



LEO F. GREENAWALT
In First Person: An Oral History

American Hospital Association
Center for Hospital and Healthcare Administration History
and
Health Research & Educational Trust

2012

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

LEO F. GREENAWALT

In First Person: An Oral History

**Interviewed by Kim M. Garber
On December 7, 2011**

Edited by Kim M. Garber

Sponsored by
American Hospital Association
Center for Hospital and Healthcare Administration History
and
Health Research & Educational Trust
Chicago, Illinois

2012

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

Transcription by Chris D'Amico
Photos courtesy of the Greenawalt Family

EDITED TRANSCRIPT
Interview conducted in Sequim, Washington

KIM GARBBER: Today is Wednesday, December 7, 2011. My name is Kim Garber and I will be interviewing Leo Greenawalt, who retired recently after serving for 30 years as the President/CEO of the Washington State Hospital Association. Leo, it's great to have this opportunity to speak with you.

LEO GREENAWALT: Thank you. Good morning.

GARBBER: You were born in 1944 and grew up in Titusville, PA. Could you talk about your family and how growing up in a rural area affected your values?

GREENAWALT: My father grew up on a farm near Titusville. He learned to work the land, hunt, and work with his hands. He was an outstanding mechanic and before World War II, worked in maintenance at the local steel mill. During the war, he served in the Navy in the Pacific where he was part of some pretty heavy fighting. Working as the engine mechanic was frightening because if the ship was hit there was little chance of escaping from the engine room. Having never been out of the Titusville area, it was a major move for my father to go overseas. I think it was a life-changing period for him. He learned of a world he had never seen before. Also, there was the whole experience of war. He never talked about it enough for me to understand fully what that was like, but he did say it was pretty scary when they were being bombarded. After the war, he went back to the same kind of work he had done before; he must have worked there 40 more years.

Titusville was a working class town. Steel and farming were the main industries. My mother was one of a handful of women who had a college education. She taught for 30 years in a one-room schoolhouse. I remember going with her to school. Often, there would be ice on the floor in winter. She would arrive very early to start up a coal stove before the children arrived.

I was an only child. Because my father was at war when I was born he didn't see me until I was a year old. In the first couple of years, my mother and grandmother took care of me. I don't think my mother expected to have a child – she was 38 when I was born. We lived in a loving home, which helped me in later years. I don't recall being punished for making a mistake or for taking a risk. I think that security helped me immensely in my career because I often needed to make decisions where there was little certainty of the outcome.

Titusville was a small town where everyone knew each other. Our front door was never locked. Neighbors would come to visit and just walk in and ring the doorbell on the way in. It was cozy, knowing each other, smiling at people when you walked down the street. I had a number of cousins around and we did a lot together. In the earlier years my aunt fixed lunch for us in her house, which was near the school I went to, so my cousin and I grew up together in that way. She was like a sister.

I became involved with sports at an early age. There was a priest, Father Cooper, who started us out in basketball in the first grade. We played every day at lunchtime. Although I also played other sports, basketball was my true love. I played basketball for about three hours a day, every day, from the time I was in elementary school until I was through college. Father Cooper had been a major part of my early life. He was a kind person who took an interest in the kids in the

school and took us to hunting and to sporting events. I did a lot with him. He influenced most of the boys and girls that grew up in Titusville.

There were only 20 students in my high school graduating class at St. Joseph Academy. The change from high school to college was difficult for me because of the smallness of my high school. I had been a big shot all through high school, which wasn't hard when there are only ten boys in your class! Maybe because my mother was a teacher, I was the only boy in my class who studied. I played sports and was involved in debating and was used to being the center of attention. But as a freshman at Notre Dame, I was one of 1,500 people, and nobody sought my opinion on anything. It was an adjustment for me that people did not ask me what I thought about things. That first year in college was difficult. I had to learn to speak up for myself or risk complete anonymity.

At Notre Dame, I tried out for freshman basketball. There were about 120 of us at the beginning. The coach only picked 20 from the original group to continue trying out and I was one of them. Then he chose the final 14, and I didn't make the cut. The guys who made the team were five or six inches taller than I and faster. It was the most difficult day of my life. My basketball dreams had come to an end.

GARBER: What did you study at Notre Dame?

GREENAWALT: I started out in pre-med, but after about two years, I realized that I didn't want to become a physician. At that point I met with an advisor about what to study if I didn't want to go to medical school. I took sociology because I would be able to graduate on time, and I liked sociology courses. I finished by majoring in pre-med and sociology.

GARBER: What made you realize that you didn't want to become a physician?

GREENAWALT: I had attended a career seminar. A couple of the speakers were physicians, who talked about the extreme hours they worked. Some regretted that they didn't think they got to know their kids well. I thought, "Oh, this doesn't sound right at all." Also, I didn't enjoy the science that I had taken as much as other courses. So, I decided that medicine was not going to be the career I was going to try. As it turned out, I probably put in as many hours in my work as I would have as a physician. So my reasoning wasn't that strong.

GARBER: Do you remember any influential professors that you had?

GREENAWALT: The one I remember most was the President of Notre Dame, Father Hesburgh,¹ who was an exceptionally talented orator. He spoke of Notre Dame students who joined the Peace Corps or did other things abroad. Students who heard that lecture were impressed; but it affected me much more. I was overwhelmed by the emotion of his message. It drove me to want to make a difference.

GARBER: You were an undergraduate in the early '60s. What was it like at Notre Dame as far as civil rights and the Vietnam War?

