



TERI G. FONTENOT
In First Person: An Oral History

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**Interviewed by Kim M. Garber
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EDITED TRANSCRIPT
Virtual Interview from Baton Rouge, Louisiana

KIM GARBER: Today is Monday, September 28, 2020. My name is Kim Garber, and I'll be interviewing Teri Fontenot, who served for most of her career at Woman's Hospital in Baton Rouge, Louisiana, including 23 years as President and CEO. During her tenure, the hospital became the state leader in number of births and neonatal intensive care unit capacity. Ms. Fontenot was instrumental in building a total replacement hospital at Woman's that opened in 2012. Throughout her career, she has been committed to participating in professional associations, including serving as Chairman of the American Hospital Association Board of Trustees in 2012. Teri, it's great to have the opportunity to speak with you today.

TERI FONTENOT: Kim, it's an honor to be with you.

GARBER: Could you tell us a little bit about your family and your hometown?

FONTENOT: I was born and raised in Mississippi, the oldest of three. My parents were born and raised on farms in Alabama and Mississippi. My family was middle class and I had a stable, almost fairy tale-like childhood. We lived in Clinton, a small town outside of Jackson, Mississippi. I attended public school, met my high school sweetheart in the tenth grade, and we married the month after I graduated. Two years later, our first child was born, and two years after that, we separated. I realized then that I needed to get a college education to be able to support my two-year-old daughter.

GARBER: In college you studied accounting, including sitting for the CPA exam eventually. When you were in grade school and high school, were you drawn towards math and science?

FONTENOT: Not at all. I was an A and B student, but I took the easiest courses I could. I was more interested in being with friends, cheerleading and sports. The high school I attended did not offer business courses other than typing. I chose accounting as my major after working for H&R Block as a tax preparer and had to take Algebra I and other remedial math courses.

GARBER: Did you play team sports?

FONTENOT: When I was in middle school, I played basketball and was on a summer league team for softball. I was not good at either, but again, it was about socializing and being with my friends. Cheerleading wasn't considered a sport so we didn't have a sponsor or coach. We handled all of the scheduling for practice and camp, designed and ordered our uniforms, and choreographed our routines, so we learned leadership, organization, and how to work as a team. I was excited to be the co-captain of both my middle school and high school cheerleading teams.

GARBER: After high school and your marriage, you went on to the University of Mississippi, known as Ole Miss. How did you come to apply there?

FONTENOT: It was the closest university to my home. Since I was a commuter and needed to earn my degree as quickly as possible, I took 15 to 18 hours each semester and attended in the summers. College was a different experience for me because I was not involved with sororities, Greek life, or any of the clubs or social activities that a college student would normally encounter. I had graduated from high school four years before I returned to college.

GARBER: What was the culture like at Ole Miss in the late '70s?

FONTENOT: In the Accounting Department, the culture was one of 'females don't belong here.' That was made clear to me early on by some Accounting professors. As a result, I questioned whether I was in the right major, even though I was doing well in my classes. There was only one female professor at Ole Miss in Accounting at that time, and she was married to a male professor who was teaching in the Accounting school, too. The older professors did not care for women being in Accounting, and two in particular overtly showed favoritism to the male students.

GARBER: We are recording this interview within a few days of the death of Supreme Court Justice Ruth Bader Ginsburg, who had the same experience when she went to law school. It is hard to believe that it was a relatively short time ago when there was that attitude on university campuses.

FONTENOT: The first time I sat for the CPA exam, only 10% of the people in the room were female. Interestingly, I didn't feel gender bias when I was interviewing for CPA positions. Accounting firms were more open to women, although the major accounting firms preferred younger students than me who did not have families and could travel.

GARBER: Where did you go to work after passing the CPA exam?

FONTENOT: I went to work at a local public accounting firm prior to passing the exam. There was an experience requirement in addition to passing the exam so graduates did not receive a license until both requirements were fulfilled. I was offered a position by Exxon but it would have required relocation to a city that I was unfamiliar with and because I was a single mother, I decided to stay where I had family support.

I didn't stay at the firm very long because the hours, particularly during tax season, were not conducive to the lifestyle of a single mother. I became the controller of a lumber and building supply cooperative company in Northeast Louisiana, which was where my parents had moved.

It was there that I got serious about becoming a CPA. I took graduate accounting courses to prepare for the exam because there were no CPA prep classes in Northeast Louisiana. I enrolled in what was then Northeast Louisiana University and by the time I passed the exam, I had two-thirds of the credits that I needed to get an MBA, so I finished course requirements for it. It took six years because in the mid-'80s, executive and off campus courses were not offered, only traditional schedules. I was taking one three-hour course night class a semester because I was also working fulltime and had a daughter. By then I had remarried and my second husband was supportive and extremely helpful.

GARBER: Is it usual that one takes the CPA exam and fails one or two times before passing?

FONTENOT: Students who sit for the exam upon graduation and take the electives that prepare them for the CPA exam do well. I didn't take any of the prep courses as an undergraduate. It took me three tries. The exam length was two and a half days and five parts. At that time, you could only take a pencil in with you and the math questions were complex. It was not unusual for someone to not pass all parts the first time. Once two parts were passed, you only took the parts that you had not passed. That's the way I did it. I got an MBA, which I had not planned to do. In retrospect, both were critical in getting my foot in the door, particularly as a CFO.

GARBER: How did you start working at St. Francis Medical Center in Monroe, La.?

FONTENOT: I was working at a lumber and building supply cooperative as their controller in West Monroe, La., and heard that the controller at the local hospital was leaving. I had never considered working in health care. In fact, I didn't realize that hospital administration was a profession. I didn't even know where the hospital was located. I had lived in that community for only a couple of years.

I was nervous about applying because it was a Catholic hospital and the administrator was a nun, and I wasn't Catholic. There were few Catholics in the Mississippi communities where I had lived. My husband was Catholic and had attended Catholic school in Southeast Louisiana. I said to him, "I've never even met a nun before. What do I do?" He said, "Don't curtsy and don't call her ma'am and you'll be fine."

Within a day of dropping off my resume, I was asked to come in and interview. Within a week, the administrator had made me an offer to be the Director of Fiscal Services of a 400-bed hospital. It was the highest-level financial position on the organizational chart.

The administrator was also an RN with an MBA. It was 1982 and she wanted to upgrade to a professional accounting staff. Prior to then, the staff were mostly bookkeepers because hospital reimbursement was based on cost. As long as the hospital could record its costs per the instructions on the cost report, Medicare would reimburse it. But the federal government had announced that reimbursement was shifting from a cost basis to a prospective payment system based on DRGs – diagnosis related groups.

That meant that the risk completely flipped to the provider because a specific payment would be made based on a specific diagnosis. As a result, there were many changes to be made operationally, but particularly financially.

She wanted a professional accounting staff with more sophisticated cost accounting knowledge who could be analytical and strategic. That's why she was interested in me. She said, "You've got the professional and educational credentials. I can teach you the health care part." She was wonderful to me and was my first mentor. She passed away a few years ago. Even after I left St. Francis, we stayed in touch. I'm grateful for her guidance and really loved her. I would not have had the career I did if it had not been for her.

GARBER: You've are speaking of Sister Anne Marie Twohig?

