COMPASS

CLINICAL CONSULTING℠

PROFILES IN HEALTHCARE LEADERSHIP

An Interview with Jim Anderson

Chief Executive Officer, 1996 - 2010

Cincinnati Children's Hospital Medical Center

Key Lessons for Hospital Leaders:

1. Our most successful efforts have been tied to doing what's right for the patients—getting to zero defects. If you set a goal at zero, it changes your aspirational framework.

2. A hospital's strategic plan must involve widespread participation by the care-giving community, trustees, hospital executives, physicians and staff. Once agreed upon, it requires persistence to stay the course.

3. Communications among hospital executives, physicians and family must be transparent. Open recognition of mistakes leads to better care and actually reduces the potential for negative legal action.

Compass Clinical Consulting's "Profiles in Healthcare Leadership"

Interviews with transformational leaders in today's healthcare industry—men and women all of whom have demonstrated courage, ingenuity and the hard work needed to create dramatic, measurable and sustainable improvements in healthcare. They challenge assumptions, see things differently and create remarkable breakthroughs. These leaders freely pass on insights that all of us can use to improve the way we deliver healthcare and, in the process, give us new ideas on how to make better American hospitals.

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An Obviously Non-Obvious Leadership Choice

Cincinnati Children's Hospital was founded in 1883, beginning a storied history and commitment to improving the health of children in Southwest Ohio—and later, globally.

William K. Schubert, MD, took over as Chief Executive Officer in 1983, after serving on the medical staff for 20 years, and led the hospital's growth through to 1996. By then, Cincinnati Children's Hospital Medical Center (CCHMC) had grown to 3,500 employees, 365,000 yearly patient encounters and $453 million in revenue.

When Dr. Schubert retired in 1996, the Board began looking for a new CEO to build on past success and accelerate even further the hospital's transformation into a higher ranking among the nation's top pediatric medical centers.

The safe, obvious selection for CEO traditionally would have been a candidate with extensive hospital administration training and long-term proven leadership experience. But the CCHMC Board didn't do the obvious. In fact, they did just the opposite.

The Board selected a lifelong lawyer with a manufacturing executive background—Mr. James M. Anderson (Jim)—giving him the responsibility of turning a very good hospital into one that could be by any measure considered a great hospital.

When Jim retired at the end of 2009, CCHMC had grown to over 11,000 employees, 925,000 yearly patient encounters and $1.6 billion in revenue. National Institutes of Health (NIH) research grants grew from less than $20 million in fiscal 1996 to $101 million in fiscal 2008, ranking it second among all pediatric hospitals in NIH funding. For each year of the past decade, CCHMC saw a 15 percent growth in revenue and 750 net new employees. The total economic impact on the greater Cincinnati community was $2.72 billion in fiscal 2007—a 78 percent increase over 2002.[1]

CCHMC is also one of 10 children's hospitals in the United States to make the Honor Roll in the 2009-10 *U.S. News and World Report "Americas Best Children's Hospitals"* issue. Now one of the three largest children's hospitals in the U.S., CCHMC is affiliated with the University of Cincinnati College of Medicine. And, in June 2009, President Barack Obama cited CCHMC as an "island of excellence" in healthcare.

The Interview

Compass Clinical Consulting (Compass or CCC) has had a long relationship serving CCHMC—and the firm takes great pride in being among Jim's many trusted advisors. Kate Fenner, Chief Executive Officer of Compass, sat down with Jim to find out—in his own words—how he views the role of a senior hospital leader and to discover insights that we could share with the healthcare community that would lead to better American hospitals.

We came to the interview with a set of discussion-point questions to ask Jim; the first led to his core beliefs about the role of a CEO in today's complex business of delivering safe, quality, cost-effective healthcare.