¹ Rev. Theodore M. Hesburgh, C.S.C., president emeritus of the University of Notre Dame, served for 35 years as president, from 1952 to 1987. He is regarded as one of the most influential voices for Catholic higher education and has served on various federal commissions and boards. He has been awarded the Congressional Gold Medal and the Medal of Freedom. More information can be found here: <http://hesburgh.nd.edu/> (accessed June 1, 2012)

GREENAWALT: Because Father Hesburgh was head of the Civil Rights Commission, he was in the vanguard on that issue and most of the campus was heavily engaged in the civil rights movement. However, with the war it was different. Notre Dame did not tolerate antiwar protests. Only a powerful Catholic school could get away with what Notre Dame and Father Hesburgh decreed. Students, including me, started marching but we were threatened with expulsion. The threat scared us enough that we quit marching and returned to our dorms. I had a number of professors who were strongly antiwar, and most of my friends felt strongly also, and even marched in South Bend. But on campus, there was no movement whatsoever. I often think of what happened in Wisconsin, and other places; how active those students were, and how repressive Notre Dame was at that time on the antiwar issue.

GARBER: Did you go right away for your Masters degree?

GREENAWALT: Yes, I attended another lecture on what to do with a background of pre-med. There was a professor from Cornell who described a career in hospital administration. It sounded interesting. I applied to a number of schools, and ended up picking the University of Pittsburgh because I was offered a scholarship. I came from a working-class family, so I was in debt and couldn't afford to go to an Ivy League school.

Dr. Hilda Kroeger,² the head of the Medical and Hospital Administration program at Pitt, took me under her wing. I was right out of school and the youngest in the class. Almost everyone else had experience. Dr. Kroeger paid attention to my courses, what I was learning, and how I was doing. We kept that relationship for quite a while.

GARBER: At Pitt, you met Bob Sigmond,³ who has been a longtime friend and mentor. Could you talk a little bit about your relationship with Bob?

GREENAWALT: Bob has some of the same attributes that I admired in Father Hesburgh. He has a view of not only the duty that we as people have to others; but also that hospitals have to their communities. At that time, he was the only person who talked this way. I was completely taken by him. He is bright, challenging – drives you crazy sometimes, pushing you one way or the other. He is provocative. Mostly, I was attracted to his call to duty and his sense that hospitals owe something to their communities and that we who were coming out of programs in health administration owed something. He really pushed that. It resonated with me.

GARBER: How well do you feel that the graduate education at Pitt prepared you for your later experiences as an administrator?

GREENAWALT: I'm not sure how good it was for those who became involved in the business side of hospital administration, but it was outstanding for the public policy kind of work

² Hilda H. Kroeger, M.D., became director of Medical and Hospital Administration at the University of Pittsburgh Graduate School of Public Health in 1968. More information on the history of the program can be found here: <http://www.hpm.pitt.edu/history.asp> (accessed June 1, 2012)

³ Robert M. Sigmond was an adjunct professor at the University of Pittsburgh Graduate School of Public Health in the '60s, during which time he was also the executive director of the Hospital Planning Association of Allegheny County. His oral history is: Garber, K.M., editor. *Robert M. Sigmond in First Person: An Oral History, Part 2*. Chicago: American Hospital Association and the Health Research & Educational Trust, 2009, and can be found here: www.aha.org/chhah. There was also a Part I, conducted in 1983. These oral histories are in the collection of the American Hospital Association Resource Center.

that I did. The courses on public health and community health and how they fit together were perfect preparation for the kind of work I wanted to do. The curriculum covered how one looks at a community and how the health care system fits into it. It was much broader than just hospitals or physicians. That part was outstanding. There were some courses in statistics and epidemiology which were helpful as well.

GARBER: You did a residency at the Veterans Administration hospital in Pittsburgh. Would you talk a little bit about that experience?

GREENAWALT: I went to the Veterans Administration because Dr. Kroeger wanted me to work for Dan Macer,⁴ who had been a mentor for a number of students and offered a great management experience for me. Remember that my relatives were laborers and farmers. My dad knew nothing about administration. He had been a union member his whole life, and probably if you asked him anything about management, it would not have come out very complimentary! That was the life I knew. I never had anyone to talk to from a management perspective.

Like Dr. Kroeger, Dan Macer took a special interest in me. When he was facing an important decision, he would invite me into the room, talk about the issue, and ask me what I thought he ought to do. He made me feel as though he was taking my thoughts into account in his decision. Then he'd make his decision and explain how he did it and why. Even when he would confront people, he would have me in the room with him and allow me to be part of it. This was helpful because I had never supervised anyone in my life. I had never run meetings either, so I learned how to conduct a meeting - something that I never learned in graduate school or college. Dan Macer prepared carefully for meetings and knew what he wanted out of them. He rotated me through the entire hospital. I spent time with no-nonsense nurses in the emergency room, with housekeepers, with physicians and with pharmacists. It was eye-opening. For a long time afterwards, I never made a move without calling Mr. Macer first and talking it over. Coincidentally he later moved to Oklahoma where I worked. He led organizations there for another 10 or 15 years.

GARBER: It's interesting how you confirm what others have said about the value of the administrative residencies in the masters programs. After your residency, you moved on to working for the United States Public Health Service in the Medicare Grants Management Office. How did that opportunity come about and what did you do there?