FONTENOT: Yes. Sister Anne Marie Twohig, from Ireland.¹ She and the Franciscan Missionaries of Our Lady from Calais, France, came to Louisiana in the early 1900s to establish St. Francis Medical Center in Monroe, La. They subsequently built Our Lady of the Lake Regional Medical Center, which is their flagship facility in Baton Rouge, and they now own several hospitals.

Sister Anne Marie had a calling to help vulnerable people struggling with issues that we now call social determinants of health. I saw her many times provide financial assistance to dietary and housekeeping staff and give them food from the cafeteria. She enjoyed visiting patients, worked with

¹Sister Anne Marie Twohig (1921-2007), from County Cork, Ireland, was a member of the Franciscan Missionaries of Our Lady. She served from 1979 until her retirement in 1992 as President & CEO of St. Francis Hospital in Monroe, Louisiana. [The Franciscan Missionaries of Our Lady. *The Sisters who served in the North American province.* <https://fmlhs.org/assets/documents/fmol-sisters-history.pdf>]

families in need, and would make generous adjustments to patient bills. She taught me about the human side of the business of health care, and that helped me greatly in my career. Her compassion for the vulnerable is the thing that I respect the most in terms of her leadership style.

I had the opportunity later to work in a for-profit system, but when I got there, I quickly realized that for-profit health care was not for me, even though I have a passion for the financial and business side of it.

Sister Anne Marie wasn't interested in being visible in the community. She lived on the hospital campus and was more internally focused. As she and I learned to work with each other, she asked me to start doing the external things – go to the Chamber of Commerce meetings, be on the local chapter of the American Heart Association board, represent St. Francis in speaking engagements. She preferred to be close to the patients and her staff, so she groomed me to be the external representative of the hospital.

GARBER: What a terrific opportunity for you as an early careerist to be out there making connections in the community. I'd like to follow up on something you touched on earlier. What makes a Catholic hospital a Catholic hospital?

FONTENOT: Faith is incorporated into everything that they do. I worked in three organizations that were not faith-based. Each of them had a spiritual component, but it was not as visible nor as high a priority as in a Catholic hospital. For example, management and board meetings opened and closed with prayer. At that time, in a Catholic hospital, nuns or priests would automatically visit you. In secular hospitals, you would be asked if you would like for a member of the clergy to visit.

There are certain procedures and other services that not be offered, such as reproductive and fertility services. When I was in Baton Rouge at Woman's Hospital, which is a community not-for-profit hospital, we worked very closely with Our Lady of the Lake Regional Medical Center, a Catholic hospital. They do not offer obstetric services so our service lines were very compatible. Woman's was the market leader in women's health care so between us, a full array of services was available.

GARBER: I'd like to jump back to the '60s – when Medicare was first implemented. This would have been when you were a teenager. Medicare, which was part of Lyndon Johnson's Great Society program, was instrumental in ending segregation in hospitals. Living in the South, did you encounter segregation?

FONTENOT: I remember going to the doctor's office and seeing signs for separate waiting rooms. I also remember water fountains and bathrooms at the zoo that were labeled, "White only" and "Colored only."

In the small town I where I went to grade school, there were separate schools for Black and White students. I don't know if the Blacks really wanted to go to school with the Whites, and the Whites knew that the Black school was there, but we didn't think or talk about it.

I was in the tenth grade, I believe, when four or five Black students came to our high school. I didn't really have any interaction with them and they kept to themselves. I don't recall that they were in my classes. It seemed like an uneventful transition but I'm sure they felt somewhat isolated. I don't know if they wanted to be there, or if this was something that their parents wanted for them, but I do now regret not making an effort to make them feel welcome.

GARBER: Do you have any evidence to draw upon to make comments as to what a segregated hospital was like?

FONTENOT: No, my first visit to a hospital was as a patient when my first child was born. I do remember that hospitals had wards or two beds in a room. Private rooms were uncommon and Medicare would not pay for them so a patient had to pay out of pocket if they wanted a private room.

Woman's Hospital was built in 1968 with all private rooms, which was unheard of, but the 21 OB/GYNs that envisioned and built the hospital never wanted a patient to share a room because of the intimate nature of obstetrics. It did not have anything to do with racial segregation.

GARBER: We were talking about a new job that you took at Southwest Florida Regional Medical Center in Fort Myers, Fla. You were telling me that this particular hospital was an investor-owned facility, and the owner at the time was Basic American Medical. How did this opportunity come about?

FONTENOT: I had been at St. Francis for about four years when I was contacted by a recruiter. I wasn't thinking about changing positions, but had determined that I really enjoyed health care administration and would like to be a CEO someday. At St. Francis Medical Center, the CEO had always been a nun. I felt that in order to become a CEO, I needed to go elsewhere.

The more I heard about the job from the recruiter, the more intriguing it became. Investor-owned hospitals were more focused on financial performance. Having an MBA and an accounting background, I was very interested in seeing how a business operates that prioritizes financial performance of provides health care services.

I had remarried and we had an infant. I was still working on my MBA, and my husband was with a national company that allowed him to transfer and establish a new territory. The transition seemed like it would be pretty easy. My older daughter was entering middle school, so it was a little traumatic for her, but she was also excited to be moving near the beach.

After just a few months, I realized that investor-owned health care was not something that I could be passionate about like I had been at St. Francis Medical Center in a not-for-profit or faith-based organization. I got homesick and we went back a year later when I was offered a position back in Louisiana.

Opelousas General Hospital in Louisiana was looking for a CFO. It was a public hospital – a regional referral center – in a rural area. This was a turnaround situation which I really enjoyed because I was able to draw on my financial skills. Eventually my duties were expanded to include the ancillary departments, physician contract negotiations and employee health benefits. In larger organizations, the CFO would be peripherally, but not directly, involved in these things.

My title never included "COO" at Opelousas General, but there was not a COO. The Chief Nurse Executive and I worked closely with the CEO as a triad for operations, finance and patient care.

I was there almost five years and would have been happy ending my career there because I really enjoyed the people. The quality of the services was great and it was a small town, similar to the one where I lived as a child.

GARBER: What did you learn during the nearly five years you were at Opelousas?

FONTENOT: One of the first things was that names matter! My husband had been born and raised about 20 miles away in Eunice, La. Fontenot is a very common name there and I was never asked to spell out my last name there.

Opelousas General was on the verge of making an offer to a CFO when they received my resume. I was told that we were equal in terms of experience and credentials, but because I would be accepted as a 'local', I had an edge. A newcomer in a small town can have challenges, especially if tough decisions need to be made, so timely acceptance is beneficial

Within the first two weeks, I quickly learned how dire the financial situation was when I encountered the gas company worker, who was there to turn off the gas to the hospital because of nonpayment. That was a new experience for me because both St. Francis Medical Center and Southwest Florida Regional Medical Center had been on solid financial footing. I was aware that the hospital was struggling but I didn't realize how bad it was until I got there. I was able to talk him out of turning the gas off to the hospital and got the past due bill paid. Apparently, there was no law against shutting off utilities at a hospital.

But the most important lesson was that what may seem like a bad decision or bad luck often will turn into something fateful and serendipitous. If I had not gone to Fort Myers and then to Opelousas General, I would have never ended up at Woman's Hospital in Baton Rouge.

GARBER: How did you come to be at Woman's Hospital?

