13/obituaries/george-b-allen-60-a-retired-executive-at-a-hospital-group.html>]

¹¹ Rev. Msgr. James H. Fitzpatrick (d.1985) served as a senior vice president at the Hospital Association of New York State (HANYS) beginning in 1970. [Msgr. J.H. Fitzpatrick. (1985, February 26). *The New York Times*, Section A, 24. <https://www.nytimes.com/1985/02/26/nyregion/msgr-j-h-fitzpatrick.html>]

¹² State Hospital Association Executives Forum (SHAEF)

¹³ J. Alexander McMahon (1921-2008), was president of the American Hospital Association from 1972 to 1986. His oral history: Weeks, L.E. (Ed.) (1987). *John Alexander McMahon in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

Later in my stay at AHA, I staffed the Committee on Hospital Governing Boards because we didn't have a program for trustees. Dr. Madison Brown,¹⁴ who had been staffing that, along with the Committee on Hospital Medical Staffs, had retired. Alex asked me to take it on. It was an interest of mine given my parents' volunteer work and some exposure I had had as I organized institutes for governing board members across New York State. I had a firm belief, maybe for obvious family reasons, that trustees could make a larger contribution to the field, if only they were asked and if CEOs would support their greater involvement.

GARBER: What leadership lessons did you pick up from Alex McMahon?

UMB DENSTOCK: You couldn't miss the leadership lessons from Alex! He was a former professor so he was always teaching. He was the quintessential mentor, with a real interest in people in general, and young people in particular.

Alex taught me that you draw consensus by always laying all the cards out face up and challenging the group to pick the ace of spades. They'll do it every time. He said that if you give full disclosure – give people the information you have – they will pick the right answer. Your job is to make sure, not that they pick your answer, but to give them one or more right answers and never let them pick a bad answer. Trust and faith in the group intelligence was certainly one lesson.

Another lesson was the use of humor to disarm either individuals or situations. Alex was terrific at that. He was born in Pennsylvania but had his own particular acquired Southern style. He used humor, sarcasm, stories and an acquired southern accent to great effect.

Lastly, there was the lesson that at the end of the day, you have to do what you believe is right. You have to stand up for it. The consequences will be what they will be. You can't get unanimity on every issue. You listen to people as much as possible, and then if you feel that there is a strong enough consensus, even if there will be fallout, you have to take a stand. Then it's your job to manage the fallout.

GARBER: In 1979, you made a significant career change.

UMB DENSTOCK: After a snowy winter here in Chicago, Barb and I decided that if we were going to have this much snow, we should be able to use it. We wanted to go to ski country. I had grown up skiing on family vacations to Lake Placid, and she had tried it a few times. We wound up picking the Inland Northwest – Spokane – a nice-sized town, livable, affordable, with terrific outdoor opportunities year 'round.

Although we moved to Spokane unemployed, we felt that our network of contacts across the country would help us. If we didn't find something and succeed in Spokane, we could network and find something in another nice place to live. We didn't have to stay close by home for our parents. Our three remaining parents were healthy and independent. Barb's dad, Dr. George D. Mohr, had passed away before we met and, unfortunately, her mom, Helen, a nurse, died suddenly about eight

¹⁴ Madison B. Brown, M.D. (b. 1911) served in various executive positions at the American Hospital Association from 1956 to 1976, including a short time as Acting President in 1972 after the death of Dr. Edwin L. Crosby. His oral history: Weeks, L.E., (Ed.). (1985). *Madison B. Brown, M.D., in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

months after we arrived in Spokane.¹⁵ We had no formal responsibilities at the time that kept us in one place. Bill Robinson, my last boss at AHA as I ran the new Programs for Hospital Governing Boards, supported our decision to leave Chicago by saying that you don't regret the things you do only the things you don't do. I've remembered that because the move turned out so well for us and I have shared this with others who have come to me for advice over the years. This experience also taught me that when you encourage someone to go out and get additional experience you often have the chance to hire them back later as a more seasoned executive who appreciates what you did for them.

About 100 days after settling in Spokane, Sacred Heart Medical Center did offer me a job. In March 1980, I started as director of special projects, which means "whatever administration assigns to you." The major responsibility was to organize a continuing medical education outreach program for the smaller hospitals in the region to help them keep up their skills, but also to help build ties, if not referrals, back to Sacred Heart. Eventually, I had administrative responsibility for the HR, PR and Education Services departments, each of which was led by a veteran manager who taught me more than I could ever teach them at such a young age.

GARBER: Sister Peter Claver was the CEO?¹⁶

UMBDENSTOCK: She was the CEO, serving about 25 years in that role. She was a former operating room nurse and a highly effective executive. I mention the operating room nurse background because I think what made Sister so effective was her respect for, but ability to work with and stand up to when necessary, the medical staff, just like a nurse has to do in the OR on occasion. She was highly respected. I worked directly with Gerry Leahy,¹⁷ who was the executive vice president and an AHA board member in the mid-80s. He succeeded Sister as CEO. I also called on the rest of the administrative leadership as I tried to reach out into that region.

GARBER: Can you give an example of Sister's leadership?

UMBDENSTOCK: We were designing an addition to the hospital. I remember many times in the planning of it when we were talking about what we needed. You always need more parking at a hospital, so the bottom level was to be parking. The next level was going to be rehab space. The top was going to address the area's greatest need – behavioral health. There was a large state-run mental health hospital in Medical Lake, Washington, to the west of Spokane. The state was emptying it out and pulling back on its commitment to mental health. Many of us saw that as a sign that the state would not support mental health going forward and we would incur all the losses – so why were we getting into it? Others, including Sister, saw the need increasing with no one else in a position to

¹⁵ George D. Mohr, M.D. (1915-1972) and Helen P. (Bradbury) Mohr (1916-1980)

[\[https://www.findagrave.com/memorial/59292865/george-d.-mohr\]](https://www.findagrave.com/memorial/59292865/george-d.-mohr)

¹⁶ Sr. Peter Claver (1916-1996) was a professed member of the Sisters of Providence and trained as an RN and as a hospital administrator. She served as the administrator of Sacred Heart Hospital in Spokane, Washington, for 24 years beginning in 1964. [Sisters of Providence. (2017). *Historic Inductee: Sister Peter Claver Is Named to Spokane Citizen Hall of Fame*. [\[https://sistersofprovidence.net/sister-peter-claver-is-named-to-spokane-citizen-hall-of-fame/\]](https://sistersofprovidence.net/sister-peter-claver-is-named-to-spokane-citizen-hall-of-fame/)

¹⁷ Gerald Leahy served as president and CEO of Sacred Heart Medical Center, Spokane, Washington, from 1988 until 1996. He had been hired in 1961 as an administrative assistant. [White, J. (1996, March 13). Sacred Heart's president will retire in July: Leahy credited with creating cooperation among hospitals. *The Spokesman-Review*. <https://www.spokesman.com/stories/1996/mar/13/sacred-hearts-president-will-retire-in-july-leahy/>]

address it. Sacred Heart was a financially strong organization. She felt it was a mission issue, but also a community support issue. I can remember the day that we had a split vote on the team as to whether or not to proceed. She put it all on faith and mission and said, “It’s the right thing to do. Let’s take it on faith and go do it.” It’s been successful and very much needed.

GARBER: What challenges did you encounter at Sacred Heart?

UMB DENSTOCK: There were challenges in working with the independent medical staff, not that the relationship wasn’t good – it was – but like all hospitals it was a challenge to always be on the same page. The hospital had many mission-oriented projects and programs – for example, a teaching mission. There were family practice and internal medicine residents, with a few OB and radiology residents. They needed to get the primary care residents more experience out in the community. The graduate medical education programs were requiring it so the Medical Center re-opened a medical practice that had closed in one of the neighboring communities. This made it look to some of the community docs like we were going into competition with them. It was still a time of unclear relationships between hospitals and medical staffs. I think it was indicative of the times, not just that particular organization. That was one challenge.

Another challenge was that it was a successful organization and, although they had progressed significantly over the years, the organization seemed to me to be a bit tied to the past in many ways. Sometimes your greatest impediment to change is your past success. As a young person who had seen the hospital field at the national level, although I’d never been responsible day-to-day for a hospital, I thought that there were opportunities that I could not convince others to pursue. This was a little bit of my youth and impatience but also some of their past experience coming to bear, I felt. I learned a lot about working in a hospital, but I didn’t think that was where my primary interests were going to be in the future.

GARBER: The next step in your career path was into consulting. How did you meet your business partner, Winifred Hageman?¹⁸

UMB DENSTOCK: Winnie was on the Committee on Hospital Governing Boards when I staffed it. She had been identified by the Washington State Hospital Association as a trustee to put forward for that committee. She lived in Seattle and we stayed in touch after I moved to Spokane. She had been invited to do some weekend retreats and some conferences as a speaker. She called me one day and said, “Are you going to stay with the hospital role? Have you given any thought to going into the trustee education field full time?” I had done a few things on vacation days and continued to write a few articles here and there for *Trustee* magazine. In 1983, we went into business. At first we were a corporation, then we dissolved it, and we were sole proprietors working and marketing together. We didn’t need all that structure. We stayed together for almost 12 years.

Besides her experience as a hospital board member, Winnie was highly self-confident and willing to be provocative but responsible, challenging in an educational way but not threatening. To

¹⁸ Winifred M. Hageman (1932-2009) began her career as a teacher and, after returning to graduate school to earn her master’s in Behavioral Science, she became a co-founder with Richard J. Umbdenstock in the governance consulting firm Umbdenstock-Hageman. [Winifred M. (Winnie) Hageman. (2009, October 15-19). *The Seattle Times*. <https://www.legacy.com/obituaries/seattletimes/obituary.aspx?n=winifred-m-hageman-winnie&pid=134415046>

strengthen her credentials and experience, she completed a master's degree in organizational leadership as her children were finishing their own educations. Her CEO clients loved her and several had her to their retreats repeatedly. She wound up a counselor to many execs, and I know I learned from her style and her sharp critique of mine! Winnie and her husband, Walt, were dear friends of ours.

GARBER: As you were starting up your consulting practice, you had three young children. How did Barbara feel about you going out on your own?

UMBDENSTOCK: I started my consulting career on March 1, 1983. We had a two-year-old daughter, Renée, and our twins, Ross and Lauren, were born on March 4, 1983. If you think about it, I had a wife, three children and no clients. Then 16 months later, our fourth child, Alex, was born. Barbara was incredibly supportive. She knew that day-to-day hospital administration wasn't my interest, that I was getting a lot of calls and saw strong potential in the trustee audience. Very few others were tending to that part of our hospital field so it looked promising as a sector and it interested me. She was very supportive, but it was a challenge with infants. One smart move we made was to hire full-time help for Barb, which she greatly appreciated. An older woman, Ingrid Mace, became part of the team that kept our young family washed and fed. We always said that our priorities were to pay the mortgage first, health insurance second and Ingrid third, then we bought food and clothes with whatever was left!

Two projects saved me in the early days of consulting. One was that I had had contact with people at the American College of Hospital Administrators (ACHA).¹⁹ They had done a national study in collaboration with Arthur Andersen, the accounting/consulting firm. They wanted to do follow-on Delphi studies about what people in the field were predicting about the future of hospitals. The writer of the first study was not available for the second report but she gave them my name. I had written for *Trustee* magazine and had samples of published articles to send to them. They hired me. It was a substantial payday, given that I had a meager clientele at the time. It also put me in touch again with people all over the country – this time ACHA leaders and Arthur Andersen partners. In the back pages of these Delphi studies, I could point to the fact that “Richard Umbdenstock” was the report writer – which was an enormous piece of credibility.

The second thing was a Crosby Fellowship from HRET.²⁰ Gary Bisbee²¹ and I had been close friends when he ran the Trust and I was at AHA. We played tennis at 5:30 or 6:00 in the mornings before work. Gary had put together the first environmental assessment for AHA. He had me help with some of the content and had me conduct seminars using the environmental assessment. I did that for state hospital associations and others. That reinforced my AHA networking and it started to get my name out.

GARBER: Then you were part of a three-year Kellogg Foundation grant. Could you describe the objectives of that project?

¹⁹ Currently known as the American College of Healthcare Executives (ACHE)

²⁰ The Hospital Research and Educational Trust, currently known as the Health Research & Educational Trust, was established by the American Hospital Association in 1944.

²¹ Gerald F. (Gary) Bisbee, Jr., Ph.D. served as president of the Hospital Research and Educational Trust (HRET) and subsequently co-founded The Health Management Academy. [Cerner. *Gerald E. Bisbee, Jr.*

<https://www.cerner.com/about/leadership/gerald-e-bisbee-jr>]

UMBDENSTOCK: Kellogg²² had been very good to the AHA for many years. While I was at AHA, we worked on a project that was an insert into issues of *Trustee* magazine – the Trustee Education Project – then we pulled those inserts together into publications. What I did later with Kellogg was to start something called the Governing Board Mentor Program. Mentoring of boards was a concept that others in the not-for-profit field, particularly higher education (the Association of Governing Boards of Universities and Colleges - AGB), had deployed very effectively. As I started the trustee education program at AHA, I had looked around for programming ideas among the different not-for-profit fields, talked to AGB, and found this group that they had used called the Cheswick Center, which was a loose network of governance consultants.

They put me onto this notion of mentoring, which is a simple but challenging concept. It involved identifying governing board members with experience who could be trained in group facilitation, would know the process – but also would know their limits – and we would then send them to boards that wanted outside assistance in helping to develop that board’s self-assessment. It was trustee-to-trustee, peer-to-peer consultation.

Kellogg, which had a real commitment to health care governance, funded the mentor project. We worked with a handful of state associations. They identified the trustees. They would then promote this program to their membership, and we would make the match between the mentor and the governing board. As project managers, we provided the training for them, elicited the feedback, made adjustments in the program and so on. For about four or five years, it continued as a program offering by AHA. I had moved on at that point. I think it was discontinued due to a combination of the challenge of keeping a cadre of board members – you couldn’t keep going back to the same ones all the time. They had another life. They were doing this as volunteers. Additionally, it wasn’t returning any substantial funds to the AHA, which was going through a significant downsizing at the time.

Winnie and I also served as faculty for a rural hospital governance project that was anchored at the University of Washington and that served selected communities in the multi-state WAMI (Washington, Alaska, Montana, Idaho) region covered by UW.

For the rest of my consulting years, I traveled the U.S. and Canada working with a wide variety of health care boards in a wide variety of situations, some of which you just could not make up. Each one, however, taught me something very useful, if not profound, either about the field or myself.

GARBER: What were your most significant challenges during that time?

UMBDENSTOCK: During the time I was consulting, it was to convince CEOs that boards were assets and that board members could be helpful. They didn’t have to make them little hospital administrators. They needed to know how to pick their brains as finance people, banking people, manufacturing people and community leaders.

Everybody had this notion that boards didn’t know anything because they weren’t expert in hospital affairs. Winnie and I believed that they knew a lot from their own experience and that it was up to the hospital to draw that out. A lot of administrators weren’t secure enough – and maybe some

²² The W.K. Kellogg Foundation provides financial support to projects that aim to improve the lives of vulnerable children and youth. [W.K. Kellogg Foundation. *Who We Are*. <https://www.wkkf.org/who-we-are/overview#:~:text=Mission,the%20larger%20community%20and%20society>]

boards had gone off half-cocked and dumped administrators that they shouldn't have, or got their hands too involved with medical staff issues or daily operations where they shouldn't have. For the most part, though, boards were underutilized and underappreciated. We tried to bridge that gap and help the CEO gain support from the inside, because we saw enough challenges from the outside.