A Hospital is a Place of Healing and Business

Kate Fenner, Compass Clinical Consulting (CCC): *Jim, can you give us an example of bringing a business mindset into a hospital environment and how you helped create a culture that balanced and embraced the concept?*

Jim Anderson, Retired CEO of CCHMC (JA): Our hospital had made many advances in caring for the children of Cincinnati and surrounding states. We all wanted to accelerate the work that had been done in previous years so that this place could become a national leader in improving health for children. But, the hospital was also a business. It had to have all the qualities that other great busi

nesses have if it was going to deliver on its aspirational mission for children. Being a business and being a hospital do not have to be at odds with one another.

By viewing CCHMC as a business, I did not mean that it had to be run by the numbers so much as I believed it should have the underlying characteristics that business leaders bring to their organizations. If we did this properly, it would set up an environment in which we all could make better decisions, we could take the right risks, we could support the priorities of our incredibly talented medical staff – and in the process we would have the necessary financial stability to serve patients and their parents and to innovate new ways to heal. Some of our approaches surprised even us.

I felt all along that senior leaders in any business had to be open to input from everyone in the organization. That means creating a culture of openness. That's the reason so many people stop our senior leaders in the halls, on the streets or in the elevator—to talk. And not only doctors or nurses. Any patient, family member or employee at CCHMC can, and does, stop to tell us what is on their mind. We give them our time and attention to listen. Really listen.

I wanted to set the example for everyone serving at CCHMC so that we would collectively exude a missionary zest and zeal about our vision to "*be the leader in improving child health*." We wanted to deliver the best outcomes, patient and family experience and value. I insisted on a business strategy emphasizing the "pursuit of perfect care" with zero-defect goals. This mentality has spread into our entire culture, and this "business attribute" has saved many children's lives, and has led to incredible healthcare advancements and improvements in child health.

Embrace the Negative to Build the Positive

CCC: *Moving to a culture of openness and perfect care delivery was a tall order that required building mutual trust between hospital executives, the staff and employees. How did you create and build that level of trust?*

JA: Let me share the example of an employee who recently stopped me for an impromptu discussion in the first-floor cafeteria. This was not just any workplace discussion. It was a discussion with a nutritionist who had just cost the hospital several million dollars in a legal settlement. I was getting a salad in the cafeteria when this nutritionist stopped me. She said, "There's something I just want you to know. This institution really walks the walk."

She had been involved in an incident where the hospital settled a claim for several million dollars. We had made a mistake. The nutritionist was the one that uncovered it and brought it to public attention.

The nutritionist continued, "There was never any hesitation or lack of support from the institution or leadership for my reporting the incident. In fact, the hospital leadership engaged with me in trying to fully understand how the event happened so we could fix it in the future."

She just wanted to thank me personally and to reassure me from the workforce trenches that our institutional credibility about genuinely caring was real. We need to know when bad things happen so we can fix them so they wouldn't happen again. As a result, our efforts to partner effectively and compassionately with parents that suffer the consequences of unfortunate events really are working. It's widespread and there continues to be nothing other than a transparent openness to constantly get better.

I thanked her and told her how much we counted on her courage to do exactly what she did, and that the only way we were going to keep getting better was for people like her to step up and help us fix problems. Frankness, credibility and transparency are absolutely essential to what we do. These are business attributes that are not common in many healing organizations; transparency and openness in a legalistic society can be costly.

The nutritionist was obviously worried about the money and

of settlement costs. I told her it wouldn't matter. What really mattered was that we didn't do it again. Out of this experience, we put together processes and systems to prevent the same mistake from ever happening again. That couple million dollars in cost was an investment in delivering the best child healthcare in the future.

Creating an Entrepreneurial Healthcare Organization

CCC: *When you took the job of CEO at Cincinnati Children's, you came with a stated focus of creating an entrepreneurial healthcare organization—one willing to take risks and invest resources to achieve big goals—and that's been one of the main reasons for its success. How did you create an entrepreneurially focused hospital organization?*

JA: The key is aligning the workforce and leadership behind a vision. Our vision is simple: *Be the leader in improving child health*. It is aspirational. Every day, it pulls us toward getting better at delivering perfect care.