FONTENOT: Vicki Romero Briggs² had been the CFO of Woman's Hospital, and she and I were active in the Louisiana chapter of HFMA (the Healthcare Financial Management Association) when I was at St. Francis Medical Center. We were about the same age, two of very few female CFOs, and had similar backgrounds – like having been raised in a small town. When she became CEO, she hired a colleague as CFO from out of the area but it didn't work out. She interviewed me, shared her vision and offered the position. Being female was not a factor because the previous CFO had been male, but Vicki does support advancement of women and has helped many women including me elevate their careers.

I was happy at Opelousas General and thought I could become the CEO there eventually. I enjoyed the small town. My husband had gone to LSU, though, so moving to Baton Rouge, where the main campus of the university is, was very appealing to him.

We had moved three times in ten years, and my older daughter was starting high school. I liked Vicki and she had said that the job would become more than CFO, that she envisioned an Office of the President. I felt that would be interesting as well.

We moved to Baton Rouge, 80 miles away, and I made a decision that my younger daughter, who was five at the time, was not going to change schools throughout her formative years, like her

² Vicki Romero Briggs served as CEO of Woman's Hospital (Baton Rouge, La.) from 1980 to 1996, subsequently leading other hospitals and serving as a consultant. [LinkedIn and UT Health East Texas names CEO for flagship facility. (2018, March 5). *KLTV*. <https://www.kltv.com/story/37648000/ut-health-east-texas-names-ceo-for-flagship-facility/>]

older sister had.

Four years into my tenure at Woman's, Vicki resigned. The board had been approached by Columbia and negotiated a sale,³ but the foundation, which is the ultimate governing body, voted it down. Vicki believed that remaining independent was not the right path for Woman's Hospital and that it would be vulnerable if it remained a freestanding hospital. To her credit, she decided that she didn't feel she was the right person to continue to lead it as an independent organization. I planned to leave with her. Columbia had offered us both jobs, and I was excited about continuing to work with her.

The board asked me to be the interim CEO. I declined because I felt like Vicki did about the future of Woman's as a free-standing hospital. The board and the medical staff leadership approached me again and said, "Tell us what we need to do in order to strengthen the balance sheet so that we can remain independent. We will support you." Ultimately, I accepted with assurances from the board and medical staff leadership that they would help me carry out some difficult actions including the first and only layoff in the history of Woman's. That's how I moved from CFO to CEO in 1996, after being there for four years as the CFO, the COO and the executive vice president.

I wouldn't call it a turnaround, but it was certainly a situation where the hospital was vulnerable because it had a 2% or 3% margin, its largest payer was Medicaid, and the state government budget, which funds Medicaid, was shrinking. This margin was not unusual in the early '90s. The for-profits started to expand, competition heated up, and commercial payers started negotiating rates with hospitals. The not-for-profits had not yet started to consolidate. At that time, physicians were also building their own hospitals and directing profitable procedures to their facilities.

GARBER: Was an office of the president ever formed?

FONTENOT: It was not labeled that but it was understood that Vicki and I worked closely. She and I became close friends and still are. We have daughters who are near the same age and took vacations together. I have a tremendous amount of respect for her. She was one of the first female nonreligious CEOs in Louisiana and taught me a lot. Until you are in that seat, you really don't know what it's like to be the CEO and president, particularly of an organization that is not part of a system, because the decisions and the responsibility start and stop with you. Our offices were next to each other, separated by an executive assistant. I went to most of her meetings. She kept me engaged. Our friendship was strengthened through our work to make Woman's an exceptional organization.

GARBER: Do you know of other hospitals that established an office of the president?

FONTENOT: I've heard of executive suites where executives are physically located next to each other and Woman's had an open architecture arrangement in the C-suite at the new hospital. There's a lot of multidisciplinary, collaborative work today, much more so than occurred in the '90s. I don't know that they call it the office of the president but they function the way Vicki and I did.

GARBER: What is a specialty hospital?

³ Columbia Healthcare Corporation had merged with Hospital Corporation of America in 1994 to form Columbia/HCA Healthcare Corporation. [Funding Universe. *HCA-The healthcare company history*. <http://www.fundinguniverse.com/company-histories/hca-the-healthcare-company-history/>]

FONTENOT: A specialty hospital focuses on a specific service line. General hospitals offer a broader variety of services and programs. Not all general hospitals offer everything, for example, Our Lady of the Lake in Baton Rouge does not provide obstetric and newborn care. Specialty hospitals are most commonly focused on women's health, cardiac care, orthopedics and pediatric services. There are also rehabilitation hospitals, behavioral health hospitals and long-term care hospitals. Although these hospitals have a narrow service line or product offering, they offer specialty and sub-specialty care that supports those specific service lines that general hospitals are often unable to provide.

What's nice about leading a specialty hospital is that it's easier to get the team focused on a mission and a vision that isn't as diverse as a general hospital. Capital allocation decisions are clearer. The cardiovascular surgery department is not competing with the lab, imaging or orthopedics for funding. In general hospitals, women's services typically have a very low margin so it's difficult to advocate for scarce resources.

Typically, specialty hospitals have much higher volume, which means that they will have more robust data. Often quality and outcomes are better because of the volume, expertise and experience, particularly among nursing and other caregivers. Subspecialty physician care is also often deeper.

Today, Woman's Hospital is the only not-for-profit, freestanding, independently owned women's hospital in the country, as far as we know. Twenty years ago, there were 12 to 15 of them – Brigham and Women's in Boston, Women and Infants in Rhode Island, Prentice Northwestern in Chicago, Winnie Palmer in Orlando, Sharp Mary Birch in San Diego – to name a few. All of them except Woman's Hospital in Baton Rouge have become part of systems.

GARBER: Do you think Woman's is going to remain independent?

FONTENOT: The reason that Woman's has been able to remain independent is because it continues to receive strong community and physician support. Most of the obstetricians in Baton Rouge only deliver at Woman's Hospital. Woman's has also been a wonderful community asset and corporate citizen – it's continued to provide wellness in women's services, prevention and quaternary medical care throughout the state. The women's hospitals that joined systems did not have enough strength in their market share and service offerings that they could negotiate managed care contracts that would allow them to remain viable.

Another unique aspect about women's services is that the largest payer is Medicaid. In Louisiana, as in most states, Medicaid does not pay at a level that covers the cost of care. You have to be able to negotiate non-government contracts that adequately offset the losses from Medicaid patients.

Those are the things that I think have allowed Woman's to be able to remain independent. As long as the medical staff is committed to supporting the hospital by referring their patients to Woman's, and as long as the community appreciates the high quality, exceptional care that they receive for women's and infants' services, in the short term, I think Woman's will be just fine.

Ten years from now, I don't know if they can remain independent. The medical staff and the women in the community really don't want it to become a general hospital, but it is also unknown how health care services and financing will change, which will impact Woman's ability to remain

independent.

GARBER: Are there leadership issues that are unique to specialty hospitals?

FONTENOT: I don't think so. Leaders in health systems today face a myriad of challenges. I never felt like any of the ones that I faced as CEO were unique to Woman's Hospital. Currently, with COVID and some of the other challenges and unrest – the political rancor, the racial divide – I think being a good listener and being able to communicate continuously with all stakeholders, internally and externally, are critical. Those have always been important but maybe not as intense compared to more normal times. Listening can't be overemphasized. We're finding out now as we're learning more about racial injustice that we haven't been listening like we should.

GARBER: We're recording this interview in fall 2020, one of the most difficult years in anybody's memory because of the pandemic and racial injustice and economic conditions and climate change. We're going to talk about disaster preparedness more in a bit, but before that I'd like to go back to the creation of Woman's Hospital.