The second challenge of my consulting life was being self-employed as a young parent. It was more than a full-time job raising one or two kids, but four children in 38 months – which eventually translated into a senior, two sophomores and a freshman – was a heavy personal responsibility. I didn't make money if I was home unless I had a writing project. For the most part, my income was based on time put in onsite at hospitals. For boards, the prime time for a conference was Friday-Saturday, because they didn't want to take two days out of their work week. At a minimum, I'd head out on Thursday and I would fly home Saturday night from wherever I was, and if I could I would start with some sort of midweek stop to make all this travel productive.

During that period, as I like to say, I learned how to play the game of life with my own money. I didn't get a salary or a steady paycheck every other Friday. I can remember going to the mailbox the Friday after Thanksgiving hoping that there was a client check in there. It wasn't easy. In the health care context, however, it helped me identify with physicians, who are undercapitalized small businesses in a lot of ways. Not to criticize them, but few administrators have had that experience, so they don't identify with the physician on that level. Although I think physicians can make things more complicated than they need to be and they can sometimes be their own worst enemies politically within hospitals – the fact is, no one is paying them every other Friday if they're not out there making the money to pay their staff and pull their own weight.

Having a family of young kids and a wife, I knew that, although we were fortunate to be healthy, we'd consume our share of health care. We had to deal with the challenge of buying health insurance as a self-employed individual in the individual market. We opted to join Community Health Plan in Spokane, a prepaid group practice otherwise known as an HMO. Later, Gail Warden,²³ with whom I worked at AHA, moved to Seattle as CEO of Group Health Cooperative, purchased what had by then become a Cigna plan, and asked me to come on the board of the new acquisition which became Group Health Northwest. I was on the board of this combination staff model and network model HMO for nine years, chairing the board for five. If I hadn't done that, I'd have had no idea about integrated health care or population health and how that might work, what it takes to make it work, or what the risks of capitation are.

Group Health Northwest almost didn't make it while I was on the board because we didn't get the enrollment and utilization data in a timely enough manner to manage the risk. I have many experiences on that side of the health care market. That period of my life was rewarding. It gave me lifetime lessons without which I don't think I could have done my job at AHA as we headed toward more integration, more accountability and more financial risk.

²³ Gail L. Warden was executive vice president at the American Hospital Association and later became president and CEO of Group Health Cooperative of Puget Sound and then president and CEO of Henry Ford Health System. His oral history: Garber, K.M., (Ed.). (2010). *Gail L. Warden in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <https://www.aha.org/oral-history-project/2018-04-03-gail-l-warden-first-person-oral-history>]

GARBER: Your next career move was to Providence?

UMBENSTOCK: Right. That came about because while I was in consulting, the Sisters of Providence, who were aging as a community and declining in numbers, decided to put a lay board between themselves as the religious sponsor and the hospitals as their sponsored ministries. They called that corporation Providence Services and invited me to be among the original board members. I was familiar with all of their entities. I had worked at Sacred Heart and in my consulting had been to three of their other hospitals.

They invited me to serve on the board which I accepted because it was applied consulting, applied governance. After a few months and a search process, we hired the first CEO. Providence Services was built in a different way than a lot of systems. It was to be a holding company, not a managing or operating company, and it existed to support the individual hospitals and other ministries. We weren't looking at it as controlling and managing them day to day. We had the reserved powers we needed to control them in an ownership or sponsorship sense but we wanted to invert the organizational structure in a functional sense so that Providence Services, the parent corporation, would spend most of its effort serving and supporting the local ministries.

The person we hired as CEO got really sick the first week on the job. She spent the better part of two months sick in bed in her new home in Spokane with no friends, no support system. When she was able eventually to venture out and be among the hospitals, she quickly realized that she was a manager, an operator, not an owner/governor/overseer. Providence Services was really a governance model. It was not a management model.

The annual retreat came up about three or four months after her return to work following her illness. I asked if I could ride up to the retreat with her because my car was out of commission. I got in her car and she said, "Have you ever considered working for Providence Services?" I said, "Well, no." I was a board member – I was one of her bosses. She said, "I'm going to leave. I'm going to tell the board at the board meeting this afternoon that this is the wrong job for me. I think you ought to consider being the president of Providence Services. This would fit your governance skills. It's here in your adopted hometown and it would get you off the road."

After telling the whole group that she was leaving, a couple of my fellow board members, a sister and a longtime, retired nursing executive from Providence, pulled me aside and said, "We think this would be perfect. Would you consider this?" I said, "Oh, no! I'm building a business. I'm finally succeeding. This is working. I'm building a reputation and a clientele. I would be walking away from everything." At this point, our four kids were in grade school, getting ready to enter junior high. These two wise women said to me, "You know, you might do well to stay home." It took about two weeks before I went back to Sister Michelle Holland²⁴ and I said, "I think you're right. I'd like to explore this."

They pulled together a three-person search committee from my colleagues on the PS board and interviewed me. We agreed. The announcement was in July '93. They originally let me keep 20

²⁴ Sister M. Michelle Holland was a professed member of the Sisters of Providence. She served, among other positions, as the director of mission and values at Sacred Heart Medical Center, Spokane, Washington. [Prager, M. (2007, May 31). Tributes: Michelle Holland gave compassion. *The Spokane-Review*. <https://www.spokesman.com/stories/2007/may/31/tributes-michelle-holland-gave-compassion/>]

percent of my time to do consulting because they liked the fact that this young budding system had some reach into the rest of the region and even across the country. That turned out to be unrealistic but it kept my hand in things. I wound down the consulting for all practical purposes by the end of 1993, certainly by '94.

GARBER: Why did it turn out to be unrealistic to continue doing a little consulting?

UMBDENSTOCK: We ran Providence Services as a governance structure, meaning it was decentralized. We had hospitals that were in Spokane and three hours to the south in Walla Walla, three hours to the east in Missoula, and another three hours from Missoula to Great Falls. We soon took in three additional Catholic hospitals from the Dominican Sisters. I wound up travelling a lot, mostly by car, across the region. The hospitals had monthly or bi-monthly board meetings, and the whole point was to partner and blend in with the local board so as to link that hospital and the system, and link that hospital and all the other hospitals.

I started to build a small staff – a CFO, an education director, and one or two others. Then we started to build out some programs. We did an obligated group for borrowing purposes, which takes a lot of time and effort to negotiate within the structure and with Wall Street. We were a small rural system, so they wanted to know a lot about who we were and what our potential was. We also became a member of Premier, which is an alliance of hospitals, and I became the representative to Premier. I was doing a lot of travel for that. I continued to get requests for speaking engagements, which I did as a volunteer. I was doing some travel in that regard. I started to serve on various committees and so on. I also got involved in more community service volunteering. Consulting took a second seat. Winnie continued on. We had always worked separately anyway, but in parallel, so it wasn't as though I had to hand off a bunch of clients to her. All of our work was retreats or short-term projects. Frankly, I was traveling enough, and the idea was to stay home.

GARBER: What were your accomplishments at Providence?

UMBDENSTOCK: Because Providence was a governance model, we needed local buy-in for this new parent corporation to succeed. We didn't believe in wielding the sponsorship heavy hand. For example, we didn't have the CEOs report to me. They reported to their local boards, and I became, in effect, a part of that local board. We needed to build a culture that people could understand and identify with and buy in to. We engaged the help of David Nygren,²⁵ a consultant who I had first met through the Cheswick Center back during the Governing Board Mentor Project. As we described to him the next iteration of the plan at that point, he said, "What you're describing is akin to an employee stock ownership plan in business (what was called an ESOP) where the employees would buy the company and every employee was an owner."

What the Sisters of Providence said was that, because they were declining in numbers, they were expecting lay people to carry on the Catholic Church sponsorship and eventually become formally recognized by the Church. They said that you don't have to be a Sister to be a sponsor. Everybody can be a sponsor if you truly take ownership in this mission and agree to carry it forward in the tradition of the Church and the Sisters' particular approach to living out the Church ministry.

²⁵ David Nygren, Ph.D., founded Nygren Consulting, an organizational consultancy focusing on organizational structure, governance and leadership. [Nygren Consulting. *About us*. <http://nygrenconsulting.com/about-us/>]

This was a fabulous insight and the ultimate leadership challenge. It said to us that we needed to help explain to people that the Sisters were certainly the leaders and had given us this history and this case study to be replicated on an ongoing basis. But, you didn't have to be a Sister, or as they said, "Don't answer *our* call. Answer the *same* call." We built a culture that truly got to this notion that everybody was called to be a sponsor, like it would be if we were each a shareholder, each an owner. We do our respective job specifically, but we have this interest in the larger whole. It really took root. It spoke to collaboration and personal responsibility and the notion of a higher calling. It was tangible. It was highly motivating.

We put time and effort into it. We hired a senior VP for mission, who was a particularly gifted teacher, a practicing attorney named Jack Mudd.²⁶ Jack had been the first chairman of the board of Providence Services and I hired him to come on staff. When the Spokane and Seattle Providence systems merged in 2006, he became one of the senior VPs for Providence Health & Services out of Seattle, working in five states to try to keep the next iteration of this Providence culture alive. That was a huge accomplishment that our small Providence Services corporate team and local colleagues were able to achieve.

The other accomplishment was more specific to operational support. I had mentioned the obligated group earlier. It was very unusual for an obligated group to have what is called a "blended cost of capital." We had a 625-bed medical center in Spokane – Sacred Heart – and we had a couple of 200-bed hospitals, and a 100-bed hospital, and several very small, soon to become critical access hospitals. A lot of systems would put an obligated group together and, based on your individual organization's strength, charge you an individual cost of capital. For the larger ones, it would be cheaper, and for the smaller ones, it would be more expensive, but at least they got access to capital. However, our largest hospital agreed that everybody in the group should pay the same interest rate. Our smallest hospitals got capital and could do things that other small hospitals couldn't do, and we were able to keep those hospitals stronger. They were still precarious operationally in a lot of ways, but the group brought strength in a very tangible way to them. Our CFO, Bill Fisher,²⁷ was highly creative in devising this structure and it bred a lot of interdependence and flexibility.

We did the same thing with purchasing. Sacred Heart had been the member of Premier. They turned the membership over to Providence Services and we exercised it on behalf of the whole group. We had great sharing which added to the culture. For a small rural-based system, we were about as well-tied together as anybody and able to do some very creative things together.

Providence Services was yet another fortunate break and the experience taught me to balance servant leadership with tangible accountability.

GARBER: Your return to the American Hospital Association – in a leadership role – started with your service on the Board. What was the path that led you to become the chairman of the Board of Trustees at AHA?

²⁶ John O. "Jack" Mudd, an attorney, was partner with Garlington, Lohn & Robinson in Missoula, Montana, before joining Providence Services in Spokane where he served first as senior vice president and later as consultant to Providence St. Joseph Health. [LinkedIn <https://www.linkedin.com/in/jack-mudd-371b52132>]

²⁷ William L. Fisher served as chief financial officer at Providence Services, Spokane, Washington, from 1995 to 2006, after which he also served as CFO for Cancer Care Northwest. LinkedIn. <https://www.linkedin.com/in/bill-fisher-5084275>

UMBDENSTOCK: While at Providence Services and a member of the Washington State Hospital Association, I got encouragement from its CEO, Leo Greenawalt,²⁸ a dear friend, to consider going on the Board of AHA. I had not actually gone through the board and chairs of the Washington state association, which is a little unusual. Most people who come on the AHA Board, certainly CEOs, would have been on their state association board. But I did business in two states, Washington and Montana, on behalf of the Providence hospitals. The way we were organized, the administrators of the hospitals served on those state association boards.

Leo had engaged me once or twice in some of his board retreats or conferences as a facilitator/speaker. When I told him that I would be interested in the AHA Board, as is the case typically, the state association put a nomination package together. I was elected to the Board for the year starting 2000.

Now in this case the “small world” story is that when I was with Alex McMahon at AHA in the ‘70s, Gail Warden was hired to be our executive vice president. I was among those who got to orient Gail because Alex was on the road. I made sure that he met all the people he needed to meet and everything else. I tried to help as much as I could. A year after Barb and I went to Spokane, Gail went to Seattle. As I had mentioned, we collaborated while he was at Group Health Cooperative after they purchased the Spokane-based HMO we were in. I served on his regional board in eastern Washington. We worked closely.

By the time my AHA board nomination came through in 1999 for the class of 2000, Gail was a past AHA Chair and chairman of the nominating committee. Sometimes the stars align. I was elected to the AHA Board and received one of the last four-year terms. We used to pivot between three-year terms and four-year terms—could never quite decide which was better as an organization. We have since settled in on three-year terms. I had a four-year term, so I served 2000 to 2003, and reconnected with AHA at that time.

GARBER: That takes us to 2003, but you were chair later.

UMBDENSTOCK: Yes, I was on the executive committee in 2002 and 2003 because I was chair of the operations committee, and that’s an ex officio appointment to the executive committee. I had been approached, as all Board members get approached at one time or another, to say, if you’re interested in thinking about running for chair-elect, here is the process. I wasn’t sure if I could do this or not. I had kids in college. Things were busy. I had a lot going on at work, with a small central office. I’m really proud of this – the third accomplishment at Providence Services was that I never charged my members more than one half of one percent of their expenses in system dues. We ran a really lean organization, but it meant that we all did everything.

I decided to put my name in for chair-elect in 2004. I was off the Board at that time, went through the nominating process, was selected the summer of ‘04, became chair-elect in ‘05, and chairman in ‘06. I should note that Gail Warden was the first former AHA staffer to become Board

²⁸ Leo F. Greenawalt served for 30 years as president/CEO of the Washington State Hospital Association, Seattle, until his retirement in 2011. His oral history: Garber, K.M. (Ed.). (2012). *Leo F. Greenawalt in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <https://www.aha.org/oral-history-project/2018-03-29-leo-f-greenawalt-first-person-oral-history>

chairman and I become the second.

GARBER: What's the year like for the chair-elect?

UMBDENSTOCK: It's a busy year. I chaired the Long-Range Policy Committee, which was later renamed the Committee on Research. That committee took on one topic and explored it in depth for the year. The subject in my year was: What would make a single payer acceptable to America's hospitals if we were faced with it? Not that we were going to advocate for it, but what would we have to see in that? That has never come to fruition so we've never dusted off that report.

The chair-elect also has a lot of travel expectations. You become one of the three active officers and visit various state associations and personal membership groups where AHA either wants a presence or that organization wants representation from AHA. You're back on the executive committee again. You're planning for what these issues are going to mean in your year coming up—the next year. It amps up significantly, mostly on the travel side, but I guess you could say a little bit in the sense of responsibility, because you know that you're going to find yourself in that chair.

GARBER: You did find yourself in that chair, but only for a part of your term because Dick Davidson²⁹ announced his retirement.

UMBDENSTOCK: Dick was very supportive of me once I indicated an interest in going for chair-elect. Dick was in his late 60's, so we all used to joke with him that we trying to get through our year as chair before he made his announcement! One of us eventually would have to manage the transition.

It was early January, 2006. Dick had a practice of calling you on New Year's Day or the second of January to congratulate you and kick off the year, a practice that I continued. I talked to him in mid-January about the draft agenda for the late January Board retreat, which was going to be in the California desert. That's where you have the mini-investiture and you get the first official seating as chair. We went through the agenda that he had sent. When we got to the end I said, "Terrific. Anything else I need to know that would help me in this first meeting?" He said, "Yep. I'm only telling you, but this is the year I'm going to retire."