All of us have to be invested in creating better outcomes, experience and value to deliver on the vision. Unlocking the energy of the workforce is the only way to really make it happen. It's not easy, of course. You have to communicate the vision in a manner that's easily understandable. It also needs to be inspirational enough to get everyone onboard. Not just doctors or nurses, but everyone from Housecleaning to Facilities Management, Human Resources, Legal and so forth. You have to invest your institutional resources in it. Prove it. Believe it. Live it. And then celebrate it when stories like the nutritionist related arise.

I came here in part because I viewed CCHMC as an organization that had a lot of growth potential that it wasn't yet tapping. That was my belief. Remember, I was on the Board for 20 years. I like being part of a growth business. That's what I did when practicing law and I felt we could accomplish aggressive growth here; growth that would fuel the addition of talent and facilities to serve children and their parents more effectively.

Workforce and Leadership Alignment

CCC: *As clinical consultants, one of the most difficult things we watch hospital leaders struggle with is senior team alignment. Getting a lot of very strong-willed personalities headed in the same direction is a challenge. How do you do it?*

JA: It's hard to do and takes time. I think the key ingredient is a strategic plan that involves widespread participation by the caregiving community, trustees and hospital business executives. You need to define what's important to the institution on a strategic level. Then you go through an elaborate and comprehensive research process that may take six to nine months to focus those goals.

These goals then need to be supported by metrics that clarify how to measure the potential success of each proposal. With that understanding and through discussion about where you want to go, you begin to map out action plans to get there. You start with a broad consensus, although it's at a very high level. It's got as much data as you can pull together to support it. Then you go to work on making it happen. The institution has to invest resources—intellectual, financial, equipment, facilities—and other assets to make it happen.

The process must be data-driven, communicated to everyone, supported everywhere and be seen as a long-term commitment.

If you achieve these basics, it's simply a matter of persistence and insistence on making progress on those fronts. Communications about priorities and results must be transparent. This prevents hidden objectives and bad decisions. Then you have to just keep pushing. It's hard work.

If you truly believe in becoming the leader in improving child health, it will become apparent to all that the organization can be both a hospital and a business. In fact, the blending of the two will make the potential for perfection in healing even more likely.

Another challenge for management is changing mindsets and habits. We are dealing with well-trained medical professionals who are busy and protect their time with a vengeance. One way they do this is to stick with well-implanted habits. The leadership is generally not young and flexible either, so you have two entrenched groups that want to keep on doing things as they always have been doing them. Persuading people to change a habit that they learned in medical school and practiced for their entire careers can be challenging.

The Extraordinary Commitment of Patient and Family-Centered Care

CCC: *In the well-known report on "Pursuing Perfection: Improving Family-Centered Care for Cystic Fibrosis Patients,"[2] you directly confronted CCHMC's fairly average record of treating this disease and then did some extraordinary things to fix the problem. To us, this was a wonderful example of how you were improving care by encouraging a culture of transparent openness. Being a corporate lawyer and CEO for 24 years prior to coming to CCHMC, did you have reservations about this openness, this possible risk? Can you share the inside story behind this transformation?*

JA: When you try anything new, there are always risks. Always worries. The experience could end badly—but it could also end wonderfully. Innovation and transformation require risk—and not just risk-oriented thinking, but also well planned action and execution. I came to the conclusion that transparency was truly an essential aspect of patient and family-centered care—a new ideal to strive for. That the cystic fibrosis (CF) project by the way, was not painless. There was pushback. But we plunged forward with the belief that we were doing the right thing.

First, we exposed the situation and the data at a meeting of patients and patient family members. Our team revealed that we were not one of the top hospitals for the treatment of CF. At the time we did this, sharing data that suggested under-

performance was not common at most hospitals. There was too large a threat for legal action. But because we were encouraging a culture that honored transparency, we got the families and patients involved in fixing the problem, even asking the patients and families how they perceived our level of care.