FONTENOT: I love to tell this story. It's unique and indicative of what Woman's has become. The strength of culture at Woman's is unmatched and a direct result of the vision and tenacity of the founders.

In the mid '50s, there were 21 OB/GYNs in Baton Rouge who were unhappy with the care that their patients were receiving at the two general hospitals. Even back then, obstetric services was unprofitable. It's staff and resource intensive. Even though they were not-for-profit, these general hospitals had a bottom line to make. Labor and delivery were provided because there was a need, not because they wanted to or because they saw an opportunity to subsidize other services.

The OB/GYNs created a not-for-profit foundation. They made personal visits to managers of industrial plants all along the Mississippi River to raise money to build a hospital for women. They applied for and received Hill-Burton funds. Hill-Burton was a program to increase access to care, particularly in rural areas. The federal government provided capital for hospitals to be built in return for providing free care for uninsured and poor patients. Each one of the founders also personally signed a \$30,000 guarantee against a bank loan. It was a lot of money then and many of these physicians were just out of their residency programs and had debts of their own as well as young families and a practice to support.

There was one other interesting funding stream from Dr. Cary Dougherty⁴ – one of the three principal founders. He had become very interested in a new test for cervical cancer – the Pap test. Dr. Dougherty, who was a pathologist as well as an OB/GYN, worked with the inventor of the test. He asked the foundation to lend him \$500 so he could buy the equipment to process Pap smears. He said, "If you will send me your Pap smears, I'll read the results, and any money that I make will be returned to the foundation to go towards building the new hospital."

The physicians did that. Some of them said that they would send tests to him, but they also sent them to other labs to make sure he knew what he was doing. They figured out that he was very

⁴ Cary M. Dougherty, M.D. (1915-1995) trained in Paris with Dr. George Papanicolaou, developer of the Pap smear. [Childers, A. (2018, November 19). Woman's Hospital celebrates 50th birthday. *WAFB9*. <https://www.wafb.com/2018/11/19/womans-hospital-celebrates-th-birthday/>]

good at it and quickly, Dr. Dougherty was processing all the Paps in Baton Rouge.

GARBER: Isn't there also a named building?

FONTENOT: It's the Cary Dougherty Cancer Detection Lab. Within the hospital laboratory is an area named for him to honor and recognize his contribution, not only to women's health and the early diagnosis of cervical cancer, but also to the revenue stream that helped build the hospital.

The hospital opened in 1968, and the physicians supported it because it focused on their patients and they had a \$30,000 debt at risk. The hospital quickly became *the* place to deliver babies.

One of the administrators at the other two hospitals that delivered babies said "You'll be closed in nine months." That was not the case. The two general hospitals closed their obstetric services within a year. One of them reopened an obstetric service in the mid-90's, but it hasn't gained much market share. It toggled between 8% and 10% while I was the CEO. Woman's still delivers 80% to 85% of all the babies in the area.

GARBER: You had the opportunity to oversee a total replacement of Woman's Hospital. Why was a new hospital needed?

FONTENOT: It was controversial because many of the founders were still alive when the decision was made. The hospital campus was landlocked. It was on a 22-acre property, which was the original site. Much of that property had been gifted to the physicians by landowners. There was a lot of sentimental value to that site.

From the day it opened, Woman's continued to grow in volume from core services and from expansion of related women's services. When it opened, labor and delivery, newborn well-baby care and GYN surgery were the only services. By the early 1990s, several floors had been added on top of the original tower, and when it couldn't support more floors, a large extension was built on one end along with a parking garage for the employees and patients and visitors and a medical office building so that obstetricians could move their practices onto the hospital campus.

After careful consideration of yet another major renovation and expansion, in 2005 the decision was made to move to a greenfield site. In the early 2000s, the board had purchased a 225-acre golf course five miles from the original site on the same road. At the time, the purchase was a placeholder – an "insurance policy" was how we described it. We knew that the value of the property would go up so it was a low-risk investment. When it came time to consider another large expansion, we thought, maybe this is the right time to think about moving the hospital to a replacement site.

In addition to the original site being sentimental, it was controversial because of worries about the increased debt load that would be required. The hospital only had \$35 million in debt, and the project needed a \$350 million bond issuance. Also significant was that most of the physicians lived or owned office buildings within a mile or two of the original location. For them to have to either move or to have longer distances to travel to see their patients was not only inconvenient for them, but also a patient safety concern.

GARBER: A patient safety concern because obstetricians have to report to the hospital at any hour.

FONTENOT: In Baton Rouge, obstetricians care for their hospitalized patients during the day on weekdays while they are in clinic, but after hours they are on call for their group. A physician has to deliver that baby, so you are correct. We listened, included them in decisions, and spent considerable time explaining the strategic, operational and clinical quality advantages of a new hospital. In the end, it came down to trust, sharing a vision, and improving efficiency and convenience for them.

We were two weeks away from issuing the bonds for the new hospital when the Great Recession struck in 2008. The interest rate on the bonds doubled, and we decided to suspend the sale. Construction of the hospital had begun several months earlier and the elevator shafts and pilings were visible. We had invested several million of our own funds while waiting for the optimal market timing to issue the bonds.

We waited a year to go back to the market and construction of the new hospital stopped completely. At the time, we didn't know how long it was going to be. It was very stressful because we had put \$80 million in the ground and didn't know how long it would be before the bonds would be issued and the project could be completed.

Most of the community understood and business leaders commended the decision. It would have been a little easier to accept if those concrete elevator shafts sticking up out of the ground going up a few hundred feet weren't so visible. I would drive home past the new campus every day and see it. It was a constant reminder that the project was at a standstill.

Functionality at the new facility was going to be so much better. Ancillary departments would be larger and physically placed near the services they supported for optimal efficiency. The patient rooms would be much larger because we had adopted "mother/baby care," where the baby stays in the room with the mother rather than going to a nursery. We also needed more patient rooms, labor and delivery rooms and operating suites. Even though the operating rooms had been expanded and renovated a couple of times, they couldn't support the electrical load needed for new technology, like robotic equipment and other clinical automation.

I'll never forget the person who was board chair that year, Markham McKnight.⁵ I was lamenting the fact that we had \$80 million stuck in the ground. He was an insurance and banking executive, and said, "Just be glad that it's in the ground and not invested, because if it had been invested, you would have lost it all." The markets were really tumbling fast. Our investments were conservative, as you might imagine, because we are a not-for-profit facility and we knew that we were about to draw down on some more of these funds. He said, "Just think about it as hiding it between the mattresses when there's a bank failure." He was very supportive.

GARBER: If you need to stop a construction project for some reason – is there some point of no return at which the general contractor says to you, "No, we simply cannot stop at this point. We

⁵ Markham R. McKnight became president of BancorpSouth Insurance Services, Inc., in 2003, and has served as chairman of the board of Woman's Hospital, Baton Rouge. [BancorpSouth (2011, October 20). McKnight named to American Bankers Insurance Association's board of directors. *PRNewswire*. <http://bancorpsouth.investorroom.com/2011-10-20-McKnight-Named-to-American-Bankers-Insurance-Associations-Board-of-Directors>]

need to move to this next point”?

FONTENOT: There is some of that. The contracts were in phases because it was going to be a three- or four-year project anyway. What I recall is that we could suspend construction for a period of time, but there was an end date where we would have had to pay restitution or damages if we didn’t resume. However, there weren’t many large construction projects anyway so I suspect the contractors were more flexible than when the market is booming. Within a year construction was restarted and we opened in August 2012.