He and I talked that through. Later that month we got to the retreat, which starts with the executive committee on Sunday morning which precedes the investiture Sunday night and the Board retreat on Monday, Tuesday, Wednesday. After we worked through the committee's agenda, we had an executive session, which wasn't terribly unusual. We were in the executive session, and we dealt with compensation or something that we typically do in executive session. Then I said, "Dick, is there anything you'd like to share with the executive committee?" That's when he let them know that this would be the year. I'm not even sure he said "This is the year." I think he said, "I'd like to start the process." He was very concerned that it be done in a smooth and responsible way. He also wanted it done quietly because of something in DC at that time dubbed "The K Street Project" where politicians (mainly Republicans) were focused on filling lobbying groups with political allies.

²⁹ Richard J. Davidson (1936-2016), served as president and CEO of the American Hospital Association from 1991 to 2007. His oral history: Garber, K.M. (Ed.). (2015). *Richard J. Davidson in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <https://www.aha.org/oral-history-project/2018-03-14-richard-j-davidson-2010-oral-history-transcript>

That executive session, which probably was scheduled to last 45 minutes, went on for about two hours. There were AHA staff sitting outside wondering what was going on! A couple of us were blowing right past our golf tee times, which on a Sunday afternoon in the California desert to staff was like, “Hello! Something is happening in there.” After that, the three officers – the chair-elect, Kevin Lofton,³⁰ me, and George Lynn,³¹ the immediate past chair – huddled and devised a process from there.

When Kevin Lofton³² became president of Catholic Health Initiatives, CHI had hired a firm whose principals had come out of the executive search world but who now specialized in high-profile transitions. Just how do you manage a process like this? How do you prepare before you start the search process? I worked with that firm to get them oriented to the AHA and to engage them on behalf of the executive committee. We still had not told the Board. They did an assessment of the job and the skill set and the measures of success, and then they said, “Okay, now it’s time to transition to the thought about how are you going to find candidates?” That’s when I said, “Okay, time out. I want you to now start working with the past chair, George Lynn.” They said, “Well, sounds like you must be interested.” I was.

That’s how my year as Board chair came to an end. I was ready to resign and become a candidate. We called a special meeting of the Board in April so that we wouldn’t have to deal with all of this at the annual meeting in May. The Board met at the O’Hare Hilton. I was chairing the meeting. Dick told the Board. The Board said, “What are we going to do?” We said, “Your executive committee has been talking with Dick, so we hired a group.” We had the principals of the Corlund Group come in and make their presentation on the perceived challenges and desired capabilities. The Board said, “Do we have any candidates?” We said, “Let’s break for lunch, and we’ll come back to that.” During lunch, I left. George then sat in the chair and informed the Board that I had resigned to be a candidate. The executive committee recommended me, and the Board that afternoon voted to appoint me – a very unusual process. That’s how I stepped out of the chair and onto the path to the CEO job. It was announced that week, and Dick and I did a duet at the Annual Meeting and the Health Forum Summit that summer. He retired at the end of the year and I took over the first of ’07. In the meantime, George Lynn had agreed to return to the chair to fill out my term for the rest of ’06 which was extremely generous of him.

GARBER: What were among the first things that you had to tackle?

UMBDENSTOCK: While we overlapped, Dick called me the COO and we started to transition some of the executive duties. Mostly, I took the seven months that I overlapped with Dick to work through the whole staff here as best I could, and the state associations, and the Board, and get oriented, and get my balance and find out what I thought the priorities were. Fortunately, the board greatly admired the senior staff and directed me to “keep the team on the field” so building a

³⁰ Kevin E. Lofton served as CEO of Catholic Health Initiatives (CHI), which later joined with Dignity Health to become CommonSpirit Health, for 17 years until his retirement in 2020. [CommonSpirit. (2020, January 22). CommonSpirit Health CEO Kevin Lofton to retire. <https://commonspirit.org/commonspirit-health-ceo-kevin-lofton-to-retire/>]

³¹ George F. Lynn is the president emeritus of AtlantiCare (Atlantic City, N.J.) His oral history: Garber, K.M. (Ed.) (2014). *George F. Lynn in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <https://www.aha.org/oral-history-project/2018-03-29-george-f-lynn-first-person-oral-history>

staff wasn't the issue.

Speaking of the team, one thing that made my transition somewhat easier was that I knew many of the key players on staff, certainly because of my board service but also because so many long-time members had been friends and colleagues since I was at AHA in the '70s. The first two with whom I shared the news (so that we could begin to plan the announcement and the up-coming annual meeting) were Mike Guerin³³ and Bob Donovan.³⁴

George Bergstrom³⁵ would buy me lunch on my first day on the job. I knew I'd be working closely with Joan Elcock³⁶ (who supported Neil Jesuele), Gail Lovinger³⁷ (who was our assistant corporate secretary) and Ellen Pryga³⁸ (who had moved from the Chicago office to DC to serve on the public policy team.)

I also think of Aggie Abbinanti (in Health Forum ad sales) and several others with whom I would become reacquainted. These relationships gave me a real advantage in being a known quantity and having the immediate support and stamp of approval from so many long-term leaders and influencers.

As I assessed the situation coming into the AHA, I called on something I had learned and been part of just before I left Providence. We merged the Spokane and Seattle systems into what became Providence Health & Services, just before I left in early '06. With many separate geographic regions and many different delivery organizations in the health, education and social services sectors, our theme was that we were "one ministry." We had to keep driving that home as we came together, that we were one overall organization with one plan.

When I came to AHA, I knew from my years on the board that AHA was a terrific organization but that it was also a bit of a collection of boutiques. Everybody was working hard and doing great work but were independent of one another, for the most part, even to the point of tensions across the organization. I came out of my assessment with a slogan borrowed from Providence, which was: "One organization, one plan, many expressions." Everybody had to be on the same page. People could not have a strategic plan in a division or a subsidiary that wasn't linked into the larger AHA plan. We really tried to take the strategic plan to a new level.

We had to get buy-in across the whole organization – as an example, if quality and public reporting and improvement was a big deal for hospitals nationally, we had to work it in D.C. with the National Quality Forum and the Hospital Quality Alliance and other entities. We had to turn our

³³ Michael P. Guerin is Secretary-Emeritus of the American Hospital Association. [American Hospital Association. (2019). *2019 directory of governance and policy development participants*. https://www.aha.org/system/files/2019-03/Directory-of-Governance-Policy-Participants_Feb-2019.pdf]

³⁴ Robert J. Donovan served as vice president of meetings and travel services at the American Hospital Association until his retirement. [Professional Convention Management Association. Greater Midwest Chapter. *GMC PCMA awards and award winners*. <https://greatermidwest.pcma.org/awards/>]

³⁵ George F. Bergstrom served at the American Hospital Association for 43 years, retiring as vice president in 2017. [LinkedIn. <https://www.linkedin.com/in/george-f-bergstrom-lfache-a866b3b>]

³⁶ Joan Elcock served at the American Hospital Association as associate director/special assistant to the EVP/LBD. [LinkedIn. <https://www.linkedin.com/in/joan-elcock-2255575>]

³⁷ Gail Lovinger Goldblatt is senior vice president and secretary, American Hospital Association. [*Executive management group*. <https://www.aha.org/about/leadership/executive-team>]

³⁸ Ellen Pryga served as policy director at the American Hospital Association.

attention to it in our payment policy. We had to turn our attention to it in our personal membership groups. How could each membership group have a quality improvement agenda? We had to turn to it at HRET, which we wound up making our quality improvement leader.

It was the development of that common plan and the knitting together of the organizational units more tightly than they had been around a common sense of priority and collaboration. I think the organization will always be working on that because of the nature of AHA being so broad with so many different constituencies and areas of expertise.

GARBER: How would you describe your leadership style?

UMBDENSTOCK: I'd like to think it's an open book. It's one where – going back to Alex McMahon – you lay the cards out face up. I have to process things. I'm a verbal and visual type. I'm someone who thinks out loud. I talk a lot about, "Well, what if we did this? What if we did that?" AHA is a highly respectful and deferring organization. I found that when the president says something, even if it's just speculative and thinking out loud, six people spring to action and want to go do something. God love them, but I think they became more understanding of my style after a while.

That's how I operate. I trust people. I don't have a need to do my own deep analysis. I probe with questions, and I develop a level of comfort, but it is heavily dependent upon outstanding folks that I know I can trust and who, time after time, prove themselves to be knowledgeable and reliable. I see myself as someone who has been blessed with a good ability to see the broad view, but I am not expert in very much. I depend upon others who go deep in those areas but whose perspectives I can connect into a larger whole.

A long time ago, back at Group Health Northwest, we did the "whole brain" exercise, which defines four quadrants of the brain. Most individuals tend to be dominant in one of those four quadrants. The object is that on any team or board, you want a cumulative "whole brain" in the room – that you have people who complement one another and cover all styles of thinking and performing. There are some people who aren't dominant in any quadrant. They are called translators. They have a more balanced profile across those quadrants, not particularly deep in any one of them. The translator/facilitator type apparently is who I am and how I made my living for years in consulting. That's how I lead – much more of a facilitator than a hands-on manager. It brings out the strengths of people if you let them do what they are best at doing. Over time, they come to respect that you can put pieces together, maybe in ways that they might not have seen.

I'm very comfortable gathering knowledgeable people together and being able to help extract the wisdom, and putting that together, replaying it back to them in a way that they say, "Yeah. That's what we said. That even sounds better than what we thought we said." Not because I'm changing it, but I'm bringing in each person's contributions. That has been a gift that I've had that I've been able to parlay as a business, then was able to depend upon as an association leader.

GARBER: Are leadership traits innate or can they be learned?

UMBDENSTOCK: I think leadership has to be learned. I think the question is: Can you identify your natural strengths, put them into a bigger puzzle where they fit, and then complement them with the abilities of others? Or go out and acquire new knowledge in some way that will help you?

I do think that for the most part, leadership style is undergirded by personality and by how you see and have experienced the world. But the question is: Can you fit that into the broader job description of “effective leader,” given the responsibilities of the position you’re in? You have to take who you are, take your knowledge of the subject and fill in the gaps around it. But ultimately, you have to feel comfortable that you have the accumulated knowledge of the group to stand on and then make a decision and that it will be a decision that people will be willing to support.

That was an early lesson when I met the Cheswick Center folks. Henry Sherrill³⁹ was the leader of this loose-knit group. He was the senior leader among a group of young colleagues and had served as an Episcopal priest. Henry knew Robert Greenleaf,⁴⁰ who wrote the classic on servant leadership. I’m pretty simple in how I analyze things. I remember Greenleaf fundamentally saying – the thing that makes leaders is followers. Will people support you, regardless of your rank or title?

It isn’t what you know, or how much you know, or anything else. At the end of the day, it’s - have you put enough pieces together from your own knowledge and that of others in a fashion that helps them see their fingerprints on that decision and it instills hope for a better way forward such that they’ll support it?

GARBER: What was the most fun about being president of the American Hospital Association and what was the most challenging part?

UMBDENSTOCK: The most fun was meeting unbelievable people across the country. The leaders in the hospital world are special folks. They’re here for a particular purpose that they believe in and that they work tirelessly to promote and pursue. You get to speak on behalf of incredible organizations that do remarkable things for people. I know it sounds like a cliché, but hospitals are cornerstones of their communities. If you ever question that, see what communities do when their hospital is threatened, or see where people run to in a natural disaster, and you will understand how important a hospital is.

That was the fun part. It was easy. People have said to me, “You’ve got 5,000 bosses!”, or, “You’ve got small hospitals and large and academic and faith-based and so on so it must be a dreadful challenge.” No, it was easy to represent hospitals, even when we as a field didn’t always get it right, because you knew that every day, 24 hours a day, people were out there putting it on the line.

The challenging part was those 5,000 bosses! There was such a variety of situations, configurations, and impacts when issues came down to the local level and what they meant. It got to be more and more about the declining amount of money and competition for the dollars.

It was about the financial pressures facing this nation. It was about the rate of increase in spending on health care that says we’ve got to get to a better place, a different place. It’s not possible to keep that group of 5,000 together on every issue. It never was, but it’s gotten more difficult. I worried that as the resources continued to decline that it would be harder and harder for everybody

³⁹ Henry W. Sherrill (1922-2001) co-founded The Cheswick Center, which had an interest in promoting good governance, in 1971. [Henry Williams Sherrill <https://www.findagrave.com/memorial/106831347/henry-williams-sherrill>]

⁴⁰ Robert K. Greenleaf (1904-1990), who had a 38-year career with AT&T, wrote the influential essay, “The Servant as Leader,” in 1970. [Robert K. Greenleaf Center for Servant Leadership. *Robert K. Greenleaf*. <https://www.greenleaf.org/robert-k-greenleaf-biography/#>]

involved to keep their eye on the bigger national picture when they had so much riding on it at home.

The thing that is the most fun, when turned around, can also be the biggest challenge. The great strength becomes the great weakness. Our job is to help hospitals have the resources to get from the present day to that future without losing them in the process, literally.

GARBER: How did you deal with the pressure of being constantly in the public eye and being conscious that you had to be careful in what you say because you were representing the American Hospital Association? Is that something that was easy for you, or did you have to think about that all the time?

UMBDENSTOCK: I did think about it all the time, but I went back to that lesson from Alex about laying the cards out face up. It's not just your members who will pick the ace of spades, but the public usually will, too. I've been blessed with this translator ability. I can explain the complex in everyday terms, typically using a business model. If you help people understand that most issues can be boiled down to a few comprehensible basics and show them how those basics either are or are not fitting together, they get it.

Take the issue of health insurance coverage, for example. The whole purpose of insurance is to pool risk. The larger the pool, the more you can spread risk. The largest pool in the United States would be all 325 million Americans, but no, we've had a system that has kept people out of the insurance pools, the very people who are sick and need it the most. That's not the way to manage risk, it's how you avoid risk. That exclusion eventually builds up some sort of force – it's going to explode on you one way or another. People get emotional about, "Well, that's a single-payer system! That's government-run! That's nationalized health care!" You say, "No, it's the ultimate risk pool. It's the ultimate way to manage and minimize the impact on any one of us and all of us." You try to take the very thing that people fear and put it out on the table in a non-threatening way.

Now, you notice we haven't gotten all Americans into the pool yet. That's still a challenge for all of us, but when you can see it that way and try to boil it down that way, you don't have to worry so much because you're not making pronouncements. You're not declaring policy every day. You're trying to help – you're teaching. Because we believe in the positions we've taken, it puts our positions in a logical context that maybe people still don't agree with, but they don't hang you on every word. More so, they'll decide that they want a totally different model or construct. That I can live with. I didn't feel as though every time I talked to a group, I had to give them the solution, I had to say the brightest thing imaginable, or that I had to worry about every word. I just tried to lay those cards out and then let them see the logic that is behind it.

But you also need to know when not to say something, when someone is trying to put you in a spot where you say what they want you to say. Reporters and congressmen are famous for that, but you know that going into those situations and you prepare for it. Most important in that game is to decide on your message and repeat it, repeat it, and repeat it, regardless of what their question is!

GARBER: What do you consider to be the characteristics of a good board chair?