Once we put the issue on the table, our team came up with a set of promises to the patients and their family members:

- We will preserve your child's lung function better than any other organization.
- We will get the care you need regardless of race, age, gender, education or ability to pay.
- We will protect your child from harm related to our care.
- We will allow you, as parents, to be involved in the care as much as you desire.
- We will respect and value your time.
- We will optimize your child's nutritional status.

This type of commitment and transparency is extraordinary—some might even say risky. But the results were spectacular:

- The percentage of cystic Fibrosis (CF) patients under the 10th percentile for weight dropped from more than 40 percent to less than 25 percent.
- More than 95 percent of patients received flu vaccines that first winter, compared to an estimated 40 percent prior to the new program.
- Compared with less than 50 percent in the three years prior, 85 percent of the patients now receive a quarterly respiratory culture.

CCC: *As I recall, a conflict arose with one of your most experienced CF doctors. He thought his method of treatment was the best, but the results didn't support that. How do you handle it*

when one of your very best and most experienced doctors tells you he's doing the best they can, and it can't be done any better?

JA: You handle it with compassion—and persistence. Our doctor had been practicing for 30 years and truly believed his methodology was the best. He stuck by this belief until the fourth or fifth data set from that project validated a different approach. While he was convinced that he was producing good outcomes, the metrics convinced him that the outcomes could be better. At first, the doctor believed the metrics were wrong. It's a matter of professional respect to get the metrics right. The numbers have to support the actions—the treatments and the results. Eventually, we all have to follow what the numbers indicate; at the end of the day costs count.

If we are going to be data-driven, our organization must be supremely capable of generating good data. We have PhD statisticians who compile, analyze and review the data so that when they sit down with the doctors, the conversation moves very quickly to the quality of the data. You need credible data when you have difficult conversations about medical protocols. The data must be at a level that is appropriate and acceptable. Providing good data is one of the ways CCHMC supports our medical staff, our patients and their families.

The CF doctor was almost in tears when he finally realized that what he had been doing for decades was really only putting us in the 20th percentile. And, you know, it was crushing. I mean it would have been to me, it would have been to you or all of us. After confronting the story the data told, he said, "Well, I need to do things differently." We did. And the results changed dramatically. Now we're in the top 10% of all CF hospitals. And despite this improvement, we're still not happy. We want perfection. Getting better relies on having solid, data-driven process improvement that ultimately impacts our medical protocols.

Creating Breakthroughs

CCC: *Was this reversal in how you treat cystic fibrosis an exception or a pattern?*

JA: CF was not an exception. We have many examples where openness of data and outcomes results have made us a better medical center. For example, we took a deep look at Central Venous Catheter-related (CVC) bloodstream infections. The generally accepted and historical norm among physicians had been in the 4.1 to 4.5 per 1,000 catheter days. In 2006, we put together a quality-improvement team to reduce the number of CVC-related bloodstream infections from an average of 4.2 per 1,000 catheter days to less than 1.0.

We were able to execute a series of needed changes on a very consistent basis to reduce that rate. For example, an insertion checklist was created and is followed to assure that no step is missed during the process. The staff is empowered to stop the procedure if sterility is not maintained—nothing extremely complicated there. Then we tracked, measured and analyzed the data.

We focused and consistently executed the changes over time. Our rates dropped from over 4.2 to 0.71.[3] It was absolutely stunning—a superb breakthrough.

There's a tactical level and a strategic level to this, of course. At the strategic level, you need to execute an adequate number of procedures to have enough data to validate successes and breakthroughs. Then people come to believe breakthroughs are actually possible. Over time, if you have enough success—which is, in my view, fairly easy to do—people begin to imagine delivering perfect care, which is our goal.