GARBER: Are there also engineering reasons why you might be concerned about a construction site that has been dormant for a number of months – like erosion and cave-ins of the excavation site.

FONTENOT: Yes, that was a big concern. Significant testing was performed to make sure there was no deterioration in the structure.

GARBER: In what ways was the new hospital different in design from the old hospital?

FONTENOT: One of the most important quality and outcomes design issues that we addressed was in our neonatal intensive care unit. The old NICU was the typical pod or ward setup, where babies were in bassinets next to each other, with a nursing area centrally located within a small, enclosed space.

The new hospital has only private rooms for neonates, and those rooms have private bathrooms, recliners, and futons for families. The model of care even 15 years ago was that visitation was limited, like you might see in typical ICUs. Now children can visit their new siblings. Parents can stay overnight. Infection control is significantly improved. The single room model was a major adjustment for the nurses because they were no longer in a central location with each other. Now there is a computer and equipment monitoring area in the hall and they can see into two rooms at a time.

Some of the benefits we didn’t anticipate that have contributed to better outcomes for neonates was the increase in breast feeding. This was noticed as soon as we moved into the new hospital. The moms have more privacy and can also relax. It really helped in improving care for premature infants.

Being able to control the physical environment was also important – lighting, noise and the temperature is individually controlled in each room. The nurses said that within two days of moving to the new hospital, some of the babies that had been fussy were much calmer as a result of being in a more soothing environment.

GARBER: Did you see a change in mortality rates?

FONTENOT: I left six or seven years after the hospital opened. I don’t think we could identify data that supported mortality improvement although we believed it did. We know it absolutely improved outcomes and the bonding of families. I’d have to say it was more subjective, but we believe those things really contributed to more positive outcomes.

In NICU in particular, the treatments, the therapies, the technology is advancing at such a

pace that today a baby born at 23 weeks gestation has a pretty good chance of survival. That wasn't the case even six or seven years ago. It seems like every two or three years, babies are surviving that are born earlier and earlier who likely would not have survived a year or two previously.

GARBER: What's the lowest birth weight that babies survive at today?

FONTENOT: I know there are babies that are born at 13 or 14 ounces that survive. It depends on if they have other co-morbid conditions – if they are born with problems other than prematurity. It's miraculous. It's a testament to the hard work of so many people improving outcomes. We talk a lot about the lifespan being extended as a result of drugs and therapies and technology and specialties. Thinking about the beginning of life, that work has been phenomenal as well by a lot of dedicated people.

GARBER: How did employees adapt to moving to the new hospital?

FONTENOT: Initially there was a lot of anxiety about moving – the physicians and a lot of employees lived close to the original hospital. Some of them asked, "Well, are you going to pay for my gas to drive five miles farther down the road?" We didn't move all services. Patient accounting, accounting, information systems, marketing, the child care center, print shop, fitness center and outpatient services remained at their original locations.

Finally, after trying to convince them that this was the best thing for our patients, our community and our organization, I finally said, "You've had five years' notice. If you don't want to drive, you don't have to. You are welcome to apply for a vacancy in a department that is not relocating and you'll be working close to home."

GARBER: I read that the employees and medical staff had the opportunity to help design the new hospital.

FONTENOT: We knew how important it was to engage the team through listening and shared decision-making. There were many ways to include employees in important decisions that affect them. While that seems natural to us in today's environment of collaboration and team-building, it was not that common in 2007-2008.

We asked the employees to help us pick the brick for the building. Three walls of different colors of bricks were erected in our plaza and the employees were asked to vote on their choice. The brick that got the most votes is now on the building. That helped them get excited about the new location, rather than fretting about what they might lose at the old location.

In designing the patient rooms, the nurses who worked directly at the bedside were invited to a conference room where all of the equipment that would be in a room had been brought in. When they arrived, they were asked, "How do you want this room laid out?" They said, "How big is the room going to be?" They were looking for tape on the floor that outlined the walls of the room. We replied, "We don't know. You place the equipment, and then the perimeter of the room will be drawn." The shape or the size of the patient room was not finalized until the caregivers decided how they wanted to work in that room.

We also set up a furniture showroom. All the recliners, the tables and chairs, the TVs, were brought into a conference room. Employees were invited to sit in options for chairs and sofas, help

us choose the fabric, and select the ones they would like to have if they were a visitor or a patient.

The NICU opened with 72 beds and quickly grew to 84 beds. The NICU team wanted an “Under the Sea” theme. The units are called Starfish, Whale, Dolphin, Fish, because they didn’t want anybody to feel like, if they were in Pod 3, that it was inferior to Pod 1, for example.

To carry out the theme, they wanted brown carpet on the floor to represent the sandy bottom of the sea. There are murals everywhere – it’s cleverly done and cheerful. I didn’t care for the brown carpet because it didn’t seem very childlike. But I said, “You’re the ones that will work here. We’re going to go with whatever it is that you want, rather than what I think it ought to look like.” The CEO doesn’t always get his/her way and it is an important attribute of servant leadership. I don’t regret deferring to them.

There are five floors of inpatient rooms in the main tower. Each floor has a different unit supervisor and some have different services. On the surgical floors, the staff wanted carpet, but staff in the labor and delivery and obstetrics areas did not. Each team selected finishes and countertops. Even though it was more expensive not to standardize, it was the right decision to let them design and select their work surroundings. The unit and room layouts are consistent throughout to reduce variability, improve patient safety, and allow staff from other units to be familiar with equipment and supplies if they are asked to work in another area. Units can easily be converted from obstetric to surgical patients, and staff will know exactly where the medical gases are and how the room is stocked. Only the décors may be different.

GARBER: Is there is anything you would have done differently during the planning and construction process, other than not have a recession?

FONTENOT: That was disruptive but ultimately turned out better than planned. When the bonds were finally issued the terms were less restrictive and the interest rate was more favorable than expected. That saved us a couple million dollars a year in interest expense.

The design was well done with plenty of room to grow and the departmental adjacencies have improved efficiency. Since then we’ve made modifications to respond to technology and new models of care. We don’t have a typical emergency department; it is called an assessment center and designed to receive patients in labor or having an obstetric or GYN emergency. It is staffed by OB/GYNs so is it not designed as a full-service emergency room where people with gunshot wounds, heart attacks, broken limbs can be treated. The size of that area was doubled in the new hospital, but within a few months, we were out of space – so the assessment center should have been larger. Starting over on a new site also meant that we didn’t have to deal with two years of jackhammers and construction disruption.

GARBER: You had mentioned the greenfield site before. What is a greenfield site?

FONTENOT: It is an undeveloped site. For us, it was a 225-acre golf course that the board had purchased several years earlier. I think we paid about \$4 million – it was a bargain even at that time. The hospital campus is on 65 acres of it, and the remainder is being developed into a mixed-use community of wellness. It will have housing, a charter school, medical and professional offices, retail, restaurants, a community pool, dog park and wellness activities. It’s also very walkable.

GARBER: How does a CEO influence culture?

FONTENOT: The CEO drives the culture. The CEO's primary role is to execute strategy and operations and a strong culture that supports the initiatives is critical to success. I'm not suggesting that the CEO has to be the culture king or queen. I never saw myself as the one that developed and led the culture. There were informal leaders that filled that role but we worked collaboratively to ensure that the culture supported the strategy.