GREENAWALT: At that time the Public Health Service counted for military service, so it was a nice option for those of us who had to deal with Vietnam. I'd applied to Indian Health Service, which is part of the Public Health Service. Perhaps due to a mistake, I was assigned to a position in Washington, DC. It wasn't a very pleasant time for me. The contract that I was supposed to be in charge of did not get implemented or funded. I was then assigned to a project making site visits across the country to see how the Medicare standards were being used by the Joint Commission in various states.

I did have one of the great experiences of my life, although it didn't feel that way at the time. I was asked to write a draft of a letter about a Medicare issue for the Secretary of HEW to sign. I must have spent 40 hours researching, writing and rewriting it. I wanted to make it as perfect as I

⁴ Dan J. Macer was director of the Veterans Administration Hospital (Pittsburgh) from 1962 until 1968, according to the Guide issue: Part 2. *Hospitals, Journal of the American Hospital Association*;37(15):203, Aug. 1, 1963; and, later editions.

could. Then it went to my boss who red-penciled it, and then it went to his boss, and then to his boss. By the time the Secretary signed it, there wasn't a sentence left that I had written. It was pretty discouraging for my first job to be so low on the totem pole and to be so irrelevant. I felt useless. I felt that there was no point in doing a good job in that organization. I called Mr. Macer, and asked if he could help me get transferred, because he knew some people in the Public Health Service, and that's how I joined the Indian Health Service.



The letter draft experience shaped me. I vowed that I would never put someone who worked for me in that position. In later years, if someone wrote a rough draft for me, I went over it with the author if I made changes. It may well be that people in my first job did value what I did but it didn't feel like it at the time.

GARBER: It became a leadership lesson for you in how you treat people and their work product.

GREENAWALT: Yes, and it's something I've preached to other people over the years to make sure that they don't do it to others within my organization.

GARBER: Now it's 1969, and you're at the W.W. Hastings Indian Hospital in Tahlequah, Oklahoma, a very different place than where you've lived before.

GREENAWALT: As we were driving into Tahlequah, there were people riding horses across the middle of the street, and every truck had a shotgun in the back of it. The only radio station played sermons from very conservative preachers. My wife said to me, "Promise me we'll be out of here in a year. I can't believe you brought me here." But a couple of years later, as we drove out of town, there were tears. We loved it – just loved it. When we left, the women in this one church in the Cherokee nation presented us with a hand-made quilt. It was just overwhelming.

Working in Tahlequah was a dream job, like going to Peace Corps or doing the things that Bob Sigmond or Father Hesburgh had talked about. The hospital board was made up of the tribes of the area. The Tahlequah hospital provided care that was necessary. We weren't talking about anything that wasn't important. We were living in the community and working with a lot of people who became close friends. The tribe appreciated it as well, because we came there and because many of us who were part of that really believed in what we were doing. It was as much learning from them as it was any kind of giving on our part. It was a great experience.

GARBER: You were there for only two years. You formed these relationships and had wonderful experiences in a very short period of time. This was a Cherokee population?

GREENAWALT: It was the Cherokee nation. In addition, it was third world in some aspects. In one county, which was part of our service area, close to 80 percent of the people were on welfare. There were many areas where there was no phone service or electricity. I remember visiting one family living in a house with a dirt floor and with farm animals that came right into the house. It was similar to what one might see in other countries but I had no idea this was taking

place in America.

The Native American population had always taken care of themselves and had done a good job of it. But welfare regulations said that they weren't allowed to own more than a certain number of animals, such as goats or chickens, so dependency was created. By the time we arrived, it seemed hopeless to think they would ever get out of poverty because of generations of bad government policy. Not that welfare is a bad idea. It's just that some of the requirements they put on people didn't allow them to do work.

GARBER: Other than the poverty, what issues did you deal with as administrator? This was a very small hospital, right?

GREENAWALT: Yes. The hospital had an average census of about 35 – it would be a critical access hospital today. There were cultural issues that we all had to deal with. There were ways of healing that weren't part of the way ordinary medical care was delivered. The medicine woman or shaman might say, "Take this medicine or don't take that medicine." There was a tradition of eating certain foods that were not good for diabetics, and so there was a high rate of diabetic complications. Lots of issues were exacerbated because the physicians were from a different culture - mostly from the East Coast. They were among the best and brightest of their class, because again remember – this counted for military service during the Vietnam era. It was difficult to get into Indian Health Service. These doctors were sharp, bright, intense, and they came to this community where people were pretty low key, with a culture that was as different as it could be from New York City or Boston. It took physicians six months to a year before they were of much value at all. I think the same was true for me but I had the big advantage of having grown up in a small town.

GARBER: Not only that, but these physicians were young.

GREENAWALT: They were young and had come from the best medical schools. So, they were used to high-tech equipment, yet we had none of that. They had to make a diagnosis the way older physicians did – by touch, by sense of the patient's history and the physical exam. It was hard for them because they felt they weren't doing good medicine.

GARBER: Why did you leave that position?

GREENAWALT: I got fired. It was one of the great mistakes in life and one of the lessons learned. During my last year at Hastings Hospital, President Nixon allowed the Five Civilized Tribes to elect their own leaders. Prior to that, all chiefs of the Cherokees and the other tribes were appointed by the President of the United States.

GARBER: Who were the Five Civilized Tribes?