UMBDENSTOCK: Listening. Stirring when appropriate. Playing back and questioning whether you've got the group's sentiments right. Something that I learned along the way is that you never have to defend a question. You always have to defend a statement, but you never have to defend

a question. A good way to stir, a good way to make a point, a good way to ask somebody to think about something else without directly attacking what they just said is to simply ask a question. You never have to defend a question. Too many people think that there are dumb questions. There aren't dumb questions. Most of the time, other people in the room have the same question, and you can often make a point with an honest question just as clearly as with a statement, but not have to defend it.

A good chair has these kinds of strengths and abilities – doesn't have to rule, but can be very influential in moving a conversation in different directions and stirring that conversation until things start to rise to the top or those cards start to fall out face up and people start to see the makings of an answer.

GARBER: What are the characteristics of a good board member who is not the chair?

UMBDENSTOCK: We always had a joke which, unfortunately, was only funny because it was true all too often. Some board members would walk into the boardroom and give you the most disheartening sound ever, which was that they'd rip open the agenda envelope – not having prepared in advance. The mailing had gone out to them but they weren't ready. That type of preparation – not just to study but to formulate their questions before they come into the boardroom – is essential.

Unfortunately, in any group process, any highly visible process, a lot of times people come into the room more with agendas or positions than with questions. The board member who can raise the right question, who can challenge the board and the staff to think a little differently or from an angle that they hadn't thought about, to think about an issue from the perspective of a stakeholder that they might not have thought about, is a terrific board member.

The fundamental issue is: What's the role of the board? Is the role of the board to out-think management? I don't think so, or you'd go out and find a whole bunch of hospital CEOs to be on the board. Is the role of the board to listen to, challenge, counsel and support management? Yes. I also think it's to protect management from going in an unproductive direction, because they haven't taken a broad enough view or thought broadly enough about the impact. Management and clinical leadership are the players on the field. They're playing the game. The board is more like an owner, maybe a coach in the dugout. The board ought not to be trying to out-think or out-play management. That's non-productive.

I often use a second sports analogy for board and management. As I mentioned, I grew up playing tennis, and I use the analogy of doubles partners. Generally speaking, we agree that you will play the forehand court and I will play the backhand court because that's where our respective strengths lie. There are definite occasions when we will need to back up or cover for one another on the other side of the court, finding ourselves in reversed roles because that's just the way the ball bounces. We don't argue about whose side of the court each one of us should stay on. The dividing line is the net. We compete against others, but we're partners. Too often, boards and managers draw a line down the middle of the court and say, "This is my side of the court. Don't ever come over here." No team could win that way. You have to be ready to support each other. So, I think boards have to be supportive of management and vice versa.

Ultimately, you can boil down the board's role and challenge to three questions. Robert

Mueller,⁴¹ who passed away many years ago, was head of Arthur D. Little Consulting and a contributor to the Cheswick Center. He taught me that every board meeting is a referendum on these three questions. Do we have the right plan? Do the numbers and measures show progress against the plan? Do we have the right leadership (board and management) to execute the plan? If all the answers are yes, great. If any answer comes up no, change must occur. This construct is built upon accountability for both the management and the Board. It's proven to be very helpful to me as a consultant to boards and CEOs and as a CEO myself.

GARBER: How did you represent the American Hospital Association in D.C. and nationally?

UMBENSTOCK: I was the CEO and chief spokesman but we had a terrific advocacy and public policy team led by Rick Pollack⁴² so I didn't need to spend all my time in that realm.

The occasion on which I almost did spend almost full time in that realm was during the debate and passage of the Affordable Care Act.⁴³ I was privileged to work closely with our respective chairmen those years and to be very active in D.C. as the AHA promoted its *Health for Life* reform framework. The activities on the Hill and at the White House were fast-paced and challenging. We tried to forge a framework with a multi-stakeholder group but we eventually announced a deal – in partnership with the Catholic Health Association and the Federation of American Hospitals – with the White House and Senate Finance Committee to help pay for expanded coverage by foregoing future payment increases and special payments. This enabled us to help shape other portions of the bill. The agreement and eventually the bill itself were supported by a majority of our membership but not all, so there was a lot of on-going dialog to help hospital leaders understand what we were doing, what we did, why we did it and what we avoided.

If I had a particular sphere of influence in D.C., based on my experience inside hospital board rooms at Providence, I believe it was in the quality realm, because quality improvement through quality measurement and payment tied to quality measures became such an issue. When I got to AHA, Dick Davidson had helped to organize the Hospital Quality Alliance, which was a broad-based stakeholder group focused on trying to make sense out of this burgeoning number of measures. People were calling it “measurement mania,” or the “measurement babble,” all of these measures that all of a sudden everybody wanted hospitals to collect and report and live to.

Subsequently, I was appointed to the board of the National Quality Forum, which is the entity responsible for vetting and endorsing clinical measures that could then be used for improvement purposes or, more importantly in the broad policy sense, used for public reporting, payment programs, and so on, by Medicare and others.

⁴¹ Robert K. Mueller (1913-1999) was chairman of Arthur D. Little, Inc., from 1977 until his retirement in 1986. [R.K. Mueller, 86, management consultant. *The New York Times*. <https://www.nytimes.com/1999/08/31/business/r-k-mueller-86-management-consultant.html>]

⁴² Richard J. Pollack has served as president and CEO of the American Hospital Association since 2015. He joined the AHA in 1982 and had served as executive vice president at AHA from 1991 to 2015. [*LinkedIn*. <https://www.linkedin.com/in/richard-j-pollack-76911911>]

⁴³ The Patient Protection and Affordable Care Act (P.L. 111-148) was signed into law in 2010 by President Barack Obama. [<http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html>]

AHA also is a corporate member of the Joint Commission. The Joint Commission and AHA had had a rocky relationship in the '90s and into the early part of the new century. I took it on as a personal project to improve that relationship because I believe strongly in the Joint Commission. The Joint Commission is us. It's the private sector. It's the hospitals and doctors of this country, and now other partners, saying that, through accreditation, hospitals are good places to receive care. That accreditation is only as good as the standards, as the core measures, as the strength of the Joint Commission.

In all of this, I was able to work with many committed leaders and was ably supported by Nancy Foster, our vice president for quality and patient safety on the public policy team.⁴⁴ Nancy, who is very well respected in DC and at the Joint Commission, and I shared a passion for quality and safety.

I've been involved in the quality improvement realm in the public policy sphere and in the accreditation sphere, and now in the member engagement sphere. One of the things I'm most proud of at AHA is how we connected the services side of the association, our leadership and business development area under Neil Jesuele's⁴⁵ great leadership, to the quality agenda. This is most evident in how we turned the Health Research & Educational Trust into a national quality improvement engagement facilitator under the leadership of Maulik Joshi,⁴⁶ our senior vice president for research and president of the Trust.

We had thousands of hospitals across the country engaged in efforts to reduce infections, to reduce surgical mishaps, to reduce preventable readmissions and unnecessary utilization. The Agency for Healthcare Research and Quality and the Center for Medicare and Medicaid Innovation and others have had such respect for the Trust that we garnered significant grants, and with that responsibilities, to demonstrate improvement across the field. One of my satisfactions is to have helped lead that redirection, which resulted in incredible engagement and success by way of better and safer care for patients.

GARBER: Are there principles of good governance that transcend the type of organization?

UMB DENSTOCK: Yes, there are common principles of corporate governance. Boards do have a particular flavor at some fundamental level – if you're in non-profit versus for-profit, if you're in multi-stakeholder versus sole proprietorship – but the principles, I have found over the years, are fairly universal.

One is that I equate the board of a not-for-profit entity to be the functional equivalent of the owner. If you're the owner and sole proprietor, you're a one-person board. You may run the organization day in and day out and also be an owner/CEO. You might not. You might just be the funder and the investor and hire a CEO. But you don't necessarily have to be the manager, the

⁴⁴ Nancy E. Foster has served as Vice President Quality/Safety Policy for the American Hospital Association since 2002. [Unpublished personal information supplied by Nancy Foster.]

⁴⁵ Neil J. Jesuele served as executive vice president of leadership and business development at the American Hospital Association and earlier in a senior leadership position with Johnson & Johnson. [Pivot Health Advisors. *Neil Jesuele: Former EVP American Hospital Association*. <https://pivotohealthadvisors.com/neil-jesuele/>]

⁴⁶ Maulik S. Joshi, Dr.P.H., served as president of the Health Research & Educational Trust for eight years, later becoming president and CEO of Meritus Health, Hagerstown, Maryland. [Meritus Health. (2019, September 11). *Press Release*. <https://www.meritushealth.com/media-center/news/2019/september/meritus-health-names-new-ceo/>]

executive.

People often don't understand what a board is. If you say to them, "Basically, you're the owner," they will say, "Oh, wow! I didn't know that." Now that would drive some people, let's say, in Catholic health care, crazy because there is no owner in a not-for-profit and specifically not in a religious entity. I'd say, "You're right." Now that I've got them in the right context, however, and I can explain that fundamental difference.

I think that concept works universally as a first principle. Number two, it explains how I work. I start where board members are, figure out what they already know and then talk to them about what's unique to the particular organization they are in. This is better than starting from zero and assuming they know nothing about hospitals. That may be true but it's also insulting because they know a lot about other things and you've got to bring that out in a hurry to show them that they can make a contribution quickly. Even if the contribution is just – "Well, in my company, we do this for this reason. How does that translate over here?" A perfectly legitimate question – now they are involved, they're engaged.

Another principle is, well, if you're not the day-to-day manager, but you're the legally responsible entity, what's the relationship between you and the executive? Once again, you can start with rules and regs and outlining turf and everything else and get lost in the argument over where to draw the line between governance and management.

So, I start someplace else – as I said, on the tennis court. People will say, "That's really helpful. I thought we were kind of on the same team, but not really on the same team." I said, "No, no, no, there's one entity. You play different roles, but you're both responsible for and to that entity. Let's not fight one another." If you've got a bad partner who can't play, can't back you up – change partners. We're not separate and we're not enemies. We're teammates. That's universal. That's true anywhere. It doesn't matter the type of corporation or the field of practice of that corporation or anything else.

Another principle is that people who understand complex organizations, who are not sole proprietors themselves, bring an understanding that's sometimes a bit easier to work with. Some people think you need a board made up of so many lawyers and so many doctors and so many architects. But if you get too heavily into individual professions like these, you've got a whole bunch of people who come out of individual contexts in the rest of their daily life. That can be a little more challenging to mold the team than if you have people who come out of a team – another corporate context, or people who understand the hierarchy within organizations. Not to say that you don't have plenty of great lawyers who can make lots of contributions, but it's like taking a tennis player – a single, solo sport – and putting them in a team context. Sometimes it works, sometimes it doesn't. So, there are principles like that – and again, I try to draw from where people start, where they already have experience and have made contributions.

The last thing is that you have to figure out who the ultimate shareholder is. If it's the person who holds the literal investment, the shares of stock, that's who you're responsible to. If it's the community at large, and they're stakeholders but not stockholders, you have to figure out how to treat them the same way you would treat a stockholder, being respectful and accountable and appropriately transparent. We're not always as good at that in the non-profit world. We've made great strides in public accountability but people find it a little hard to relate to that great amorphous public set of stakeholders. I'm not here to say I've figured it out totally but the principle is the same. You've got

to figure out how to be accountable, and it's better for the board to know what's going on than to find out on the front page of the paper or in a law suit.

GARBER: Are there characteristics of health care provider organizations that lead to special challenges for boards?

UMBDENSTOCK: Certainly. There are different forms of "ownership" – sponsorship, whatever you want to call it. The public model, governmentally-sponsored model is probably the toughest, just because of the nature of public institutions generally. Sunshine laws have to be respected and managed. Sometimes public boards are elected, so you have to state your agenda before you actually show up in the board room. And if you win, I think you're obligated to your stakeholders to carry out that agenda. It might not be the same agenda as other people in the room. How do you reconcile that? That's the challenge.

It's a little easier in the not-for-profit model, whether community-based or faith-based, although that amorphous stakeholder group is the same in the community-based model that I was talking about a minute ago. It's probably most clear in the investor-owned model, where you know who holds the votes, so to speak. So, it varies by the basis on which the organization is founded and controlled.

The other thing that's unique about health care and hospitals in particular is the existence of a medical staff. Business leaders on the board would say something like "How do you get the docs on board? They're not team players." I would tell them to think about it this way: if this were your business, what roles do you see the doctor playing? To start with, you could say that the doctor is your chief sales person, because if doctors don't refer and admit, you don't have patients.

Doctors are not purely salespeople, though. They're more like independent brokers because historically they haven't worked for one hospital exclusively. They might admit to you, they might admit to the hospital down the street where they also have privileges, or they might just do procedures in their offices.

Doctors are your chief of production as well. They're the captain of the ship. They have the highest degree and they've got the most responsibility for the patient, but they're also directing people who you do employ – nurses and others. Doctors may not work for you but they oversee quality to tell you whether or not what they've done is good.

Think about all of those roles – and there are probably more. Does that sound like anybody who works for you in your company? Would you farm out all of those roles to people who don't work for you? Not only do they not work for you, they work for themselves, and at times compete with you. Board members would say, "Heck, no!" I would say, "Well, now you understand an independent medical staff perfectly, and how you have to meet them somewhere where the two of you can find common ground and work together.

Of course, a lot of the structural nature of the relationship changes when a hospital employs its medical staff and that is much more common now. But that does not automatically change the cultural and historical aspects of the relationship, nor the legal responsibilities of physicians.

GARBER: Can you think of any other field or industry where there is something close to the

historical hospital – medical staff relationship?

UMB DENSTOCK: No. People sometimes ask, “Well, how about universities? Faculty independence, academic freedom and all of that.” I’d say, “You’re right, except that every other Friday at 4:30, the faculty come to the university for a paycheck. Don’t confuse the principle of academic freedom with the reality of employment.” There’s lots of case law trying to sort those two out. We all know that. But at the time, doctors were not coming to the hospital for a check every other Friday at 4:30.

Professors are not self-employed people. The doctor is self-employed and, in a lot of specialties, is an under-funded, under-capitalized small businessperson. They get paid last after they pay their staff and their bills. Every other Friday at 4:30, administrators show up for a paycheck. They’re not playing the game of life with their own money. Faculty members are not playing the game of life with their own money. Doctors are playing the game of life with their own money.

None of that has anything to do with a medical license or, except for that “captain of the ship” comment, has anything to do with understanding why a large number of doctors behave in a particular way or come at an issue from a particular bent. If you can help people understand how it wouldn’t work in their own business, they’ll start to understand a medical staff and the uniqueness of hospitals pretty quickly.

GARBER: You’ve been grappling with concepts related to governance for many years. Have you seen broad trends from the beginning of your career until now?

UMB DENSTOCK: Yes, there have been common topics. Things seem to come back around again every so often. Your audience of board members continuously changes. Most boards have terms, and some number of terms may have a limit. You’re renewing the need to attract, to orient, to involve, and then they cycle off the board. Issues and questions and debates keep coming around – the learning curriculum keeps repeating itself.

Some questions are never answered, so they keep coming around, like should we pay volunteer boards? That was a headline before I got into this field, and I just saw an article somewhere recently that asked the same question.

GARBER: What’s your answer to that question?