Through constant communication and observation, I made sure that our team knew that I was committed to our values, our mission and our vision, and expected the same of all team members. In communication, we would often cite our values. We also used the values and vision statement as a guidepost when making difficult decisions and would explain unpopular positions in the context of the values. Team members were told that they were empowered to make decisions. At Woman's, my predecessor told staff that if they made a decision based on our values, it would never be a bad decision even if it didn't produce the outcome we desired.

Culture is intangible. It means different things to different people. Woman's has been recognized nationally for its culture, which has resulted in strong employee and physician engagement. Often, we've been asked, "What do you do that makes your culture so strong?" The best way to describe it is the Golden Rule. Treat others as you want to be treated. That's the way I tried to approach every day at Woman's Hospital, by setting the example, walking the talk, not expecting special treatment because I was the CEO. Executives had very few privileges and benefits that the lowest paid employee didn't have. Employees were encouraged to call me Teri. I did not want to be called by my last name because I really believed I was an equal member of the team. Because culture is abstract, the challenge is continuing to strengthen it while making changes.

When you have to make unpopular decisions or you're dealing with a crisis, the impact on culture can be positive or negative depending on how it is handled. That's why I just keep going back to listening and communication. People need to have an opportunity to participate in decisions, understand why you're making the decisions you're making, and if those decisions are tied to the values and vision, it is easier to accept. Being transparent and inclusive has been a recipe for success in my career.

GARBER: You were succeeded by Dr. Barbara Griffith,⁶ who is the third female to have been CEO at Woman's. Is there an expectation generally that a female CEO should lead a women's hospital, that someone who is Jewish should run a Jewish hospital, that someone who is Baptist should run a Baptist hospital and so on?

FONTENOT: At Woman's, now that there have been female CEOs it may be an expectation. Prior to Vicki, all of the CEOs were men from the founding of the hospital through about 1990. At one time, the CEO, CFO, COO and CNO were all male.

As far as other specialty hospitals, an expectation that the CEO be representative of either the sponsor of that organization or the typical patient, would probably be a board preference. I have heard that some Catholic hospitals and Jewish hospitals expect their CEOs to be of the same faith. I don't think it's as prevalent as it was at one time.

⁶ Barbara Griffith, M.D., has served as the CEO of Woman's Hospital, Baton Rouge, La., since 2019. [Woman's Hospital. (2019, August 18). Woman's Hospital selects Dr. Barbara Griffith as CEO. *Press release*. <http://www.womans.org/news/2019/08/dr-barbara-griffith-as-ceo>]

GARBER: When you were Chair-Elect of the American Hospital Association, you mentioned in an interview, “We must make sure that we’re doing everything we can so that patients in our community are as healthy as possible, not just from the standpoint of medical care, but all the other things that make a person healthy.” This sounds like the principle of social determinants of health. What sorts of things were you involved in when you were at the helm at Woman’s along the lines of those types of services?

FONTENOT: We tended to stay in our lane regarding women’s services and focused on a very vulnerable population. The things that we did initially were primarily to help women deliver healthier babies through access to early prenatal care, preventive care during pregnancy such as dental care, and managing chronic conditions.

One program that comes to mind – I believe it was the first in the country – was a prenatal HIV program, which was case management for patients who tested positive for HIV during their first prenatal visit. They were referred to a hospital-sponsored program with nurses and social workers trained in HIV management. Patients received counseling, treatment, and drugs at no cost, along with a very thick manual with a lot of information about HIV, and regularly checked in for support and assistance during and after pregnancy. The goal was to prevent the baby from being born HIV-positive.

At the time that I left, the program had been in place for over ten years. To my knowledge, no baby had been born with HIV to mothers who had been compliant during pregnancy. In addition to medical care, we helped them with social and ethical issues. HIV is still a stigma for some and patients didn’t know how to tell their families or their partners.

Another program under development when I left was focused on broader social determinants of health. An assessment was performed at the first prenatal visit to identify challenges related to transportation, housing, food, access to medical care, child care, living in a safe place, etc., and that they knew who to call and what to do if they were in an abusive situation.

GARBER: Disaster preparedness is an important topic in this time of disease pandemic, but hospitals in Louisiana have always had to deal with hurricanes and flooding.

FONTENOT: That is so true. The 2020 hurricane season set a record for the number that made landfall in Louisiana. I’d love to tell you our Katrina story. It’s an interesting one, and the most memorable moment of my career to be a part of a team who understood and fulfilled our mission. It was a crisis at many levels, but when recovery was over, I couldn’t have been prouder to have been a part of that team.

In late August 2005, Hurricane Katrina made landfall near New Orleans, 65 miles northeast of Baton Rouge. The storm didn’t cause much damage in Baton Rouge and it seemed that New Orleans had also escaped with little more than power outages and trees lying across roads. However, New Orleans is below sea level and the next morning, the levees broke and the city flooded. It filled up like a soup bowl. People were stranded on their rooftops. Hospitals lost power. Hospitals and nursing homes were surrounded by water and unable to evacuate. The only access was by boat or helipad.

Over the next five or six days, New Orleans residents attempted to evacuate. At the time, the

population of New Orleans was well over a million people. Residents who had cars or other means to get out of town evacuated, and most of them came to Baton Rouge. They had friends and family here, and it was the closest city. People who left before the storm expected to return home in a day or two because that's typically what happens after a hurricane. When evacuating, you are advised to take enough clothes and medicine for two or three days.

When the levees broke, the entire city needed to leave. The emergency command center that coordinates the work of the state agencies was overwhelmed by the magnitude of urgent needs by so many constituent groups. People were being rescued from the rooftops of their homes at the same time that nursing homes needed to be evacuated. Hospitals also needed evacuation but had moats around them which made access difficult. People who had lost their homes were walking in knee-deep water by the thousands for the Superdome for food, clothing and shelter.

The Louisiana Hospital Association was notified by a nurse hunkered down at one of the flooded hospitals that they had neonates and mothers in labor or receiving postpartum care. Because it was August, the heat and humidity causes mold and mildew to grow quickly. It's a dangerous situation for anybody, but particularly for neonates, the elderly and other medically compromised people.

When we learned about the stranded patients, the chief of neonatology and I went to the state command center, which happened to be less than a mile from Woman's, and asked them to let us assume responsibility for evacuating the neonates and mothers from those hospitals. They quickly said, "Thank you so much! God bless you!" Because evacuating neonates is different from evacuating adults and Woman's was a statewide provider of high risk maternal and infant care, we had transport equipment and specially trained teams of nurses, doctors and respiratory therapists. We worked with teams from the Wildlife and Fisheries Commissions of Louisiana and other states who had the boats that could get to the hospitals, and with the National Guard and other military that had aircraft.

A steady stream of Blackhawk helicopters landed on our rooftop helipad. When one landed, anyone available went up, including me. Many of us didn't have a clinical background but we knew how to carry a bassinet from the helicopter to the NICU. I remember seeing one Blackhawk on the roof, one on the ground on the service road next to the garage, and two hovering overhead waiting to offload babies.

The babies were in portable bassinets that resembled small bins and some of the babies were provided manual breathing assistance because the helicopters were not designed for medical transportation. Evacuations could only occur during daylight because the city was completely dark due to the power outage. It was surreal. It took four days to get all the babies evacuated.