GREENAWALT: The Five Civilized Tribes were moved from the East Coast by President Andrew Jackson. They were marched across the United States – the "Trail of Tears." It was the Choctaw, Chippewa, Cherokee, Seminole, and Creek. Their chief was appointed by the President as part of trying to make them "not Indian" any more. Government policy was to assimilate Indians into the dominant culture. The five tribes had been governed this way for more than a hundred years. To the surprise of many President Nixon announced that the US would end its colonial relationship and that the tribes were finally going to be allowed to elect their own leader.

The current President of the Cherokee tribe had been the head of a major oil company. As I recall, he had only one Indian ancestor - a great, great grandmother. He had been appointed chief by the President, but he announced he was going to run in the election. In my community, there was a minister - a full blooded Cherokee, who also announced he was going to run. I attended meetings and met with constituents, stumping for him. I was a federal employee and, as such, was expressly prohibited from campaigning. My behavior was just stupid. The other thing that was stupid was my political naiveté. The former chief, the one that had hardly any Indian heritage won by 85 percent of the vote. It was one of my first forays into politics and learning how to count votes and understand the system a little bit better before jumping in on pure idealism.

When I said I got fired – what really happened is that I was moved out of that position and into Oklahoma City in Indian Health Service. I was just moved into a kind of non-position for a while. I literally had nothing to do. I had always planned to go to law school, so I applied then. My mother had always wanted me to go to law school. I don't know that she ever said it to me, but I think she wanted me to be either a doctor or a lawyer. I was always good in debate, and I think she thought because I could argue well, it would make me a good lawyer. I went to law school, but never with the intention of being a lawyer. It was public policy that I loved.

In 1971, it looked like national health insurance was going to pass. All the Washington people were talking about how Kennedy and Wilbur Mills and others had put this plan together.⁵ I had done staff work for a group called the Committee of 100 in Washington, DC that was established to enact national health insurance. I thought it would be a great combination to have a health administration background and a law degree as we entered into health care reform and a new health law. It seemed like a perfect combination.

There was a professor at the University of Pittsburgh School of Public Health, Nathan Hershey.⁶ Professor Hershey had established the only health law program in the country. He and I had jogged together when I was at graduate school and we had been good friends. He was one of the founders of Aspen Systems Corporation, a company that published health law books and produced seminars. When I finished college, there weren't that many people going to law school. My college roommate attended Berkeley and another friend attended Harvard, and they had about the same grades and LSAT scores as I did. I assumed that's where I would be going. But, it turned out that by the end of the Vietnam War, law schools were flooded with applicants, and I didn't get into any of the places I thought I could. Professor Hershey called up and said, "Listen, I can get you into Pitt. If they will take you, will you come?" I said, "Absolutely." He said, "I've got a job for you at Aspen Systems."

Even though I come from a family where my mother taught English, among other things, and I had been in good writing programs, Nathan Hershey is the one who taught me to write. He

⁵ In 1971, Senator Edward M. Kennedy became chair of the Senate Health subcommittee and proposed the "Health Security Act," a single payer plan. The Nixon administration countered with the National Health Insurance Partnership Act. In 1974, Senator Kennedy partnered with Representative Wilbur Mills, head of the Ways and Means Committee, on an unsuccessful attempt to establish a compulsory national health insurance plan. More information can be found here: <http://www.kaiserhealthnews.org/Stories/2009/August/26/Kennedy-health-care-timeline.aspx> (accessed June 1, 2012)

⁶ Nathan Hershey, JD, is professor of health law (emeritus), Department of Health Policy & Management, Graduate School of Public Health, University of Pittsburgh. More information can be found here: <http://www.hpm.pitt.edu/directory/bios/hershey.asp> (accessed June 1, 2012)

was a great writer, using just the right words and not too many of them. He was a tough editor. It was a painful, but a good learning experience.

GARBER: At this time, I think while you were working on your law degree, you became an associate director for the Association of University Programs in Health Administration (AUPHA).

GREENAWALT: Yes.

GARBER: How did that opportunity come about?

GREENAWALT: I liked my first year and a half of law school better than any other academic experience of my life. I enjoyed contracts and constitutional law. It was a brand new way of thinking and of looking at things. It was challenging. But by the end of my second year, it seemed that the courses I was taking had no relevance to what I wanted to do. I was going to quit. I had about had it. Dr. Kroeger called Gary Filerman,⁷ who was at AUPHA and said, “I’ve got this guy here who has two years of law school and would really like to learn some things about lobbying. Any chance you need anyone?” He said, “Well, if he’ll come down and run the inside of the organization, I’ll share the lobbying with him, and he can finish his schooling at night school.” I finished at Georgetown and worked during the day at AUPHA.

GARBER: This was in the mid ‘70s. What were the key issues that the association was working with at the time?

GREENAWALT: Gary Filerman and John Griffith,⁸ who was chairman of AUPHA at the time, had been working to get health administration recognized as one of the health professions in order to be eligible for funding under a new law, the Health Professions Educational Assistance Act.⁹ This new federal law provided funding for medical and nursing education and for a number of other professions, but not health administration. They were working hard to get some funding for the health administration programs, most of which were just running on a shoestring.

GARBER: You moved on to Michigan Hospital Association. How did you end up there?