UMB DENSTOCK: If you are trying to convince a skeptical stakeholder in the community that paying a volunteer is a good thing and that a volunteer can remain an independent thinker even though you’ve paid them – somebody is going to say, “No, they’re not. They’re in your pocket now.” Nobody’s ever made the convincing case to pay volunteer trustees in my opinion. Paying reasonable expenses – absolutely. If you’re part of a public entity and you’re a public hospital district, and the water district commissioners get paid and the port district commissioners get paid – yes, you may get paid. You don’t get paid your value for the grief you might take but you might get a stipend per meeting plus expenses. That’s different than what I see in some cases today, where the dollars are significant. They’re almost corporate-like. I’ve never heard the public say that they think that’s a good idea. The public may not fully understand the commitment board members make, but at the same time, that means you’re now in an argument where you’re having to do the explaining.

GARBER: Are there any other big issues?

UMBDENSTOCK: Some things come in from the corporate world. For example, should the Chairman and CEO position be the same? An executive chairman, if you will. Some organizations in health care have gone that way – not necessarily in hospitals. I think more corporations have dropped that combined model for accountability reasons. For a while, some people in our field dabbled in that – is that a good idea or not?

GARBER: Is that more of a concept for systems than for hospitals?

UMBDENSTOCK: Maybe, and some related health care companies, some of the alliances and so on. In most cases, that has sorted itself out. Other issues are more operational, like how do you orient trustees? How do you organize board committees? How many people should a board have on it? What's the right size for decision making? Those are the cyclical debates.

GARBER: Let's talk about a typical community hospital. Is there a best practice model for the structure of such a board?

UMBDENSTOCK: I don't think so. I do believe there's a strong logic, however, to how you go about it, but it doesn't necessarily produce similar answers once you work your way through it. For example, if it's in the plan, it's important and you'd better focus on it. The plan is the foundation. What are we trying to do? Where are we trying to go? How will we define success at the end of that journey, or at the way-stations along that journey? If it's in the plan, it's important.

If it's important, it ought to drive the ongoing agenda of the board. What's on the agenda? Stuff from the plan. What's all this other stuff? Well, this is nice to know. Wait a second, time out. We've got to set priorities here. Maybe those things can be done in written reports.

If it's important and it needs to get done, who should be focusing on it? That leads in the end to the question of board and management responsibilities, but also to committee structure. Why do you have all these committees if they've got no relationship to the priorities in the plan? What do we do? We've got the wrong structure or we've got the wrong plan. Let's align them as much as we can.

How will we know success? What do you want the committees to accomplish? The work of committees has to feed the board's deliberations and decisions toward the success measures in the plan. What does the board need to know? They ought to be educated around the things they're being asked to work on.

It's a more integrated approach. If you're a public board with five or seven people on it, it's going to lead to a different configuration or a different way of going about it than if you're a board with 17 or 19 or 25 members on it. That's why I say, the logic is the same, but the results vary on the nature of the organization, the organizations priorities and needs, and I guess you could say, what you have to work with or the parameters within which you are expected to work.

GARBER: Are there certain committees that you've got to have?

UMBDENSTOCK: Three come to mind. Some sort of accountability committee – some people call it a compensation committee or an evaluation and compensation committee – something

that oversees the board/management relationship and the accountability of management back to the board on the accomplishment of objective measures from the plan – number one.

Number two, dollars. People say, “You’re the fiduciary.” That means trust, it doesn’t mean finance only, but certainly one of the two big fiduciary responsibilities is the oversight of the assets broadly.

Number three, the other fiduciary responsibility equally or more important, depending on your opinion, is quality and safety. Again, it’s a matter of trust and living up to that trust as a fiduciary, the trust that’s put in you to put out a quality product in a safe environment and make sure that you know that in fact that’s what you’re delivering. The whole quality/safety/performance improvement – some sort of structure that addresses those three things is absolutely essential.

Do you need some sort of facilities committee? It depends upon where your facilities are at the moment and whether or not there are major projects or investments being made there. A community relations committee? Maybe that’s a staff function. Maybe it is a board function. Certainly, the three I just mentioned are core.

People argue all the time about whether or not you need an executive committee. Everybody is pretty sure that if you have one, they make all the decisions and nobody else knows what’s going on. If you don’t have one, you need one because the board is too inefficient. There is constantly a circular argument over an executive committee.

It’s healthy to go through the process every couple of years to say here’s the updated plan. How does this affect what we focus on month in and month out over the course of a year? What does it tell us about our board structure? What does it tell us about the expertise we need on this board? It should drive the conversation and updating of the board agenda and structure.

GARBER: How many board members should there be?

UMBDENSTOCK: Thirteen to 15, somewhere in there, especially if you’re going to have a committee structure that you want to have at least led by board members. It doesn’t mean that all committee members have to be board members. You can use that as kind of a farm system, to use the baseball analogy.

My first consulting project was with a board of 36 women, appointed for life. When we got done with that project, I was proud that it had become a board of 36 women, appointed for 20 years. We made major change. Why was that a success? Their mothers and grandmothers had founded the place, and it was a strong tradition of women on the board. They had started the discussion of whether or not their daughters would be in a position to follow them.

What does that tell us? First, that they needed to think about men on the board but were not yet ready to move on that. Number two, appointed for life? Nobody in the 1980s was willing to be appointed for life. That was such a ‘50s-‘60s thing. They decided on something like four 5-year terms, or five 4-year terms, something longer than the norm, certainly even at that time, but not indefinite.

The place where we made the most inroads was on their committee structure and their meeting schedule. They were meeting every other Wednesday so by the time management had written the first

set of minutes, they had another meeting upon them, and had to get the materials out and everything else. They had dozens of committees and we streamlined that.

Why did I consider that a successful project? First, the place wasn't broken. It was performing extremely well by all measures. Why mess with success? Second, we got them thinking differently and they acknowledged that they needed to continue that conversation and make changes. Today I understand there are men on the board and I don't believe it took 20 years.

Another life-changing experience of that project was knowing the woman who was chair of the committee, who'd pick me up at the airport. I'd fly from Spokane to Seattle and she picked me up. We talked about the agenda on the way into town, do the meeting, and then if I didn't take a cab, she drove me back to the airport. All the while, she was giving me copies of articles about her son's new business. She was Mary Gates⁴⁷. I've never met Bill Gates but I got to know his mother through this experience. She was a lot like my mother. Those were two women who were born to be chairmen of everything, and at one time or another, they were.

GARBER: Do you know of other examples of all-female boards, or other boards in which members have similar characteristics?

UMB DENSTOCK: It was not uncommon. You can do variations on the theme, such as the lead people on the board are from a family that built the hospital. Or, you can open up the criteria a little broader than that. Everybody on the board has to give X amount of dollars per year. Well, can everybody afford to do that? What about the viewpoint of people using the hospital, but who aren't necessarily funding it? How do we broaden the stakeholders?

If it's a Catholic hospital, do you have to be a Sister or Catholic to be on the board? When I worked at Providence Services, the Sisters of Providence thought that was the craziest question ever asked. What do you mean, do you have to be Catholic? Of course, you don't have to be Catholic. That's their answer. Other systems and other parts of the Church would have had a different answer.

GARBER: Before we move on to a different topic, do you have any predictions or thoughts about how governance might change in the future?

UMB DENSTOCK: The model is in pretty good shape if it is taken seriously and executed as it should be. Public reporting and transparency have been helpful. It tends to focus the mind. I think that's a good thing, a real motivator and a reality check on accountability.

GARBER: The next topic I'd like to consider is your reflections on being a CEO. Is the President/CEO of the American Hospital Association more of a leader or a manager?

UMB DENSTOCK: The clear answer is leader, no question. I viewed my role at AHA as being like an executive chairman or the CEO of a holding company that had two major lines of business; one was advocacy and public policy, and the other was member service. I had two CEO

⁴⁷ Mary A. Maxwell Gates (1929-1994) a well-known community figure in Seattle and mother of Bill Gates helped pave the way for women to serve on governing boards. [Andrews, P. (1994, June 10). Mary Gates dies: Cancer claims longtime Seattle civic leader and mother of Microsoft founder Bill Gates. *Seattle Times*. <https://archive.seattletimes.com/archive/?date=19940610&slug=1914904>]

types who reported to me – Rick Pollack, in the case of the public policy side and Neil Jesuele on the other side. Yes, I had to manage, and yes, they brought me management issues, both large and small. Mostly I had to lead the direction of those two functions and connect those two to the membership, and the membership back to those two functions.

I think it's about 70% leadership and thinking about those connections and working to strengthen them and to keep them strong, and about 30% management. I didn't do budgets, but certainly people brought me budgets along the way, and we would kick the tires and strengthen them and so on. Then people would go back and do that work, and I would go back and relate to members or to other organizations and things like that.

Depending upon how the place is organized, that ratio could easily shift. Or if you have a CEO with a different set of strengths, it will shift. Maybe they want to be a lot more involved in the management of it. That wasn't my style.

GARBER: You mentioned your style as more of a translator between others.

UMBDENSTOCK: Yes, facilitator, translator.

GARBER: You mentioned two individuals who were Executive Vice-Presidents.

UMBDENSTOCK: Yes, right.

GARBER: They were your direct reports. Did you have anybody else who reported to you?

UMBDENSTOCK: Yes, the Corporate Secretary, Mike Guerin, reported to me. All things governance came through his office and then mine. Lisa Allen⁴⁸ in HR. Dick Davidson had brought HR into the Office of the President to elevate its stature and importance within the organization, and we built on that and worked not only on the HR functions – the typical managerial functions like compensation, but also organizational development and putting it on more of a common development process and opportunities for the staff across the organization. Originally, Steve Ahnen⁴⁹ reported to me as VP and Special Assistant to the President until he left to become the CEO of the New Hampshire Hospital Association. Throughout my time there I had two office personnel; my Assistant to the President, Becky Meadows, and our Executive Assistant, Shami Scott.⁵⁰ In terms of direct reports, I had a relatively small number – half a dozen or so.

GARBER: It seems like a lot of the management responsibility for somebody who also has to be jetting all over the country.

UMBDENSTOCK: On the other hand, by having two Executive Vice-Presidents – and

⁴⁸ Lisa Allen served as senior vice president, chief human resources officer at the American Hospital Association until 2018. [American Hospital Association. (2018). *2018 directory of governance and policy development participants*. <https://docplayer.net/89432549-2018-directory-of-governance-and-policy-development-participants.html>]

⁴⁹ Steve Ahnen served for 16 years at the American Hospital Association until he became President of the New Hampshire Hospital Association in 2008. His last position at AHA was as senior vice president for association development. [New Hampshire Hospital Association. *Staff*. <https://www.nhha.org/index.php/about-nhha/staff>]

⁵⁰ Shami Scott serves as senior executive assistant with the American Hospital Association.

having them working the day-to-day operations of the organization and just bringing you the problems or the options, it frees you up to fly around the country and to relate to members or do other things, too.

GARBER: They functioned in a way as co-COOs, then?

UMB DENSTOCK: Yes, each had his area of responsibility. In a lot of ways, they certainly played off of and collaborated across their two realms. With the three of us at the table, we had the entire entity in the room.

GARBER: Three seems like a pretty good number.

UMB DENSTOCK: Yes, our executive leadership team was larger than that because several of the Senior VP and VP levels would sit in as full-time members of that team as well. But if it was a tough decision – the three of us would be in the room. I have to say that Rick and Neil were terrific executives. I could not have had better partners at the top of our organization.

GARBER: You traveled a lot. What processes did you put in place to make sure that you were still communicating with staff and members?

UMB DENSTOCK: In my prior experience with Providence Services, I was on the board of Premier and I was on the board of AHA. Before that, I was in self-employed consulting. Airports and airplanes and long-distance communication was the way I lived from the early '80s until 2015. But at AHA, unlike in self-employment, I had the staff support of Becky and Shami to keep me on schedule and in the right city!

Telephones and computers were important. I owned the first Apple Mac laptop model that came out so that I could work on airplanes and in hotel rooms. When I got home, I could be with my family and not in the office writing client reports. Then this thing called the Internet came along and that helped things. The capabilities of communications grew throughout my career and made staying in touch a whole lot easier.

Structurally, we had regularly scheduled meetings of executive teams as often as we could on a biweekly basis or so. The cycle of the AHA made it a little easier because AHA is on an annual cycle that almost runs itself. You come out of the fall and enter the new year with one-third new board members, the full board coming to a retreat in January, driving the agenda for the year, which drives the councils and committees and RPBs⁵¹ in their three cycles, all of which feed into the next board meeting of that cycle. Then it's the end of the year and you start all over again.

So, in that sense, the sheet music, if you will, doesn't change. Obviously, stuff pops up in the meantime, or you've got to make decisions about how to frame issues, or you don't want people getting tired of just coming and sitting at a meeting, so you develop new exercises to generate new thinking. All of that will change, but the annual cycle is the annual cycle, and you work to it, knowing

⁵¹ Regional advisory boards, later renamed Regional Policy Boards (RPBs) were established by the American Hospital Association in 1968 in each of the nine regions of the country to help foster discussion of issues and to advise AHA staff and board members. [American Hospital Association. *Regional Advisory (now Policy) Boards*. <https://www.aha.org/about/history>]

that there are AHA members involved in each of those meetings, and you want to look your best in front of those members, and you want to get the best out of them by way of input. I don't want to make it sound too much like its cookie-cutter because it's not. An awful lot of work goes into it, staff time and creativity and investment. But at the same time, the calendar never changes and the cycle never changes, at least the way it has operated for a long time.

GARBER: Do you have any sense of how long that structure has been in place? I imagine it evolved, but was there anyone in particular who was responsible for creating that?

UMBDENSTOCK: Back in the '70s, when I first was at AHA, it was fairly similar. The board retreat was in April, and moving that up to the beginning of the calendar year made sense. The annual meeting used to be in January, and the Chair would take office. But Congress was never in session, so you were bringing people to D.C., with largely staff there in the dead of winter. At some point, those two meetings got flip-flopped. It now makes more sense to have your strategic planning meeting in the first month of the year and your next meeting – the annual membership meeting – in D.C. when public policy officials and elected officials are usually in D.C.

Other than that – we used to call them Regional Advisory Boards rather than Regional Policy Boards. I think that change was made under Carol McCarthy and I think there was some change of emphasis there, but I don't think it changed the cycle particularly.

GARBER: Could you talk about how you handled relationships with other organizations?

UMBDENSTOCK: That was a big part of any CEO's job. It was at Providence Services. I mentioned being a shareholder of Premier and having that relationship. I was an AHA member, so I participated in the AHA structure.

At AHA, the CEO is like a Secretary of State as well as the Chief Executive. You work with everybody. You work with allies and you work with some who are not quite as friendly as your allies, maybe have different points of view or competing interests. You do your best.

Spending a lot of time outside the organization with the members is number one. Obviously, spending time with the government, given our role as advocate, is number two. With other organizations, to find ways to work together, to find out where problems might exist that you can try to head off before they burst into full view, or just simply asking, "Why are you doing what you're doing, and how can I learn from it?" There were people in our building when we were on 7th Street NW in D.C. who were in the business. It might be the National Federation of Independent Businesses – just going to lunch with that CEO and talking about their governance and membership structure vs. ours – so there were learning opportunities.

GARBER: What were the key issues in your last couple of years at AHA?