In 2005, electronic medical records were sparse and unsophisticated, and hospitals didn't transmit information between facilities. The babies would arrive with their paper medical charts under them in the bin. In addition to their hospital bracelet, nurses had written their names, date of birth and other identifying information on their skin with a black marker in case they were separated from the medical record or the bracelet was lost. The parents of these babies did not know where their children were, and we didn't know where the parents were in many cases.

There were 122 infants evacuated in addition to mothers who delivered during the hurricane and evacuation. The babies were brought to our NICU and triaged by our neonatologists. Our NICU

was full before these babies arrived but the ones that needed the highest level of care stayed, and the other less critical infants were transferred to lower level NICUs in hospitals around the state. It took about two weeks to arrange for the families to be reunited. Some parents had gone as far as Oklahoma. Many of them were in Texas. I'm pleased to say that all of them survived.

GARBER: You and your team have a lot to be proud of.

FONTENOT: Thank you. My role was supporting the staff. In normal times, but particularly in a crisis, the CEO's role is to provide the resources, remove the obstacles and make sure they know that if they make decisions based on the values, they will be supported.

As the team cared for all types of patients and their families, not just in the NICU, the administrative team delivered meals to the units and staffed the serving line in the cafeteria. We made rounds and were visible day and night. It was hard to go home to change clothes or rest. We all wanted to be there to make sure that we could help in any way that we could. Some of us slept in our offices for nearly a week.

GARBER: It surprises me that these tiny babies were able to survive for several days before getting to you at Woman's.

FONTENOT: That's a real testament to the caregivers and the support that they received in those hospitals. They did really well, fortunately, and the neonatologists and the nurses that would arrive on the Blackhawks with those babies would insist in returning on that Blackhawk. I remember one neonatologist who wanted to stay on for the return trip. We convinced her to at least go into the doctor's lounge, eat a hot meal, take a shower, and get some clean scrubs. She did, then went back on the next helicopter.

We also sent ice, clean clothing, supplies, and food on the return flights. They had eaten what they might have brought to work that day or had in their lockers but little else. Those nurses, physicians, respiratory therapists and other caregivers were committed to making sure those patients did well. It was a true team effort across two cities.

Before Katrina, Baton Rouge and New Orleans were competitive in many ways. Since Katrina, the two communities have become collaborative. They've created a regional economic effort, and the lines between New Orleans and Baton Rouge have blurred, which is a good thing for our state.

GARBER: I read that a number of people from New Orleans moved to Baton Rouge after Katrina and then, not many years after that, there was another major flood, this time in Baton Rouge.

FONTENOT: In 2016, we had what was classified as a "1,000-year flood." This was a very slow-moving storm that hung over Baton Rouge and produced torrential rain for several days. The tributaries to the Mississippi River backed up and flooded the lower-lying areas of Baton Rouge. It almost flooded the campus we had moved to just four years earlier. Tens of thousands of people lost their homes, and some of them are still trying to rebuild.

GARBER: How do hospitals undertake disaster preparedness?

FONTENOT: It starts with a strong emergency preparedness plan and an understanding of each leader's role. Often the role is not related to your title or responsibilities. At Woman's, for

example, the incident command center is activated at different levels depending on the threat level warnings for hurricanes. The administrator on call at Woman's is in charge of the command center. If that happened to be your week to be administrator on call, you were the point of contact and coordinator.

As CEO, I was involved in the decision making, but it was not always my ultimate decision. I was not the command center leader because I needed to be available for the media, and be visible with the physicians and team members. I suspect that other health systems are similarly structured.

The coronavirus crisis is different. The pandemic has been going on for months and it is a national and global disaster rather than impacting a small region. We don't know when it's going to end. With a hurricane or some other natural disaster, there is a beginning and an end to it. You often have time to prepare and most of the work is in recovery.

A strong disaster preparedness and response plan is built around the unexpected because every disaster is different, even hurricanes. Community-wide drills are held and The Joint Commission surveys on disaster preparedness. Tabletop exercises and simulations are done for a plant explosion, a plane crash, a bridge collapse, but disaster preparedness plans are not designed to address a pandemic. The exhaustion level of the frontline caregivers as well as the risk to their health is testing the resilience, innovation and the speed in which health care can move in a way that has never been tested in our lifetime.

GARBER: What is the structure and composition of the Woman's board?

FONTENOT: The Woman's Hospital board has 12 elected members, five of which, according to the by-laws, must be physicians, and four of those must be OB/GYNs. That's unique because many community hospitals don't have physicians on their boards, or have a limited number of physicians. The chief of staff and the CEO serve as ex-officio, so there are 14 total members of the board. Directors serve three year terms with a maximum of three terms.

The board is relatively small for a not-for-profit organization. As a result, every member needs to be actively engaged. They need to come prepared for the meetings, read the materials in advance and contribute to the discussions. Often when there are 30, 40, or 50 members on a board, some don't feel like their contributions make a difference, or they're not really aligned or passionate about the work.

The board chair at Woman's Hospital serves a one-year term. There is no limit on the number of terms so they can be an officer longer if they are reelected. During my tenure as CEO, the board chairs served one-year terms, so I had 23 different board chairs. I enjoyed having the board chair change annually because there were different challenges each year. Also, the board chair would have been on the board at least four or five years, so they were familiar with the issues. Our board was cohesive, collegial, and because they were community leaders, they had personal and professional relationships, which made the board chair role easier.

I really appreciated their insight, leadership, guidance and passion for the work that we were doing. First and foremost, a board chair should be as passionate as the CEO. I was fortunate throughout my career to serve board chairs who were supportive, had my back when necessary, and helped me think through controversial topics that might get presented to the board or in the

community. We had excellent board chairs during the building of the hospital, during and after Katrina and during other challenges during my tenure.

GARBER: What was it like to be on the American Hospital Association Board of Trustees and what was the process that got you there?

FONTENOT: Serving on the board of the AHA was the pinnacle of my career. I served in many capacities for the American Hospital Association. Each time that I interacted with the professional staff as well as colleagues throughout the country, I learned so much, not only about governance, but also about health care operations, strategy and leadership.

My first role with the American Hospital Association was as a member of the Maternal Child Governing Council in the late '90s. I served on the council for three years, and was then asked to serve on other committees and task forces. As the chair of the board of the Louisiana Hospital Association, I also attended the AHA's Regional Policy Board meetings. It was there that I had exposure at a national level to the policy-making process at the American Hospital Association. The AHA board chair, president and trustees regularly attended the quarterly meetings. The talent and the commitment of those leaders were impressive.

I was approached by a colleague who was on the board about an at-large seat. The American Hospital Association Board has recognized the critical importance of having representatives on the board from a variety of backgrounds, fields, experience and credentials. They were deliberate in having representation of gender, race, and size and type of institutions. I was thrilled to be considered, and served a three-year term which is the maximum for trustees other than chair officers.

I completed my term, having made lifelong friends and utilize information on strategy and governance that I learned at the American Hospital Association. Governance at the AHA was cutting edge and many aspects of AHA governance were implemented at Woman's and other boards that I've served on.

A couple of years after I left the board, I was on an AHA committee with former AHA Chair Gary Mecklenburg,⁷ who said, "Why didn't you ever run for chair of the board?" I said, "They would never want someone from a specialty hospital or a female" – at that time, there had not been a female board chair for a couple of decades. He said, "You need to consider it, and I will help you submit your nomination". I was thrilled to have a sponsor like Gary Mecklenburg helping me. I went through the process, and the first time that I ran for the office, I was selected. I was the fifth female Board Chair in the 112-year history of the AHA, and the first person from Louisiana to be elected.