GREENAWALT: I was recruited to Michigan. It came out of the blue. Pat Ludwig,¹⁰ president of the Michigan Hospital Association, called me. He had already checked up on me with a lot of people, so it wasn’t a completely blind call. He said that he wanted to put together a government affairs program – they had never had one – at the Michigan Hospital Association, and

⁷ Gary L. Filerman, Ph.D., was the first president of the Association of University Programs in Health Administration. More information can be found here: <http://www.aupha.org/i4a/pages/index.cfm?pageid=3319> (accessed June 1, 2012)

⁸ John R. Griffith is the Andrew Pattullo Collegiate Professor Emeritus at the University of Michigan. His oral history: Garber, K.M., editor. *John R. Griffith in First Person: An Oral History*. Chicago: American Hospital Association and the Health Research & Educational Trust, 2010, can be found here: www.aha.org/chhah

⁹ The Health Professions Educational Assistance Act of 1976 (PL 94-484), signed Oct. 12, 1976, was intended to increase the number of primary care practitioners and to improve the availability of caregivers in health manpower shortage areas by providing support for training programs. More information can be found here: http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_ERICExtSearch_SearchValue_0=ED148192&ERICExtSearch_SearchType_0=no&accno=ED148192 (accessed June 1, 2012)

¹⁰ Patric E. Ludwig was head of the Michigan Hospital Association from 1974 to 1985. More information can be found here: http://www.mha.org/mha/public_site/awards/ludwig/ludwig_about.jsp (accessed June 1, 2012)

would I be interested in coming? He said, “You have exactly the background I’m looking for, with a law degree and health administration and some association work.” He had recently hired Ken Raske,¹¹ who is now the head of the Greater New York Hospital Association, as the other vice-president, and wanted to know if I would come up. It was an interesting opportunity. It was a progressive organization. John Griffith was then chairing a major committee to rewrite all the public health laws of the State of Michigan. I was interested in that as well. It was an exciting time. Our kids were little. It was a good time to move.

GARBER: What was Pat Ludwig like?

GREENAWALT: He was a hands-off manager. He hated the legislature and government affairs. I think that’s part of why he hired me – he didn’t want any part of it. He was good at getting resources to people who needed them. If there was something I came up with and I thought it through, he always found the money some way. He was good at supporting his staff. He liked working with the members. He also taught me a lesson on the finances of running a hospital association. He was an engineer by training, but had no interest in public policy and not much interest in economics, which is what the other vice-president did. He was a very good association executive. In fact, a number of us across the country trained under him, for instance, the head of the Ohio Hospital Association, the Detroit Metropolitan Hospital Association, and there have been others.

GARBER: In the mid-’70s, when you started at the Michigan Hospital Association, there was a malpractice crisis. Did the association get involved in malpractice insurance?

GREENAWALT: We became heavily involved in malpractice legislation, trying to get the law a little bit more favorable toward the delivery system. Yes, it was a time when there was one of many crises in malpractice. At that time, all companies had decided not to write insurance in the state of Michigan for the Michigan hospitals. So the hospital association formed a malpractice insurance company, and hired a former head of a major insurance company out of Chicago to run it. It’s still going strong. It’s been a cash cow for them. I had little to do with the running of that company. I worked on the legislative side.

Another big issue was certificate of need legislation. There had been a study done that said there were too many beds in the state of Michigan; that there were too many hospitals. There was an argument that if you have too many hospitals, they get filled up.¹² Therefore, the agenda of the day was that we needed to close hospitals. Professor John Griffith had developed a formula for defining how many beds there ought to be in the state of Michigan, and a way of determining which hospitals ought to stay open or be closed.

A coalition was formed with the United Auto Workers and the three motor companies, the most powerful organizations in Michigan, to enact a hospital closure law. The first frightening moment of my career was when the coalition announced plans to force this law through over the

¹¹ Kenneth E. Raske, has been head of the Greater New York Hospital Association since 1984. More information can be found here: <http://www.gnyha.org/3157/Default.aspx> (accessed June 1, 2012)

¹²Milton I. Roemer, Ph.D. was a health services researcher who studied a concept that became known as Roemer’s Law – that a hospital bed built is a bed filled. This concept was influential at the time of the enactment of the certificate of need laws. More information can be found here: <http://www.ph.ucla.edu/pr/miroemer.html> (accessed June 5, 2012)

hospitals' objections. I thought if they had been successful, the hospital association would never be able to manage again because other would know that we were too weak. So I made the decision that we would fight it. I thought, *if that doesn't work out right, the association may have to get rid of me*, because my credibility would be so damaged.

I said to Pat Ludwig, "Listen, they're going to try to ram it through us. Our members are not going to be happy with it. I think we ought to fight it." He said, "Do what you think is best." He understood. Here was the first lesson in grassroots lobbying I learned: If you let the small towns in Michigan know that their hospital is at risk from something that power brokers out of Detroit are prescribing, the small town trustees and other community members that know the legislators well will spring to action. We blocked it. It shocked the UAW and the motor companies. It was a great lesson for me. You can't do it very often, but hospitals are a hell of a source of community power around this country. There was a long political fight over this issue, but we ended up writing a piece of legislation acceptable to hospitals that was incorporated into the rewrite of the public health laws.

This rewriting of the public health laws was the biggest issue at the time. I think the laws hadn't been rewritten since the 1850s. People were proposing all kinds of things, like health manpower and health planning. A lot of things that Bob Sigmond advocated were part of that discussion. For me it was exciting to talk about how you put a health system together that wasn't exclusively hospital-oriented. The question of "how many hospitals there ought to be" was just part of that debate.

Michigan turned out to be a great experience. Our kids were little and we had a wonderful neighborhood. My wife had a great job that she liked. For me, the work itself was exhilarating. With public policy work, you never know what a Monday is going to be like, because something will have appeared in the press, or a hospital member or a legislator will call. It really played to my strength because I'm good at reacting to things, and not panicking. It had excitement to it. There was also a rigor and mental discipline to it. I liked analysis. The lobbying was relatively new to me. There was a lot of contact with members – and I particularly enjoyed the rural members. It felt like going home.