Don't Ever Say, "Bad Stuff Just Happens"—Not Here

CCC: *You talk a lot about perfect care. We're all familiar with zero-defect models in the manufacturing world. But healthcare is so complex, I can see where you would be met with skepticism. Can you talk about your zero-defect goals? What can other hospital CEOs learn from your approach to altering a hospital's culture?*

JA: As a lawyer, I started out with a great and profound disbelief that you could provide perfect care. I changed, because I came to believe that systems and processes could be put in place to deliver perfect care.

Years ago, I was having a conversation with our then Chief of Staff. We were talking about cases that went badly and he said, "Sometimes, this stuff just happens."

Something just clicked in my head and I told him, "Don't say that to me again. When kids and parents are here, they're in our care and what happens is our responsibility. It doesn't 'just happen.' It's not an acceptable excuse and don't ever say it to me. Don't say it to anybody else, either."

That conversation helped us aim in a different direction, with a different mindset toward perfect care—zero-defect goals. How do we get at it? How do we improve? How can others do the same thing? One way is to impress upon clinicians that we will support and invest in whatever they need to provide the best care possible to get the metric down to zero.

Zero-defect goals are set for serious safety events like death from medication error or any life-threatening medical error. We're inflexible about it. This can lead to quick and beneficial change.

For example, we put together a multi-disciplinary team to pursue a systemic analysis of what we did with kids while on ventilators and how we might improve our treatment to prevent an infection that gives rise to pneumonia. It's called Ventilator-Associated

Pneumonia (VAP) and is the leading cause of morbidity in adult ICUs and the second most common hospital-acquired infection in pediatric ICUs nationally. Published literature documents that VAP occurs in about five percent of mechanically ventilated children, and of those children who acquire VAP in the hospital, almost 20 percent die.

Almost 20 percent die.

Our VAP quality improvement project was a collaborative improvement effort among pediatric, cardiac and newborn ICUs, and was comprised of 99 beds.[4] The improvement team included respiratory therapists plus doctors, nurses, infection control and quality improvement staff. It also involved intensive care doctors, and they were the most vocal skeptics of the project when it started. They said, "We'll do it, because that's what we do, care for kids. But don't expect any real change."

It was startling to see how quickly outcomes improved. When we went through the six-month process and looked at the data set, you could see it was continually improving—and dramatically so. Our starting point was approximately 80 ventilator-associated pneumonia cases per year. Couple that with the 20% mortality rate and that meant 16 kids who would die. We cut that to zero. And now we're at 0.5 cases per 1,000 ventilator days. As it turned out, some of the things our staff did were really quite simple, like placing the head of the bed at a 30-degree angle, which prevented a fluid build-up in the lungs. Innovation doesn't always have to be complicated. It can be simple. That process change saved lives.

That's a pretty powerful motivator for anyone. The doctors were just sort of shaking their heads, amazed. Everyone involved celebrated the outcome. There is power in changing mindsets by setting your goal of serious events to zero. No matter what your current results are, you need to have the mindset that they can be improved.

Remember what I said about investing in whatever the medical team needs to provide the best care and get the metric down to

zero? That helps change mindsets too. But, it needs to be communicated clearly without financial jargon. You don't want clinicians to think in terms of financial returns. No longer do we talk about taking out costs and maximizing efficiencies. That kind of talk makes the eyes gloss over. Eliminate it, so they're not thinking, "Should I take care of this child so that it maximizes profitability?" The mindset has to be taking care of the child to deliver the best quality outcome. Our most successful efforts have all been tied to doing what's right for the kids, getting to zero defects. When we do that, we've found that profitability and financial returns take care of themselves.

Now, the interesting dynamic of this turns out to be that when a new process or quality improvement project is initiated, everybody really dives into it. It's a successful, positive experience for everyone. That's just one example of many.