UMBDENSTOCK: My tenure at AHA was marked by the signing of the Affordable Care Act, now 10 years ago next month. The lead up to that, the debate and passage of it, the legal challenges to it, and then the rollout of the regulations, which came in the later years of my tenure – that's the singular marker of my tenure. It's the thing I'm most proud of, extending coverage to 16 million more people. It came at a cost. In order to get that coverage and help fund it, we had to forego payment increases and other payment reforms or formula changes to help offset the cost of that extended

coverage. We went at risk, because the cuts were going to come first and then coverage was going to come later, and you were at risk to make sure that in fact you ever saw it. The Medicaid expansion is a good example of that. It wasn't our choice of how to expand coverage, but at some point, politically, that's what had to happen to get it done. Then not all states expanded, and then the courts said they didn't have to expand, and many didn't, so we and the affected members went at risk in doing that.

Other things that happened that I saw – public accountability, quality reporting, pay for performance, the linkage between payment and outcome – began before I got to AHA. I talked about it with my member organizations at Providence Services for years and gave them this illustration: your finances will be published on one side of a piece of paper for the public, and on the facing page, your quality measures will be published. Besides how we want to treat patients, how do we want to look? The pressure is going to increase. That was certainly pushed forward in the Affordable Care Act. That led us into the initiative that we called Hospitals in Pursuit of Excellence, and that in turn gave us the credibility to be an applicant, and eventually a contractor, for the Hospital Engagement Networks from Medicare and the Center for Medicare and Medicaid Innovation. Those were defining elements of the agenda, as far as my tenure was concerned.

Once you start to measure, the question becomes, is every patient the same? Is every circumstance the same? Do adjustments have to be made? That gets you into the realm of trying to equalize or adjust for things across different circumstances. One of the things that pops out that's very different hospital-to-hospital, community-to-community is what we now call the social determinants of health. Do you factor those in or not?

All of this led us to say, “A hospital is not a hospital anymore.” In order to change and respond to these things, the fundamental understanding of and construct of a hospital had to change. We started to talk about “redefining the H.” The H is a powerful, strong, universal symbol. We had to redefine it so that we understood it better and so that the public understood it better. I used to say “the hospital of the future will be more integrated, more at-risk and more accountable” – things are going to change significantly. A friend once added to that we'd also be “more remote” - more remote electronic monitoring and treatment and more dispersed around the community. It's no longer just one building at one address. That whole effort – redefining the H - was to help us better understand what was going on in the field, and to nudge the field in ways that maybe some hadn't been thinking about.

The last major issue on my watch was the Ebola outbreak in Africa and the possibility of its introduction into the United States. There was a bit of a crisis of confidence in the Centers for Disease Control and Prevention due to some early communications difficulties. Fortunately, I had visited the CDC to see their scope and operations so I had no questions about their leadership and knowledge. To everyone's relief, there were very few cases in the US of this incredibly dangerous and deadly disease but we learned a lot about how to isolate patients and protect our hospital staff members.

GARBER: I spoke to Barb Lorschach⁵² before coming to visit with you. She said that one of the interesting things about your career is how you had been a leader at a time when hospitals were changing to become more like health systems. That had been going on for a long time, but I think she

⁵² Barbara Harness Lorschach served as senior vice president of the American Hospital Association and has gone on to serve as president of Great Hearts Initiatives. [About governWell. <https://digital.governwell.net/htnys/about-governwell/>]

was talking about some of the same things that you were just addressing.

UMBDENSTOCK: Yes, system development started back with a variety of leaders in the '70s. Initially it was mostly horizontal – hospital to hospital. Then it started to become more vertical – hospitals and clinics, hospitals and home health or long-term care, and more recently hospital to insurance or provider and payer integration. There were several notions that helped to drive it. It used to be that if you were sick, you were in a hospital, and if you were in a hospital, you were in a bed. The bed became the most expensive place. It also became the riskiest place because of “hospital acquired conditions” such as infections. And, hospitals came under scrutiny for readmissions.

With technology and incentives, outpatient services started to take hold, and “outpatient” went from just hospital-based outpatient to expand into community-based services, and now to remote/telephonic/telehealth. That really starts to change the fundamental profile of an organization. I'd be most worried today as a hospital exec about making a 30-year bet on a capital investment – more buildings, more overhead, more unpredictable payment systems and whether or not we'd ever get the return on that.

Systemization in a structural sense was a key phenomenon during my career. Also, more so in the later part of my career, was the notion of systems thinking, that A is connected to B, which drives C, which you hope moves you on to D. Everything is connected or should be more connected than it is, especially if you look at the “system” from the point of view of the patient.

The ongoing quest for electronic system interoperability so that the medical record can be accessed from place to place was a big project of ours at Providence Services with our competitor, Empire Health Services, in Spokane. We saw the benefits, for patients and providers, of being able to do that. It was an incredible system. I analogized an electronic medical record to an intercom when the record was only accessible inside a single building, but that it paralleled a phone system when it was accessible multiple locations in a given community. I always thought these systems and the massive investments in them were under-leveraged. Understanding how things ripple through an organization and the leaning out of the process – getting rid of the extraneous steps and duplications or expenditures along the way – is a huge issue going forward. It's now all about internal systems capabilities and strategic thinking in the system context.

GARBER: How did you decide when to retire?

UMBDENSTOCK: When I took the job, I was 55. From day one, I thought that 10 years would be a good target for a couple of reasons, primarily because 10 years is a long time to be away from your family when they live in the Pacific Northwest and you're living on the East Coast.

People asked, “If we hire you, how long will you stay?” I said, “This is my ideal job, and I really don't want to go anywhere else except into retirement. So, I think about 65.” Then every year I'd have a conversation with the board. “How are you doing? How's your health? How's your energy? What are you thinking?” I would tell them every year, “Yes, 65 is getting a little closer, but I'm good until then.”

All of a sudden, we started to have grandchildren. Three of our kids got married and they started to have families. In late '13, Barb took a vote, as I like to tell it, and it came out Grandkids 4, Grandpa 0. We'd had four grandchildren by then, and she wanted to move home to be close to the

babies.

We bought a condo in Spokane in late 2013 and sold our house in D.C. in early 2014 and Barb moved back to Spokane. That was a clear signal of our intent and at the end of 2014, I gave the board a year's notice and said, "Yeah, it's official." They were not surprised. We had put in place a talent management process and other things that set the organization up for that sort of transition and gave the search process a good grounding. We announced in late 2014 that I'd be done by no later than the end of 2015.

GARBER: That seems like a very generous notice that you gave. Is that common for CEOs of large organizations?

UMBDENSTOCK: It's not uncommon. Sometimes organizations don't publish that and just start the early stages of the search quietly. I understand that. Once you announce, the phone stops ringing. "He's going to be gone tomorrow. I've got to figure out who to deal with next." That's said somewhat in jest, but your life does change once you go public.

The other thing, the factor that made age 65 and the year 2015 realistic was the approach of 2016, which would be the next presidential election. From the day I walked into the job, that was never going to change. Bush had termed out; Cheney wasn't running. We were going to have a new president elected in 2008 one way or the other. At max, that person could only serve two terms. So, you know that 2016 is likely to be the next big election. As it turned out, Obama termed out. It's best to get a new team in a year before and give them the time to get their feet on the ground. The timing of my retirement vis-a-vis the election calendar was another factor.

GARBER: Is there anything else you'd like to say about comparing the two selection processes?

UMBDENSTOCK: My selection process was unique. I was a board leader who had already worked for the AHA in the Office of the President, who knew the job, at least as it was at that time, and who had served the better part of five years or so on the board. Some people wanted to see me apply and I wanted to apply. As George Lynn, my predecessor, and then the person who picked up the end of my Chairman's year, liked to say, "We did a search, and we found the right person on the first interview." It was very nice of him to put it that way. That was not your traditional approach to an executive search. I must say it took great courage on the part of the 2006 Board.

The organization took a much more traditional approach the next time with my successor, and they had the time to do it. I was fine with the announcement being made so that people knew the process was under way. We had done the initial rounds of the talent management process and its guiding documents. That became the foundation for the search process. They hired a search firm and went through a much more traditional process, led by the board.

GARBER: How did the transition go?

UMBDENSTOCK: The transition was great. I think it went every bit as well as my transition with Dick, because Rick and I knew each other quite well. I was happy to have him free himself up a little bit from his day-to-day activities so that he could do his homework about the organization, so that he could hit the ground running when he took over on September 1. It was smooth in that sense,

certainly between the two of us, and it was the least disruptive and most productive for the organization I believe.

GARBER: Did you have any other learnings from this process?

UMBDENSTOCK: Yes. Once you announce that you're leaving, life changes. Once you announce, you inject a certain amount of change into the rest of the organization. Staff become more nervous. Change is always difficult and the unknown is not exactly settling. People understandably were worried. The way I approached that was to tell them that regardless of who the board chose, the one thing I could guarantee was that it would be an upgrade. It got a lot of chuckles. You try to disarm some of that nervousness. I said, "They've had one example – me – recently. Now they can go out and find somebody that's a lot more than me and that's the way it should be." You have to help people deal with that uncertainty. You have to find a way to communicate and put people at ease as much as you can. Once you set up the process, you have to trust it and get out of the way and trust in the board. I always have trusted the board – we've always been blessed with very good boards – and leave it to the people that have to live with the result.

GARBER: How many presidents have you shaken hands with?

UMBDENSTOCK: Two. President Bush was in office when I arrived in 2006. He came to an annual meeting and spoke. The other board officers and I were behind stage at the Hilton, and we each got about seven seconds to shake hands, have a picture taken, and then a Secret Service person gently took you by the elbow and moved you out. He did not stay and talk to us as a group. That's not the way they operated.

President Obama held two early summits at the White House, one an economic summit post-election, and the other a health care summit. I think they were in March and May 2009. I was invited to each of those and saw the President in a rope line kind of handshake.

There was a time also in a personal meeting in the Roosevelt Room at the White House – the leaders of a group that we were part of pre-ACA, called the Health Reform Dialog, trying to figure out where the common ground was around pharma and unions and nursing homes and hospitals and doctors. We shook hands with President Obama and were in a meeting there with him. Tom Priselac⁵³ was our chair, and he was at the big table. I was staff in the back row.

I never met President Clinton because I wasn't on the scene then, and I was gone before the 2016 elections. Let's put it this way – I met 100% of the Presidents who were in office while I was at AHA.

GARBER: Did you have any experiences where you were in on the startup of something?

UMBDENSTOCK: The Hospitals in Pursuit of Excellence improvement initiative was a major undertaking. My contribution there was to move us from being a management-centric and reimbursement-centric organization more into the patient care and clinical realm. It certainly got clinical by the time the Medicare improvement contracts around readmissions and infection control

⁵³ Thomas M. Priselac has served as president and CEO of Cedars-Sinai Health System since 1994 and served as chairman of the American Hospital Association Board of Trustees in 2009. [Cedars Sinai. *Thomas M. Priselac*. <https://www.cedars-sinai.org/about/leadership/thomas-m-priselac.html>]

and things like that came along. We became a very different organization for all the right reasons and we got credit for it. But it was certainly better for patients, number one. Number two, we were going to get penalized for our mistakes, or maybe gain based on our better outcomes, so clinical improvement was in our own self-interest on the reimbursement side. Thirdly, it positioned us as a more credible organization and it built upon AHA's mission of always putting patients and communities first. It had started under Dick Davidson, with the Hospital Quality Alliance. Carrying that forward, we helped put the Quality Alliance out of business – something that rarely happens in a place like D.C. We had moved on to the National Quality Forum – you know, real measure vetting and measure development and so on – and they were advising Medicare on the payment side, what measures to use. I'm most proud of being part of and a leader in this important set of quality improvement initiatives.

Another “start-up” was around the ACA's expansion of coverage. To roll out the Affordable Care Act and activate the new coverage, I was part of an effort called Enroll America, which helped to develop strategies and materials and messaging to help states and insurers and everybody else – community groups, coalitions – to get more people engaged during the enrollment years of the ACA.

I am also pleased to have played a part in the AHA's focus on addressing health care disparities. Over the years, past chairmen Kevin Lofton and Gene Woods⁵⁴ and others provided great leadership to focus the board on the need to address this issue, and our friend and colleague Barry Passett⁵⁵ staffed the initial effort. There had always been the moral imperative to address inequities but, as pay for performance gained strength, it became obvious that inequities would be an inherent limitation as hospitals worked to improve performance and outcomes. HRET had already developed a sophisticated format for collecting race and ethnicity data at admission and was selling it at a nominal price to recover their costs; I made an internal purchase of it, so to speak, paying off their costs with AHA dues dollars and making this construct available to all hospitals at no additional cost. Hospitals need this data to address this priority of reducing ethnic and racial disparities in health and outcomes.

Lastly, I'm still involved as a board member, with an informal AHA link, of something called the Coalition to Transform Advanced Care – CTAC. I helped fund the early stages of that, especially their national symposium. CTAC's a broad umbrella organization, trying to coalesce the social movement around palliative care and end-of-life care. We had the AHA Circle of Life award, but no membership program so I saw this as a chance to subcontract, in effect, or contract out for that kind of expertise around the important and often ignored process of making your wishes known before you are critically ill.

GARBER: Could you talk about the writing you've done? Are you planning to write anything in retirement?

UMBDENSTOCK: I am not planning to write anything. That sounds like way too much work!

⁵⁴ Eugene A. Woods, president and CEO of Atrium Health, served as Board Chairman of the American Hospital Association in 2017. [Atrium Health. *Atrium Health Leadership*. <https://atriumhealth.org/about-us/leadership>

⁵⁵ Passett, Barry A. (1934-2019). Served as CEO of the Greater Southeast Healthcare System in the 1980s and as a consultant to the American Hospital Association. [Barry Passett. *The Washington Post*. <https://www.legacy.com/obituaries/washingtonpost/obituary.aspx?n=barry-passett&pid=192630603>]

GARBER: I loved finding this 1979 article that you and Barbara wrote together: New JCAH standards stress quality and flexibility.⁵⁶

UMBDENSTOCK: I'm trying to think of why we might have written that. Just kidding! The answer is that by that time, we were both in consulting and had just moved to Spokane – Halloween of 1979. According to the article summary – the new accrediting standards were to go into effect January 1. She was in quality assurance consulting and I was interested in helping boards understand their responsibilities for quality. That's when I also wrote that little book, because I had a lot of free time.

GARBER: The little book you are referring to is: *So You're on the Hospital Board?*⁵⁷

UMBDENSTOCK: Yes.

GARBER: Tell us more about retirement.

UMBDENSTOCK: Retirement has been a blessing. I'm proud of how good I am at it. My motto has been "I don't want to do anything so that I can do *anything*." I did not accept a lot of offers that came along in the last six months I was working, and the first two or three months in retirement, but I eventually took on a few responsibilities.

I agreed to CTAC, the Coalition to Transform Advanced Care. Also, some friends had self-funded something in the Baldrige Performance Excellence realm called "Communities of Excellence 2026." Their mission is to adapt the Baldrige excellence criteria that are prominent in health care and manufacturing and other realms to be used by full communities, to improve community life and performance.⁵⁸ Lowell Kruse,⁵⁹ who ran Heartland Health in St. Joe, Missouri, and Rick Norling,⁶⁰ who ran Premier – both of whom I worked with when I was on the board of Premier and who respectively had led their organizations to national Baldrige recognition - invited me to be on the board of Communities of Excellence. We're close to requesting that Congress recognize it as the seventh sector of the Baldrige Excellence Program.

AHA was approached by Baldrige and was the first to fund any portion of Baldrige from the

⁵⁶ Umbdenstock, R.J., and Mohr, B.J. (1979, December). New JCAH standards stress quality and flexibility. *Trustee*, 32(12), 16-19.