GARBER: Do you recall any particularly influential hospital CEOs?

GREENAWALT: I met Stan Nelson¹³ at Henry Ford Hospital in the most uncomfortable of ways. I had sent a letter to the trustees of member hospitals on a particular issue, without thinking through the political aspects of that distribution very well. One of the people who got the letter was Henry Ford himself. Stan Nelson called up my boss and said, "If Henry Ford ever gets another letter, I want that guy out of here." Despite that inauspicious way of meeting Stan Nelson, he was later gracious about the whole thing and laughed about it, and I've had a lifelong friendship with him.

The other was Ed Connors,¹⁴ who was the head of the Sisters of Mercy system. He and a

¹³ Stanley R. Nelson was head of Henry Ford Hospital (Detroit) in the '70s and '80s. His oral history, Weeks, L.E., editor. *Stanley R. Nelson in First Person: An Oral History*. Chicago: American Hospital Association and Hospital Research & Educational Trust, 1987, is in the collection of the American Hospital Association Resource Center.

¹⁴ Edward J. Connors became president of Sisters of Mercy Health Corporation (Farmington Hills, Michigan) in 1976. His oral history: Weeks, L.E., editor. *Edward J. Connors in First Person: An Oral History*. Chicago:

couple of nuns at Sisters of Mercy always told me that if I ever needed a retreat, that that was the place to go. Sometimes when stuff would get really crazy, I went and spent the day with them. Ed Connors paid a lot of attention to me. Then there was Ed McRee,¹⁵ in Lansing, Michigan – someone who stuck by me. He was CEO of Ingham Medical Center, and just a great person.

GARBER: We've reached the point in your career when you're about to make a move to Washington state. It's the early '80s. How did the opportunity come about?

GREENAWALT: I wanted to get into a multi-hospital system. I had talked to Ed Connors at Mercy, and they did have a slot for me, but it was more on the legal side. Pat Ludwig advised me to interview for this position at the Washington State Hospital Association. He said, "If nothing else, this is worth the experience of going for the interview." I didn't have any interest in it because I thought it was just a typical trade association that would be trying to protect the status quo and it wouldn't fulfill the part of me that loved policy-related work.

I remember the interview clearly. There were 13 people who were on the selection committee. It was like there was electricity in the room – we were brainstorming a vision for health care for Washington State. We weren't talking about just hospitals, either. It was exactly the kind of place I wanted to work.

Washington is interesting in that it's very community-oriented. There are a lot of cooperatives out here. In fact, they used to refer to it as the "Soviet State of Washington." There were some parts about this opportunity that were really attractive to me. I remember calling my wife immediately and I said, "Boy, I hope we get offered this!" They offered it by the end of the interview, even though there were other interviews going on. We just clicked. It was a great moment.

GARBER: That's exciting. The people who interviewed you were trustees of the association?

GREENAWALT: Yes, the other thing that's unique about Washington is they had trustees of hospitals as well as CEOs as board members of the association. Yes, it was a great interview.

GARBER: That's similar to Maryland. Dick Davidson¹⁶ told a story about how he had hospital trustees as his board members.

GREENAWALT: He had only hospital trustees. He had a unique organization. Most other associations were just hospital CEOs. This is one that had about a quarter hospital trustees, and we also had a physician member.

GARBER: Do you remember any individuals on that selection committee?

American Hospital Association and Hospital Research & Educational Trust, 1983, is in the collection of the American Hospital Association Resource Center.

¹⁵ Edward B. McRee became president of Ingham Medical Center (Lansing, Michigan) in 1961, according to the Guide issue: Part 2. *Hospitals, Journal of the American Hospital Association*;36(15):119, Aug. 1, 1962.

¹⁶ Richard J. Davidson was president and CEO of the Maryland Hospital Association from 1970 to 1991, and then became CEO of the American Hospital Association from 1991 to 2007. His oral history, Garber, K.M., editor. *Richard J. Davidson in First Person: An Oral History*. Chicago, IL: American Hospital Association and the Health Research & Educational Trust, 2010, can be viewed here: www.aha.org/chhah



With Janet Skadan, Chair of the Washington State Hospital Association

GREENAWALT: I remember a couple of them. One has been a lifelong friend, Rick Linneweh¹⁷ who was the CEO of the Yakima Hospital and had been on the board of the American Hospital Association. Janet Skadan, who was the sister of the President of the University of Washington, and I hit it off really well. She was the first hospital trustee to become chair of the board of the Washington State Hospital Association. She became the Chair of University of Washington Health System and a member of the AHA Board – a very close friend of Alex McMahon, then president of the American Hospital Association.

GARBER: Let's frame the discussion of your leadership at the Washington State Hospital Association by looking at six goals that were adopted by the board in 2010. What was the process of developing the goals?

GREENAWALT: One thing that I really liked about the hospital association in Washington was that every year we'd have a board retreat. I would often go into it wondering, "Do I still want to do this kind of work or not?" So, even though I'd been working for the association quite a while, every time I'd attend these retreats, I'd be amazed. The members would set aside their hospital hats and declare, "We want to be advocating for the people of the state and for health care." The first goal came out of that. It's something I wholeheartedly agreed with, but it wasn't something I tried to force on them. It came the other way.