Process vs. People

CCC: *Setting your goal at zero has a lot of different and difficult implications. How many deaths are acceptable?*

JA: Yes. Exactly. Which parents are you approaching to say, "Your kid will die?" Think about that. What if it were your child? If you set a goal at zero, it changes your aspirational framework. Honestly, if you set a goal at anything other than zero, then you have to try to figure out which cases of ventilator-associated pneumonia are okay.

Having the institutional courage to set very high aspirational goals removes all of those emotional conflicts. It removes all thinking that "it's okay that bad things happen." You can focus all of your thoughts on how you can make good things happen, how you achieve zero-defect goals. It has a very salutatory effect.

CCC: *When you do have defects, serious events, how do you remove the natural tendency to hunt for the person who made the mistake? How did you create a blame-free, yet error-finding environment?*

JA: An important element is to create an institutional response that is "process-oriented" and not "person-oriented." An event might be one in which a patient was harmed, or it might be one where the outcome was different from expectations.

We typically assemble a team of five people (a lawyer, the Chief of Staff, someone from Human Resources, a doctor and a nurse) who are very senior, non-hysterical types and who are also very well-known to the clinicians, so that they have confidence in the objectivity and competence of the process.

The group is run by the lawyer, because while they don't have medical credentials, lawyers are experts at running objective processes. Also, because they are removed from the event, lawyers do not have that automatic defensive mechanism with regard to outcomes. They debrief and gather facts. It's purely a fact-gathering process—the "who, what, why, where, when and how." Then the group reviews the medical records and assembles all of the documents related to incident.

The next step is the root-cause analysis, which leads to a list of causative factors. The next step is to analyze how to change the system so the causes never occur again. Those changes are identified, documented and implemented. We follow up to make sure the changes have been made, and a year later we go back to make sure they have been sustained.

The key is to take the emotion out of the analysis. Get it into a dispassionate, objective process, and it will be fixed—and done well.

Transparency Is Difficult—But It Works

CCC: *A lot of organizations have devoted considerable resources to the quality-improvement philosophy. But you're the only one I know that leads it with lawyers. I see some distinct advantages that I've never thought of before. One, of course, is the business of shielding the objectivity and legitimacy of the process with a "just the facts" mentality.*

JA: Yes, but don't think the lawyers are always happy about it. We also ask them to do some things that are in direct conflict with what they may have learned coming up the ranks through law school. In fact, we often have them do the opposite of what they were trained for, like engaging with the family within hours of the event, and telling them everything we know.

Transparency is difficult. It can be painful. But it's right. You know what we find? The more we invest in the "right" of the event and openness with the family, the better quality gets, the better experience the family has, and our legal fees go down. It's counter-intuitive, but it works.

CCC: *The impressive piece of this is that you get somebody who's trained to look at things a certain way to view them differently. Law school education is a rigid discipline. And because you bring in someone who doesn't have a clinical bias—a lawyer, or one who isn't going to say "we've always had ventilator infections"—it allows you to get to the crux of the problem much quicker and with total objectivity.*

JA: We've been stung badly in the past. We'd end up battling it out with the family when they thought we were wrong. This was when our Chief of Staff was the one who was reaching the conclusions about whether we did something wrong. This type of self-judging led to battles with families, not to fixing a broken process.

Now, we abide by the process, and it works. Even if it's a minor event, we provide the families with all the facts and information as soon as possible. We'll tell them to think about it, come back, and we'll talk more with them. If they want to get a lawyer, that's not only okay, it's good if in the end we are doing the right thing.

CCC: *Did you just say that?*

JA: Yes (with a chuckle). We'll help them find a lawyer if they want. We try to partner with families to help them understand the whole situation. That's something we believe in—engaging fami

lies and patients, using this system of openness, embracing the negative, partnering with the family to resolve the situation, even helping them find a lawyer. What we've found is unquestionable; our legal bills have dropped dramatically both in terms of the cost of ongoing legal processes and the cost of litigation.