Serving as a chair officer was a phenomenal experience. I traveled a lot to interact with members across the United States, made a couple of international trips, and met incredibly committed leaders. It was 2012, which was also during the implementation of the Affordable Care Act⁸ and the

⁷ Gary A. Mecklenburg served as CEO of Northwestern Memorial Hospital (Chicago) from 1985 to 2001 when he became president and CEO of Northwestern Memorial HealthCare, the parent corporation. He retired after two decades with Northwestern Memorial in 2006. [Japsen, B. (2006, Jan. 10). Downtown hospital changes leadership: Northwestern healthy for Mecklenburg split. *Chicago Tribune*. http://articles.chicagotribune.com/2006-01-10/business/0601100246_1_teaching-hospital-gary-mecklenburg-northwestern-memorial-hospital]

⁸ 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>]

Supreme Court challenge. I met the Secretary of Health and Human Services and some other high-ranking officials in the White House. It was without question a career highlight to serve in such a profound way and learn so much from amazing leaders.

GARBER: Would you speak to the value of ACHE – the American College of Healthcare Executives – and how you’ve benefited by being involved in leadership there?

FONTENOT: The American College of Healthcare Executives is our professional society. In addition to providing certification in health care leadership and competence, it provides education on emerging issues through face-to-face meetings, annual congress, and virtual learning options.

The American College of Healthcare Executives is similar to the American Hospital Association in that it grooms leaders for health care and makes sure that those leaders are well-versed, educated and knowledgeable about the current topics and trends in health care leadership, as well as the challenges, operationally, with government regulation and agencies, and advocates for health care leaders in America’s hospitals. It also provides numerous networking and career development education to assist healthcare leaders reach their professional goals.

GARBER: As we conclude, are there any individuals you would like to mention?

FONTENOT: When I’m asked what makes a CEO successful, at the top of the list is the support of family. My husband has been extremely supportive. He’s moved around the country so that I could fulfill my health care leadership dreams. My children have been supportive. There were many times I felt guilty about being away, particularly as I had the opportunity to participate in external organizations such as the American Hospital Association and the American College of Healthcare Executives. That requires a lot of travel and interfacing personally – or it did prior to the coronavirus. My family has been extremely supportive of the work that I have done.

The best compliment that my daughter ever gave me was maybe three or four years ago, when she said, “I learned so much by watching you in the work force and in leadership positions, and it has made me more confident in my career.” She traveled to meetings when she was as young as eight years old and attended social events as appropriate. She said, “I had opportunities that I know others didn’t that have given me an advantage. Now in social settings and around powerful people, I am not nervous. I can talk to them and look them in the eye.”

GARBER: Do you have any other closing comments?

FONTENOT: You cannot do this work alone. Your success is dependent on the support of others both personally and professionally, mentors, and sponsors. The most successful leaders really listen, are transparent, inclusive and genuine.

I’m grateful to the men and women who helped me along the way. A lot of women look for women mentors, but I encourage them to look for male mentors. Gary Mecklenburg was a mentor who helped me to ascend to the chair of the Board of the American Hospital Association. That would not have been possible without his encouragement and involvement. Sister Anne Marie Twohig, who took a real chance on me when I had no health care experience, was the springboard of my career and I’m so appreciative of her generosity and kindness.

Vicki Romero Briggs, who recruited me to Woman’s Hospital and who has remained a dear

friend is an inspiration not just to me but many female health care executives She was one of the first female hospital CEOs in the country and has led many other health systems successfully. A few close female colleagues – some in health care, some not – are my ‘board of advisors’ and have helped me navigate challenges more effectively than coaches could because they know me so well. I encourage anyone who is in leadership to find those three or four intimate friends and colleagues who can sympathize and empathize with what you are going through and give you sound advice.

GARBER: Thank you for making time for this interview today.

FONTENOT: Thank you, I’ve really enjoyed it. Thank you to the American Hospital Association for their incredible influence and support during my career.

CHRONOLOGY

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| 1953 | Born June 16 in Biloxi, MS |
| | Married to Gerald Fontenot; Daughters: Rachel, Stephanie |
| 1979 | University of Mississippi (Oxford, Mississippi) Bachelor’s degree, Accounting |
| 1979-1980 | M.M. Winkler & Associates (Tupelo, Mississippi) Staff Accountant |
| 1980-1987 | St. Francis Medical Center (Monroe, Louisiana) 1980-1983 Director, Fiscal Services 1983-1985 Assistant Administrator, Fiscal Services 1985-1987 Chief Financial Officer |
| 1987-1988 | Southwest Florida Regional Medical Center (Ft. Myers, Florida) Chief Financial Officer |
| 1988 | Northeast Louisiana University (Monroe, Louisiana) Master’s degree, Business Administration |
| 1988-1992 | Opelousas General Hospital (Opelousas, Louisiana) Chief Financial Officer |
| 1992-present | Woman’s Hospital (Baton Rouge, Louisiana) 1992-1993 Chief Financial Officer and Treasurer 1993-1994 Chief Operating Officer 1994-1996 Executive Vice President of Woman’s Health Foundation 1996- 2019 President and CEO 2019-present CEO Emeritus |

SELECTED MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives

Chair, Chief Executive Officers Committee

Fellow

Member, Board and Officer Nominating Committee

Member, Board of Governors

Member, Regents Advisory Council for Louisiana

American Hospital Association

Chairman, board

Member, board

Member, board (Health Forum)

Member, executive committee

Amerisafe

Independent director

Baton Rouge Area Chamber of Commerce

Member, board chair

Baton Rouge Health District

Member, board

Capital Area United Way

Member, board

Healthcare Research & Development Institute

Member, board

Hospital Billing & Collection Service, Ltd.

Member, board chair

LHA Professional and General Liability Insurance Funds

Chair, board

LHC Group

Independent director

Louisiana Hospital Association

Chair, board

Member, board

Member, lifetime

National Institutes of Health

Member, Advisory Committee on Research on Women's Health

New Orleans Federal Reserve Bank

Member, board

Sixth District Federal Reserve Bank (Atlanta, Georgia)
Chair, Audit Committee
Member, board

AWARDS AND HONORS

Businessperson of the Year, *Baton Rouge Business Report*

Distinguished Service Award, American Hospital Association

Health Hero Award, Louisiana Department of Health

Healthcare Leadership award, *Becker's Hospital Review*

Inductee of the E.J. Ourso College of Business Hall of Distinction, Louisiana State University

Service Award, American College of Healthcare Executives

Spirit Award, American College of Healthcare Executives

Top 25 Women in Healthcare, *Modern Healthcare*

Top 100 Most Influential People in Healthcare, *Modern Healthcare* (awarded twice)

25 Most Influential Women in Baton Rouge, *Greater Baton Rouge Business Report*

Woman of Achievement Award, YWCA

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- Fontenot, T.G. (2013, January-February). Interview with Teri G. Fontenot, FACHE, President and Chief Executive Officer of Woman's Hospital. *Journal of Healthcare Management*. 58(1), 3-7.
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- Shiver, J.M., and Cantiello, J. (2016). Conveners, collaborators, and facilitators: Leaders of the future, An interview with Teri Fontenot. In *Managing integrated health systems*. (pp. 313-319). Burlington, Massachusetts: Jones & Bartlett Learning.

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