With the first goal about access to care, they were saying, "We need to make sure that people in this state are healthier in the future." It isn't just about making hospitals better. There was a lot of debate about this goal, and whether we should put ourselves out in front, saying, "This is one of the things we're going to stand for," knowing we couldn't control the outcome. But they also felt that once we had stated it, then we could bring coalitions together and start working on it.

GARBER: Bob Sigmond told me that an issue that has been important to you has been universal coverage. Why does this resonate with you?

GREENAWALT: It resonates with me because I came from a working class family. We couldn't have afforded health care if it hadn't been for the health care coverage won by years of hard work by my father's union. I remember times when our family didn't have money, and it became clear to me that health care was a fundamental need. How can children learn in school without good health care; or, how can people advance in any way? I believe that unless we cover everybody, we can't reform parts of the system. You can't have a system where a certain percentage is getting

¹⁷ Richard W. Linneweh, Jr. became administrator of Yakima Valley Memorial Hospital (Yakima, Washington) in 1976 and has served for over 30 years there, according to *American Hospital Association Guide to the Health Care Field*, 1977 ed. Chicago: American Hospital Association, 1978, and later editions.



Richard Linneweh, Jr. (left) with Leo Greenawalt

charity care, and you don't have a way of accounting for how they get the care, or how they deal with it. It needs to include everybody.

GARBER: Perhaps your experience at Hastings Hospital contributed to your feelings.

GREENAWALT: At Hastings, the entire tribe *was* covered, and you could plan for the health needs of the tribe, as opposed to just the sickness needs. As underfunded as Indian Health Service was, it delivered care better than many places I've been.

GARBER: Is that still true today, do you think?

GREENAWALT: I don't think so. I think Indian Health has been even more severely underfunded. In Washington State, we did pass health care reform in the early '90s and had a stretch of time where we had almost every child covered, and most working adults. Unfortunately, that eroded over time; so, by 2010, we said we've got to get back to that.

GARBER: Was the Washington State Hospital Association supportive of that legislation?

GREENAWALT: We were a major part of it. Gail Warden¹⁸ and I were part of a coalition called the Committee for Affordable Health Care. The coalition included unions, the public health department, Boeing, and the health plans. We came together once a month to try to get some form of universal health care in the state of Washington. When Gail left, I chaired the group because we needed to keep it going. That group worked hard to get health care reform passed. Our first law was called the Basic Health Plan, which covered about 150,000 workers and their families in the state who hadn't been covered previously. We also passed a law that covered almost all children.

This coalition held together for a long time. We made a commitment to each other, which was: We'll all work as hard as we can to further the goal that brought us together, but not enough to get ourselves fired! We agreed that if we were forced to go against the group, we would come in here first and let the others know. The group had an interesting mix of members. Representatives of the union were there seated next to some of the people they had struck against. But, we maintained this coalition for a long time. Most of us, at some point, went out on a limb in our own organizations trying to push this point of getting coverage for everyone.

¹⁸ Gail L. Warden has had a varied career as a prominent health care executive in the provider, payer, and association settings and is currently a professor at the University of Michigan. In Washington, he was president and CEO of the Group Health Cooperative of Puget Sound from 1981 to 1988. His oral history: Garber, K.M., editor. *Gail L. Warden in First Person: An Oral History*. Chicago, IL: Center for Hospital and Healthcare Administration History, 2010, is available here: www.aha.org/chhah

GARBER: Other than you and Gail Warden, were there other individuals who were instrumental in getting this legislation passed?

GREENAWALT: I think the problem with any kind of legislation is there are probably 100 people that you could say it wouldn't have passed without them, but none of them could claim it as their own. Bill Dowling,¹⁹ who was the head of the Program of Health Administration at University of Washington, was a major factor in this. At the time, he worked for Providence. Some of the union heads were active. The head of the Blue Cross plan was very forward-thinking and helpful during that stretch.

GARBER: Who were the key opponents?

GREENAWALT: The opponents included Republicans who viewed it as “socialized medicine.” We heard that criticism frequently. We ran into it with the small business community as well – some of the same groups that have opposed health care at the national level were very strongly opposed to it in Washington State. It took about ten years. The first couple of years we couldn't even get a hearing. It was very difficult.

GARBER: How did the Washington State Hospital Association approach advocacy in Olympia?

GREENAWALT: Some of my philosophy relates to my early life in my home town. In a small town, everybody talks to each other. You can't have a permanent enemy and survive. I think it is the same in advocacy. I believe in bringing coalitions together. Whether it was unions, chiropractors, drug companies or whomever our group might not necessarily like, I thought they had to be in the room for the discussion. I spent much of my time with various groups trying to work on issues and trying to be careful not to push a point of view too much. I was extremely fortunate to have a very strong and competent Executive Vice President who managed the association so that I would be free to be away so much.

At the same time, we had hired a group of lobbyists in Olympia that was good at doing groundwork. We worked hard on the grassroots part of advocacy, creating a network of hospital people across the state who learned how to lobby, how to talk to legislators and how to arrange local meetings over dinner or coffee. We started a political action committee. In summary, over time we had developed a highly skilled team in a very comprehensive structure for advocacy.