It's another positive indicator that the institution is sincere when it says it's interested in the patients and families first. Even when bad things happen, instead of shutting down and suddenly going from caregiver to adversary, we continue to be caregivers. The families are enormously appreciative.

CCC: *You brought process-oriented experiences and systems from manufacturing to this hospital. Was that hard for some of the doctors to accept—that you're not focusing on people but you're focusing on the process? How can focusing on the "process" rather than the individual result in better patient outcomes, experiences and value? It seems almost contrary to typical healthcare thinking.*

JA: The processes and systems deliver the care. This is not a new idea; it's certainly not unique to me. But one of the major components of delivering quality is focusing on the systems. Healthcare is largely system-delivered as opposed to individually-delivered, and if the systems work, you can deliver perfect healthcare.

Of course, the individual's role is to monitor and modify what the system does. But if the system is the primary driver, it will produce reliably excellent care. The reason we dropped ventilator-associated pneumonia cases is because the system we developed drove out variance.

It's really standard manufacturing statistical process-control thinking. And as you get more standardized components working together in a predictable and reliable system, you'll get predictable and reliable results—which should be zero defects. And, that can

Fresh Eyes – Different Perspectives

CCC: *In what circumstances do you bring in specialized, external healthcare consultants, like Compass Clinical Consulting, to help your hospital organization?*

JA: Many circumstances could cause us to bring in consultants, for example, whenever we need their unique expertise, or to offer a fresh set of eyes or a different perspective on a complicated problem. We could bring them in to help us implement quality improvement projects. Because, like I said earlier, it's the systems that deliver the care. Highly skilled and professional consultants will have specialized systems experiences that can either troubleshoot a process problem or even create an entirely new set of processes and systems to help us deliver on our goal of being the leader in improving child health.

Epilogue: The True Measure

It's a commonly accepted adage that in the end, the true measure of a great leader is results. In all measures, the hospital's success and growth under Jim Anderson's visionary and entrepreneurial leadership has been extraordinary. The transformation of CCHMC to an internationally recognized leader in improving child health can only be described in terms that would most often be considered hyperbole—stunning, astounding and unparalleled. But put into context with the leadership that, first, Dr. Schubert and then Jim Anderson accomplished, the terms could be considered understated.

When you mention CCHMC's impressive growth, Jim Anderson's response is instant. "Our strategy has never been to grow. Our strategy and promise is to *be the leader in improving child health*. Growth follows only after we deliver on that promise."

Jim Anderson retired from Cincinnati Children's Hospital on December 31, 2009. He left behind an impressive legacy of insti

tutional growth and improvement. But he also took with him a living legacy of children whose lives have been saved, touched and improved by his courageous and transformational leadership.

Because he fully realized that the new CEO, Michael Fisher, deserved the same chance to bring a new level of reform and transformation to this successful pediatric center, Jim resigned from the Board and every CCHMC committee. Every CEO stamps his or her imprimatur on the organization. Jim did. Michael will.

About James Anderson, CREDENTIALS?

James Anderson was President and Chief Executive Officer of Cincinnati Children's Hospital Medical Center from 1996 to 2010. He has been instrumental in shaping the extraordinary growth at the medical center over recent years.

His appointment as President and CEO followed 20 years of service to the Cincinnati Children's Board of Trustees, including four years as chairman, as well as involvement on the Executive, Finance, Investment, Compensation, Personnel and Nominating committees.

Prior to joining the staff of Cincinnati Children's, Mr. Anderson was a partner in the general corporate department at Taft, Stettinius & Hollister for 24 years (1968-1977;1982-96) and president of U.S. operations at Xomox Corporation (1977-82), a publicly traded manufacturer of specialty process controls.

Mr. Anderson is a graduate of Yale University (1963) and Vanderbilt School of Law (1966). He was a captain in the U.S. Army (1966-68) and spent a year in Vietnam with the First Infantry Division, becoming a decorated veteran.