⁵⁷ Umbdenstock, R.J. (1981). *So you're on the hospital board?* (1st ed.). Chicago: American Hospital Association. This book was to have a total of four editions.

⁵⁸ The Malcolm Baldrige National Quality Award is the highest award in the U.S. for performance excellence. Established by Congress in 1987, today there are awards made in six categories, of which healthcare is one. [American Society for Quality. *What is the Malcolm Baldrige National Quality Award (MBNQA)?* <https://asq.org/quality-resources/malcolm-baldrige-national-quality-award>]

⁵⁹ Lowell C. Kruse served as president & CEO of Heartland Health (St. Joseph, Missouri) from 1984 to 2009, after which he became a senior fellow with the Heartland Foundation. His oral history: Garber, K.M. (Ed.), (2015). *Lowell C. Kruse in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from www.aha.org/chhah]

⁶⁰ Richard A. Norling served as president and CEO of Fairview Hospital and Healthcare System (Minneapolis) and then from 1998 until his retirement in 2009 served as president & CEO at Premier, Inc. (Charlotte, N.C.) [Premier Inc. plans transition in executive leadership. (October 16, 2008). *Business Wire*. <https://www.businesswire.com/news/home/20081016005617/en/Premier-Plans-Transition-Executive-Leadership>]

private sector. We sponsored the health care criteria which not only got some prominence for AHA, but also helped spread it out to more hospitals. A lot of hospitals are using it. A lot of hospitals are Baldrige award recipients. As a matter of fact, health care is probably the most successful sector in the Baldrige program.

I eventually took on two small company board memberships. One is a small publicly-traded company that has an electronic inventory management platform that allows hospitals to buy, sell and trade excess medical supplies and capital equipment; it also allows product manufacturers or brokers to reach hospital clients directly. The other company is privately-held and has an ultrasonic surgical device that addresses tendinitis and diabetic foot wounds. These experiences have taught me quite a bit about aspects of the health care marketplace that I had not experienced before, as well as the trials and tribulations of small entrepreneurial companies, including investor financing, reimbursement issues, product approval processes inside hospitals and, in the one case, stock exchange requirements.

GARBER: Congratulations on doing well at retirement! Do you have comments about work/life balance?

UMB DENSTOCK: I always took all of my vacation – for two reasons. Number one, I felt it was healthy for me, healthy for my family. Number two, I thought it was important to set an example for staff. I was stunned at how many people left vacation in their account. I can understand a year when something happens and it gets away from you but I don't think it's healthy on a long-term basis.

Before I retired, Barb said to me, "You won't know what to do." I said, "Honey, that's based on the premise that I ever really wanted to work!" We laugh about that but we also are working together in retirement to retain our good health and enjoy our time together, something we often had very little of as I traveled and she raised the kids.

GARBER: I'd like to give you the opportunity to speak about anybody else that you might have missed and particularly about your wife and her contributions to your career.

UMB DENSTOCK: About others in the field – the good news is I've had so many contacts and so many people that I worked with side-by-side, so many people I could learn from. I used to say to people, "One thing I have is a very good Rolodex." I had so many contacts throughout my career.

I know I'll leave a whole bunch of people out, but George Allen at HANYS gave me my first job and also my first big break when he recommended me to Alex McMahon. Alex was an incredible mentor. He was a teacher and a taskmaster. I reported to Bill Robinson, as I said, who was very good to me, very helpful as well.

As I think about my career in writing and speaking, there were others who I need to credit at AHA. One was Vicki Osterman, Alex's executive secretary. Vicky came into my office one day with a pen and a dictation pad and said, "You should stop writing drafts. Just dictate." That seemed pretty intimidating to a young man at the time but, in effect, she became the first audience I had ever spoken to and it was helpful. That's what I wound up doing my whole career – speaking, teaching, facilitating, working and thinking on my feet more so than at a desk. Vicky was a great teammate and a task master as well.

Of course, Alex himself taught me a lot about writing. The last thing you ever wanted to do

was give Alex a grammatical error in a draft. He could use a red pen faster than anybody. So, I developed a discipline about the written word and communications that served me well.

Credit also has to go to Karen Porter⁶¹, then the editor of *Trustee Magazine*. Karen was a very patient teacher. She always was looking for material for *Trustee* magazine, and I had the interest in this topic because of my parents, and because I had staffed the Committee on Hospital Governing Boards. She guided me as I wrote articles for the magazine and taught me a lot about editing. Vicky and Karen are some early unsung heroes in my career.

Gail Warden came to AHA in about 1976 or '77 and we became lifelong friends. He taught me a lot. I went to Spokane in 1979 and by 1980 or '81, he was in Seattle at Group Health Co-op, and he bought from Cigna the little community-based plan in Spokane. I was on his board at Group Health Northwest – learned an awful lot about HMOs and risk and quality – getting it right the first time. The executive there at the time was Dr. Henry Berman.⁶² He had come from New York City so we had East Coast roots in common. He taught me a lot about how to encourage self-reporting because you only can fix the mistakes you know about. It was countercultural for people to report errors in those days because they had fear of reprisal, rather than the potential for improvement.

Leo Greenawalt at the Washington State Hospital Association has been a great long-time colleague and mentor in association work – somebody who I always admired because he would think out loud, which is my style too, but it exposes you to both sharing your ignorance and starting a staff stampede in a direction they think you want to go in, when all you're really doing is exploring ideas. Leo was very good at managing that process. He also saw value, not just competition, in collaborating with the state medical association.

There were other state association execs who became great friends and who shared their experiences as well. Duane Dauner,⁶³ Spence Johnson⁶⁴, Joe Parker⁶⁵ and Carolyn Scanlan⁶⁶ were some

⁶¹ Karen Porter served as manager of the Department of Public and Member Communications at the American Hospital Association and later was associate director of the Society for Healthcare Strategy and Market Development. [Phillips Medical Writers. *Testimonials*. <http://www.phillipsmedicalwriters.com/testimonials/>]

⁶² Henry Berman, M.D. (d. 2020), a specialist in adolescent medicine, served as president and CEO of Group Health Northwest. [Henry Berman, M.D. *The Spokesman-Review*. <https://www.legacy.com/obituaries/spokesman/obituary.aspx?n=henry-berman&pid=195533271>]

⁶³ C. Duane Dauner (d. 2020) served as CEO of the Kansas Hospital Association from 1965-1975, the Missouri Hospital Association from 1975-1985 and the California Hospital Association from 1985-2017. [California Hospital Association. (2020, July 14). Obituary: Former California Hospital Association president Dauner. <https://www.aha.org/news/headline/2020-07-14-obituary-former-california-hospital-association-president-dauner>]

⁶⁴ Spencer C. Johnson (1944-2019) served as CEO of the Michigan Health & Hospital Association for over 30 years beginning in 1985. [American Hospital Association. (2019, November 11). Obituary: Longtime hospital association CEO Spencer Johnson. <https://www.aha.org/news/headline/2019-11-11-obituary-longtime-michigan-hospital-association-ceo-spencer-johnson>]

⁶⁵ Joseph A. Parker served as president and CEO of the Georgia Hospital Association for 27 years until his retirement in 2013. [Long-time Georgia Hospital Association and CEO Joseph A. Parker announces retirement. *Savannah Business Journal*. [https://www.savannahbusinessjournal.com/news/health_hospitals/july-16---long-time-georgia-hospital-association-and-ceo-joseph-a-parker-announces/article_cb7f1e83-7ce7-50c5-af06-1c18c18e37b4.html]

⁶⁶ Carolyn Scanlan served as CEO of the Hospital and Health System Association of Pennsylvania for 18 years until her retirement in 2012. [Penn Medicine Lancaster General Health. (2019, July 12). Meet Carolyn Scanlan, LG Health board of trustees. <https://www.lancastergeneralhealth.org/health-care-professionals/for-physicians/progress-notes/2019/july/meet-carolyn-scanlan-lg-health-board-of-trustees>]

of the more senior state execs when I arrived at AHA and they were all very supportive.

Working with Alex put me in contact with the chairman officers, starting with Wade Mountz⁶⁷ in 1975. The officers were all great role models and friends throughout the next 40 years. There are too many to name individually but I hope you might be able to append a list to this report. [See the following list.]

American Hospital Association: Chairmen of the Board of Trustees from 1975 to 2015

Year	Name	Institution	City	State
1975	Wade Mountz	Norton Children’s Hospital	Louisville	KY
1976	H. Robert Cathcart	Pennsylvania Hospital	Philadelphia	PA
1977	John M. Stagl	Northwestern Memorial Hospital	Chicago	IL
1978	Samuel J. Tibbitts	Lutheran Hospital Society of Southern California	Los Angeles	CA
1979	W. Daniel Barker	Crawford W. Long Memorial Hospital of Emory University	Atlanta	GA
1980	Sister Irene Kraus	Providence Hospital	Washington	DC
1981	Bernard J. Lachner	Evanston Hospital	Evanston	IL
1982	Stanley R. Nelson	Henry Ford Hospital	Detroit	MI
1983	E.E. Gilbertson	St. Luke’s Regional Medical Center	Boise	ID
1984	Thomas R. Matherlee	Gaston Memorial Hospital	Gastonia	NC
1985	Jack A. Skarupa	Greenville Hospital System	Greenville	SC
1986	Scott S. Parker	Intermountain Health Care	Salt Lake City	UT
1987	Donald C. Wegmiller	HealthOne Corp.	Minneapolis	MN
1988	Eugene W. Arnett	Memorial Hospital of Taylor County	Medford	WI
1989	Edward J. Connors	Mercy Health Services	Farmington Hills	MI
1990	David A. Reed	St. Joseph Health System	Orange	CA

⁶⁷ Wade Mountz (1924-2020) served as president and CEO of Norton Healthcare in Louisville, Kentucky. [Wade Mountz 1924-2020 *Courier Journal*. <https://www.legacy.com/obituaries/louisville/obituary.aspx?n=wade-mountz&pid=195615350&fhid=29361> His oral history, Garber, K.M., (Ed.). (2009). *Wade Mountz in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from www.aha.org/chhah]

1991	C. Thomas Smith	Yale-New Haven Hospital	New Haven	CT
1992	D. Kirk Oglesby, Jr.	Anderson Memorial Hospital	Anderson	SC
1993	Larry Mathis	Methodist Hospital System	Houston	TX
1994	Carolyn C. Roberts	Copley Hospital	Morrisville	VT
1995	Gail L. Warden	Henry Ford Health System	Detroit	MI
1996	Gordon M. Sprenger	Allina Health System	Minneapolis	MN
1997	Reginald M. Ballantyne III	PMH Health Resources, Inc.	Phoenix	AZ
1998	John G. King	Legacy Health System	Portland	OR
1999	Fred L. Brown	BJC Health System	St. Louis	MO
2000	Carolyn B. Lewis	Greater Southwest Community Hospital	Washington	DC
2001	Gary A. Mecklenburg	Northwestern Memorial HealthCare	Chicago	IL
2002	Sister Mary Roch Rocklage	Sisters of Mercy Health System	St. Louis	MO
2003	Dennis R. Barry	Moses Cone Health System	Greensboro	NC
2004	David L. Bernd	Sentara Healthcare	Norfolk	VA
2005	George F. Lynn	AtlantiCare	Atlantic City	NJ
2006 (April)	Richard J. Umbdenstock	Providence Services	Spokane	WA
2006 (December)	George F. Lynn	AtlantiCare	Atlantic City	NJ
2007	Kevin E. Lofton	Catholic Health Initiatives	Denver	CO
2008	William D. Petasnick	Froedtert & Community Health	Milwaukee	WI
2009	Thomas M. Priselac	Cedars-Sinai Health System	Los Angeles	CA
2010	Richard P. de Filippi	Cambridge Health Alliance	Cambridge	MA
2011	John W. Bluford	Truman Medical Centers	Kansas City	MO
2012	Teri G. Fontenot	Woman's Hospital	Baton Rouge	LA
2013	Benjamin K. Chu, M.D.	Kaiser Foundation Hospitals and Health Plan	Pasadena	CA
2014	James H. Hinton	Presbyterian Healthcare Services	Albuquerque	NM

2015	Jonathan B. Perlin, M.D.	Hospital Corporation of America	Nashville	TN
------	--------------------------	---------------------------------	-----------	----

Source: American Hospital Association Office of the Secretary

At the national level, I had the opportunity to meet and work with many great leaders, especially in the quality realm. They included HHS Secretary Kathleen Sebelius,⁶⁸ Don Berwick at IHI and latter CMS,⁶⁹ Carolyn Clancy at AHRQ,⁷⁰ Chris Cassell at NQF,⁷¹ and Mark Chassin at the Joint Commission.⁷²

In the association realm, I worked with Sister Carol Keehan at the Catholic Health Association;⁷³ Chip Kahn at the Federation of American Hospitals;⁷⁴ Dr. Darrel Kirsh at the Association of American Medical Colleges;⁷⁵ and Tom Dolan⁷⁶ and Deborah Bowen⁷⁷ at ACHE.

There were business leaders I met along the way – Walt McNerney,⁷⁸ when he was at the Blue

⁶⁸ Kathleen Sebelius served as governor of Kansas from 2003 until 2009 when she became secretary of the U.S. Department of Health and Human Services. [Kathleen Sebelius. *Kansapedia*.

<https://www.kshs.org/kansapedia/kathleen-sebelius/17129>

⁶⁹ Donald M. Berwick, M.D., a pediatrician, is president emeritus and senior fellow of the Institute for Healthcare Improvement. He also served as administrator of the Centers for Medicare & Medicaid Services, among many other positions. [Profiles in leadership: Don Berwick. *IHI Open School*.

<http://www.ihio.org/education/IHIOpenSchool/resources/Pages/ProfilesInLeadershipDonBerwick.aspx>

⁷⁰ Carolyn Clancy, M.D., served as director of the Agency for Healthcare Research and Quality for nearly 10 years beginning in 2003. [Hagland, M. (2013, April 10). A tough act to follow: Carolyn Clancy exits AHRQ. *Healthcare Innovation*. <https://www.hcinovationgroup.com/finance-revenue-cycle/blog/13020773/a-tough-act-to-follow-carolyn-clancy-exits-ahrq>]

⁷¹ Christine K. Cassell, M.D., served as president and CEO of the National Quality Forum from 2013 to 2016. [National Quality Forum. (2015, December 17). NQF President and CEO Christine Cassel to step down. *Press release*.

https://www.qualityforum.org/News_And_Resources/Press_Releases/2015/NQF_President_and_CEO_Christine_Cassel_to_Step_Down.aspx

⁷² Mark R. Chassin, M.D., a board-certified internist, has served as president and CEO of the Joint Commission since 2008, succeeding Dennis S. O’Leary, M.D. [Robeznieks, A. (2007, Aug. 6). *Modern Healthcare*, 37(31), 6-7.

<http://www.modernhealthcare.com/article/20070806/NEWS/70803019>

⁷³ Sister Carol Keehan served as president & CEO of the Catholic Health Association of the United States from 2005 until her retirement in 2019. [O’Loughlin, M.J. (2019, June 6). Sister Carol Keehan is leaving the Catholic Health Association: Here’s what she thinks about U.S. health care. *America: The Jesuit Review*.