About Kate Fenner, RN, PhD

Kate Fenner understands how hospitals work. First as a nurse, and later as an education leader and consultant, she has the ability to problem-solve and communicate at all levels of an organization – from staff members to Board members. As Chief Executive Officer of Compass Clinical Consulting, she uses this talent to help clients meet their clinical and cultural goals. Kate obtained her doctorate in Ethics and Law in Healthcare, and also holds a Master's degree in nursing.

In addition to her numerous national speaking engagements and papers, Kate has authored a leading college text in law and ethics in healthcare, was senior author of Aspen's Manual of Nursing Recruitment and Retention, and with Richard Coffey & Sheryl Stogis co-authored the Jossey-Bass text, Virtually Integrated Health Systems: A Guide to Assessing Organizational Readiness and Strategic Partners. Dr. Fenner can be reached via email at KFenner@compassgroupinc.com.

About Cincinnati Children's

Cincinnati Children's Hospital Medical Center is one of 10 children's hospitals in the United States to make the Honor Roll in the 2009-10 U.S. News and World Report "Americas Best Children's Hospitals" issue. It is #1 ranked for digestive disorders and is also highly ranked for its expertise in respiratory diseases, cancer, neonatal care, heart care, neurosurgery, diabetes, orthopedics, kidney disorders and urology. One of the three largest children's hospitals in the U.S., Cincinnati Children's is affiliated with the University of Cincinnati College of Medicine and is one of the top two recipients of pediatric research grants from the National Institutes of Health.

About Compass Clinical Consulting

Compass Clinical Consulting (Compass) has been caring for hospitals for over three decades so that providers can deliver efficient, effective care to patients. We have walked miles of hallways at hundreds of hospitals. We bring experienced eyes that have seen just about every kind of issue possible. We have achieved remarkable results, working in close collaboration with our clients. Compass assists leaders of hospitals in reducing the cost of delivering safe, quality patient care through workforce planning and productivity, management of clinical departments, patient throughput and case management, executive leadership, board development, physician relations, accreditation and regulatory compliance (surveys, immediate jeopardy and CMS recertification.

Footnotes:

1. The Economic Impact of Children's Hospital Medical Center on Greater Cincinnati http://www.economicscenter.org/research/reports/economic-impact-childrens-hospital-medical-center-greater-cincinnati

2. Pursuing Perfection Report http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/ImprovementStories/PursuingPerfection-ReportfromCincinnatiChildrensImprovingFamilyCenteredCare.htm

3. Central Venous Catheter-Related (CVC) Bloodstream Infections http://www.cincinnatichildrens.org/about/measures/system/patient-quality/cvc.htm

4. The VAP initiative at Cincinnati Children's Hospital Medical Center http://www.cincinnatichildrens.org/about/measures/system/patient-quality/vaps.htm

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Profiles in Leadership

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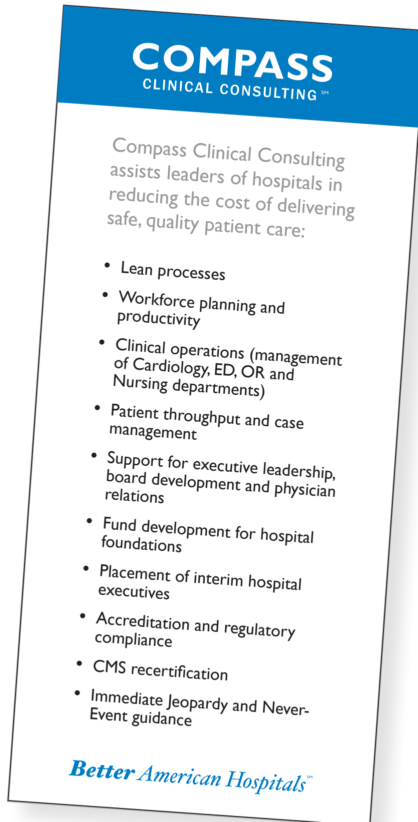

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