<https://www.americamagazine.org/politics-society/2019/06/06/sister-carol-keehan-US-health-care>]

⁷⁴ Kahn, Charles N., III, has served as president and CEO of the Federation of American Hospitals since 2001. [FAH staff. <https://www.fah.org/about-fah/bio/president>]

⁷⁵ Darrell G. Kirch, M.D., served as president and CEO of the Association of American Medical Colleges from 2006 to 2019. [Darrell G. Kirch, MD. <https://www.aamc.org/who-we-are/our-leadership/biography/darrell-g-kirch-md>]

⁷⁶ 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>

⁷⁷ Deborah J. Bowen has served as president and CEO of the American College of Healthcare Executives since 2013. *Deborah J. Bowen, FACHE, CAE*. <https://www.ache.org/people/Deborah-J-Bowen-FACHE>]

⁷⁸ Walter J. McNerney (1925-2005) served as president of the Blue Cross Association (later known as the Blue Cross and Blue Shield Association) from 1961 to 1981 after which he went on to become the Herman Smith professor of health policy at Northwestern University’s Kellogg School of Management. His oral history: Weeks, L.E. (Ed.) (1984). *Walter J. McNerney in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center. [Saxon, W. (2005, August 14).

Cross and Blue Shield Association. A man named Karl Bays⁷⁹ was at American Hospital Supply. I'll never forget, one of us asked Karl, "They're all forming group purchasing organizations. What are you going to do?" He said, "If that's the way they want to buy, that's exactly how I want to sell. Now what am I going to do about it? How am I going to make that happen?" I mean, it was that kind of seasoned executive perspective to which I had a front-row seat.

And, of course, there were the AHA member CEOs. As I said, nothing like have 5,000 bosses. But truly, I always felt very well supported by the members and many have become life-long friends.

You asked about Barb. In addition to a being a fabulous life partner and best friend, she has been my personal quality consultant. She was one of the first nurses hired by The Joint Commission – an early quality assurance pioneer. She is a good debater – I remember debates in the early days about definitions. What's quality assurance? What's risk management? What's utilization review? All of those were terms coming into the lexicon.

The biggest contribution that she's made has been as the mother and educator of our four kids. She did all the homework assignments, all the science projects. I was on the road, and not very good at that anyway. She did it faithfully. As I've said, I worked a lot in my consulting days on weekends. Barb would get the kids through five days of school and practice and everything else, only to then have them by herself on the weekend as well. I'd come home on Saturday night or Sunday, and then I'd take off again the next Wednesday or whatever it was. She did it all and has always been my greatest supporter.

Her last big contribution was to move us to DC for the AHA job, introduce us into new social circles there around golf and tennis, act as the AHA's First Lady and lead all the Board spouse activities, and then move us back to and resettle us in a new home in Spokane.

I often say, the biggest gift you have is when people believe in you. Of course, it started with my folks. George Allen believed in me. Alex believed in me. I never thought I'd go back to work for a hospital group once I was in consulting, but the Sisters of Providence believed in me. The 2006 AHA board certainly did. Barb always has. I've been a pretty lucky man. I've had a lot of great contacts, a lot of great support, but none more important than Barb's love and that of our four children – Renée, Ross, Lauren and Alex, and now their wonderful spouses and our seven grandchildren.

CHRONOLOGY

- | | |
|------|---|
| 1950 | Born in Islip, New York |
| 1972 | Fairfield University (Fairfield, Connecticut)
Bachelor of Arts, Politics |
| 1974 | State University of New York at Stony Brook (Stony Brook, New York) |

Walter McNERNEY, 80, dies: Helped shape health policy. *The New York Times*.

<https://www.nytimes.com/2005/08/14/us/walter-mcnerney-80-dies-helped-shape-health-policy.html>

⁷⁹ Karl D. Bays (d. 1989) started at American Hospital Supply as a sales representative in 1958 and became president in 1970, serving as CEO and then chairman until after the company was acquired by Baxter Travenol Laboratories in 1985. [Key, J. (1989, November 7). Karl D. Bays, Whitman chief and former chairman of Baxter. *Chicago Tribune*. <https://www.chicagotribune.com/news/ct-xpm-1989-11-07-8901280799-story.html>]

- Master of Science, Health Service Administration
- 1974-1975 Hospital Association of New York State (Albany, New York)
Institute Coordinator
- 1975-1979 American Hospital Association (Chicago)
1975-1978 Special Assistant to the President
1978-1979 Director of Programs for Hospital Governing Boards
- 1977 Married to Barbara J. Mohr
Children: Renée, Ross, Lauren, Alex
- 1980-1983 Sacred Heart Medical Center (Spokane, Washington)
1980-1981 Director, Special Projects
1982-1983 Vice President, Management Services
- 1983-1993 Umbdenstock-Hageman
Governance Consultant
- 1983-1986 Hospital Research & Educational Trust (Chicago)
1983-1984 Crosby Fellow
1984-1986 Project Director, Governing Board Mentor Program
- 1993-2005 Providence Services (Spokane, Washington)
President and CEO
- 2006 Providence Health & Services (Seattle, Washington)
Executive Vice President for Advocacy, Governance and External Affairs
- 2007-2015 American Hospital Association
President/CEO

SELECTED MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives
Fellow

American Hospital Association
Chairman, board
Chair, Long-Range Policy Committee
Chair, Operations Committee
Member, board
Member, Executive Committee
President & CEO
President Emeritus

CAQH

Member, provider council

The Cheswick Center
Member, board

Communities of Excellence 2026
Member, board

Enroll America
Member, board

Family-A-Fair
Member, advisory board
Member, honorary board

Gonzaga Preparatory School
Chairman, board
Member, board

Group Health Foundation
Member, board

Group Health NW
Chairman, board
Member, board

Hospital Quality Alliance
Chairman

Intercollegiate Center for Nursing Education
Member, Advancement Council

National Quality Forum
Member, board
Member, National Priorities Partnership Committee

Premier, Inc.
Chairman, board
Member, board

Providence Services
Member, board
President & CEO

Spokane Chamber of Commerce
Member, board

Spokane Diocesan Foundation
Chairman, board
Member, board

AWARDS AND HONORS

- 1972 St. Ignatius Loyola Medal, Fairfield University
- 2003 Doctor of Laws, hon. caus., Gonzaga University (Spokane, Washington)
- 2006 Bishop's Medal (Co-Recipient with Barbara), Catholic Diocese of Spokane
- 2006 Holy Names Award (Co-Recipient with Barbara J. Umbdenstock), Sisters of the Holy Names of Jesus and Mary
- 2014 National Healthcare Award, B'nai B'rith International
- 2015 Gail L. Warden Leadership Excellence Award, National Center for Healthcare Leadership
- 2015 Gold Medal Award, American College of Healthcare Executives
- 2015 Honorary Member Award, American Organization of Nurse Executives
- 2015 Inaugural Healthcare Leadership Award, Federation of American Hospitals
- 2015 President Emeritus, American Hospital Association
- 2015 Richard J. Umbdenstock Executive Fellowship, Institute for Diversity in Health Management
- 2015 Special Recognition Award, Association of American Medical Colleges
- 2016 Health Care Lifetime Achievement Award, Seattle Business magazine
- 2017 Distinguished Service Award, American Hospital Association

SELECTED PUBLICATIONS

Umbdenstock, R.J., and Mohr, B.J. (1979, December). New JCAH standards stress quality and flexibility. *Trustee*, 32(12), 16-19.

Umbdenstock, R.J., and Hageman, W.M. (1984, April). Governance and management: Where do you draw the line? *Trustee*, 37(4), 19-24.

Umbdenstock, R.J. (1984). *Hospital corporate leadership: The board and chief executive officer relationship*. Chicago: American Hospital Publishing.

Umbdenstock, R.J., Hageman, W.M., and Bader, B.S. (1986). *Improving & evaluating board performance*. Rockville, Maryland: Bader & Associates.

Umbdenstock, R.J. (1987). *The future of healthcare: Changes and choices*. Chicago: Arthur Andersen & Co., American College of Healthcare Executives.

Umbdenstock, R.J. (1989). *Focus on the future of hospital-physician relations: Implications for hospital governance*. Chicago: Hospital Research and Educational Trust, 1989.

Umbdenstock, R.J., Hageman, W.M., and Amundson, B. (1990, Winter). The five critical areas for effective governance or not-for-profit hospitals. *Hospital & Health Services Administration*, 35(4), 481-492.

Umbdenstock, R.J. (1990). *Hospitals and physicians in the year 2000*. Chicago: Hospital Research and Educational Trust.

Umbdenstock, R.J. (1991). *The future of healthcare: Physician and hospital relationships*. Chicago: Arthur Andersen & Co., American College of Healthcare Executives.

Umbdenstock, R.J., and Hageman, W.M. (Eds.). (1991). *Critical readings for hospital trustees*. Chicago: American Hospital Publishing.

Umbdenstock, R.J. (1992). *So you're on the hospital board* (4th ed.). Chicago: American Hospital Publishing.

Umbdenstock, R.J. (1993). *Trustees and the integration of community health care*. Chicago: Hospital Research and Educational Trust.

Umbdenstock, R.J. (2013, May/June). Equity in care: Picking up the pace. *Journal of Healthcare Management*, 58(3), 165-167.

INDEX

- Abbinanti, Aggie, 24
Ahnén, Steve, 37
Allen, George B., 11, 46, 51
Allen, Lisa, 37
Allen, Steve Jr., M.D., 10
American College of Hospital Administrators, 15
American Hospital Association
 annual meeting, 23, 39
 Board of Trustees, 22
 Board retreat, 22, 23
 Committee on Hospital Governing Boards, 12, 14
 Health for Life, 29
 Long Range Policy Committee, 22
 Programs for Hospital Governing Boards, 13
 Regional Advisory Boards, 39
 Regional Policy Boards, 38
 Arthur Andersen, 15
 Association of Governing Boards of Universities and Colleges, 16
 Bays, Karl D., 51
 Bergstrom, George F., 24
 Berman, Henry, M.D., 47
 Berwick, Donald M., M.D., 50
 Bisbee, Gerald F., Jr., 15
 Bonilla, Brother James, 6

Bowen, Deborah J., 50
 Brown, Madison B., 12
 Bush, George W., 43
 Capital financing, 20
 Cassell, Christine K., M.D., 50
 Catholic Health Association of the United States, 29
 Catholic Health Initiatives, 23
 Chassin, Mark R., M.D., 50
 Cheswick Center, 16, 19, 26, 29
 Clancy, Carolyn, M.D., 50
 Claver, Sister Peter, 13
 Coalition to Transform Advanced Care, 44
 Communities of Excellence 2026, 45
 Crosby Fellowship, 15
 Dauner, C. Duane, 47
 Davidson, Charles, 6
 Davidson, Richard J., 22, 23, 29, 37, 42, 44
 Dolan, Thomas C., 50
 Donovan, Robert J., 24
 Dunaye, Thomas M., 9
 Ebola, 40
 Elcock, Joan, 24
 Enright, Michael, 9
 Fairfield University (Fairfield, Connecticut), 6, 7
 Federation of American Hospitals, 29
 Fisher, William L., 20
 Foster, Nancy E., 30
 Gates, Mary, 36
 Good Samaritan Hospital Medical Center (West Islip, New York), 4, 10
 Governing board, 16, 18, 19, 23, 27, 28, 30, 31, 32, 33, 34, 35, 36
 Greenawalt, Leo F., 21, 47
 Greenleaf, Robert K., 26
 Group Health Cooperative of Puget Sound (Seattle), 17
 Group Health Northwest, 17, 25, 47
 Guerin, Michael P., 24, 37
 Hageman, Winifred M., 14, 15, 16, 19
 Health insurance
 coverage, 27
 Health Reform Dialog, 43
 Health Research & Educational Trust, 30, 44
 Healthcare disparities, 44
 Holland, Sister M. Michelle, 18
 Hospital administration
 administrative residencies, 10
 Hospital Association of New York State (Albany, New York), 9, 10, 11, 46
 Hospital Quality Alliance, 24, 29
 Hospitals
 Catholic, 36
 Hospitals in Pursuit of Excellence, 40, 43
 Jesuele, Neil J., 24, 30, 37, 38
 Johnson, Spencer C., 47
 Joshi, Maulik S., 30
 Kahn, Charles N., III, 50
 Keehan, Sister Carol, 50
 Kellogg (William Keith) Foundation, 16
 Governing Board Mentor Program, 16
 Kirsh, Darrell G., M.D., 50
 Kruse, Lowell C., 45
 Leadership, 25, 36, 37, 39
 succession, 23
 Leahy, Gerald, 13
 Lofton, Kevin E., 23, 44
 Lorschach, Barbara Harness, 40
 Lovinger Goldblatt, Gail, 24
 Lynn, George F., 23, 42
 Mace, Ingrid, 15
 Malcolm Baldrige Quality Award, 45
 McCarthy, Carol M., 9, 39
 McMahan, John Alexander, 11, 12, 21, 25, 46, 51
 McNerney, Walter J., 50
 McTernan, Edmund J., 10
 Meadows, Becky, 37, 38
 Medical records
 computerization of, 41
 Medical staff
 hospital relations, 14, 32
 Mentoring, 16
 Mohr, George D., M.D., 12
 Mohr, Helen P., 12
 Mountz, Wade, 48
 Mudd, John O., 20
 Mueller, Robert K., 29
 Multihospital systems, 18, 19, 20, 41
 National Quality Forum, 24, 44
 Norling, Richard A., 45
 Nursing, education
 diploma schools, 3

Nygren, David, 19
 Obama, Barack, 43
 Osterman, Vicki, 11, 46
 Parker, Joseph A., 47
 Passett, Barry A., 44
 Patient Protection and Affordable Care Act,
 29, 39, 44
 Peterson, Edward J., 10
 Pollack, Richard J., 29, 37, 38, 42
 Porter, Karen, 47
 Premier, Inc., 19, 20, 38, 39
 Priselac, Thomas M., 43
 Providence Health & Services, 24
 Providence Services (Spokane, Washington),
 7, 18, 19, 20, 21, 36, 38, 39, 40, 41
 Pryga, Ellen, 24
 Quality of health care, 25, 40
 assessment, 29, 40
 Redefining the H, 40, 41
 Robinson, William T., 7, 13
 Sacred Heart Medical Center (Spokane,
 Washington), 13, 14, 18, 20
 Scanlan, Carolyn, 47
 Scott, Shami, 37, 38
 Sebelius, Kathleen, 50
 Shallew, Helen, 3
 Shallew, Vincent, 3
 Sherrill, Henry W., 26
 Sisters of Providence, 13, 18, 19, 36, 51
 Southside Hospital (Bay Shore, New York), 4
 State Hospital Association Executives Forum
 (SHAEF), 11
 State University of New York at Stony Brook,
 7, 9, 10
 Sullivan, Brother James, 6
 The Joint Commission, 30
 Town and gown, 14
Trustee (magazine), 16
 Trustee Education Project, 16
 U.S. Congress
 Senate, 29
 Umbdenstock, Barbara Mohr, 11, 12, 15, 41,
 45, 46, 51
 Umbdenstock, Eileen Shallew, 1, 2, 3, 4, 5
 Umbdenstock, James B., 1, 2, 5
 Umbdenstock, John, 2
 Umbdenstock, Jules, 3
 Umbdenstock, Peter A., 1, 5, 8
 Umbdenstock, Robert P., 1, 5, 8
 Umbdenstock, Robert R., 1, 2, 3, 4, 5, 10
 University of Washington, 16
 Warden, Gail L., 17, 21, 47, 54
 Washington State Hospital Association, 21
 Williams, Ollie, 11
 Woods, Eugene A., 44