Something that I emphasized early was to find top quality analysts. I always felt that we could overcome the bias that we were a “special interest group” if the work that we did was so well done that people would just accept it. I was careful to hire very talented and highly qualified staff members. I also valued people who had the integrity to tell me when I was wrong, to say “We're not going to do it.” We had top analysts, we had a grassroots organization, we had a PAC, we had lobbyists in Olympia, and we formed coalitions. Finally, we committed to each other never to give false information to win a fight – no matter how important the issue. In advocacy, integrity is the single most important asset an organization possesses. If lost, it can take years to regain. That's how we moved things. Much of my training came from my Michigan experience

¹⁹ William L. Dowling, Ph.D. was a vice president with the Sisters of Providence Health System (Seattle). More information can be found here: <http://www.pce.uw.edu/bio.aspx?id=2782> (accessed June 5, 2012)

I believed that passage of legislation took a minimum of six to eight years. Consequently, when I got excited by some new great idea, I'd ask myself, "Am I willing to put that kind of time into it?" If I were not willing to make that personal commitment, I knew it wouldn't pass unless some other group took up the issue. Some of that persistence I learned from Gail Warden. He was the most patient person. I remember when we first formed the Committee for Affordable Health Care, I was more impatient than I am now. I'd be forcing the issue, while Gail would sit back. I remember once talking to him about it, and he said, "I've learned, you don't force it on anybody. You just take your time and let it work through. When that moment comes, you must be ready and be present." He was incredible at knowing that moment. He knew when the opposition was ready to bargain. I learned a lot from him.

GARBER: We've had the opportunity to include Gail Warden as part of this oral history series. Do you have any other good Gail Warden stories?

GREENAWALT: This is a personal one. Gail and I are both somewhat introverted, but we like each other. We'd sometimes go to lunch together and struggle with conversation. Always a peculiar thing because we knew each other well enough and liked each other well enough that there was sort of a flowing of information, even with little conversation. We used to laugh when we'd do that.

GARBER: The second WSHA goal is to "promote the viability of the health care delivery system, including hospitals, physicians and health systems." Would you draw a picture for us of hospitals in Washington?

GREENAWALT: When I served on the committee that John Griffith put together in Michigan to revise the public health laws, the goal was to get to 1,000 days of care per 1,000 population at some point in the future. That was what they thought was the correct hospital need ratio. When I moved to Washington, the hospitals were already at 700 days per 1,000 population. Today, inpatient utilization in Washington is 350 days per 1,000. We've had a tremendous drop.

Especially in rural areas, Washington hospitals are outpatient facilities with an inpatient facility attached. Almost all of them employ physicians. Many have a public health department housed in the hospital, and they are really community institutions. There are still some strong private hospitals that are pretty much geared toward the fee-for-service system and are having a hard time trying to figure out what comes next. We have different types of physicians across the state, from those who are in group practice to some in their late 50's who are still wishing for the old days and somehow struggle through.

GARBER: The hospital has an inpatient core, and then there's a big outpatient side and a public health department and maybe some nursing home beds, too?

GREENAWALT: In the rural areas, there will be nursing home beds. The urban hospitals mostly will have a visiting nurse service or something like that, or a hospice program, and a lot of them have primary care physicians that are attached to the hospital as well.

GARBER: Is there a well-established referral relationship so that all these small acute care facilities are sending patients in to the urban centers?

GREENAWALT: Yes, we spent a lot of time on that issue. The rural hospitals went

through a strategic planning process in the last couple of years, and came up with a strong statement on quality – saying that no patient should be treated in a rural area who could get better care in the urban area. The rural hospitals maintain that in primary care and in nursing home care and a lot of other types of care, they do it as well as anyone. But when a patient needs highly specialized care – that would be done better in urban areas. There’s been a lot of conversation between the referral centers – Swedish, Virginia Mason, and the University of Washington and, on the other side of the state, with Sacred Heart in Spokane – and these networks of rural hospitals that have been formed. There’s a health information system out of Spokane that has, I think, 30-some hospitals on it.

Washington also has Group Health Cooperative, which is a true HMO with employed physicians, insurance, the whole package, which does affect the way health care is delivered in this area. We have the University of Washington, which trains the most primary care physicians of any medical school. They are set up for that purpose. I think that affects the way medical care is delivered here and why we have such a low use rate for inpatient hospital care.

GARBER: Because of the high degree of managed care?

GREENAWALT: There is a fair amount of managed care and a lot of primary care. We aren’t as heavily specialized as other parts of the country are. A lot of the studies show that if you have a lot of surgeons, a lot of surgery is done. It’s not that we don’t have enough, but we have a little more bias to primary care.

GARBER: I was thinking about the establishment of the referral networks. There’s the argument that patients don’t want to travel, that they would prefer to be cared for close to home. Is this not an issue?

GREENAWALT: Yes, it is an issue. The Seattle and Spokane health systems do send specialists out to the rural community. There’s some of that. Follow-up care, in particular, they’re trying to take care of like that. We’re in the early stages of something in telemedicine. But the issue you raise is a huge one. People don’t want to travel from Sequim to Seattle for cancer care.

When it comes to hospitalization in the rural areas, if it’s something that requires high specialty care, the referral centers are trying hard to get the referred patient back to the local community. It wasn’t always that way, but there’s a lot of work going on in that area. There’s been an emphasis on it the last couple of years, to make sure that the patients get home as soon as possible and get the follow-up care at home, instead of having to travel to Seattle or Spokane.

GARBER: A few minutes ago, you mentioned sending specialists out circuit-riding to provide care in remote areas. Do the physicians like traveling around like that?

GREENAWALT: No, the specialists don’t like it, but I think they see it as a valuable mission. There has also been a change in that more specialists are employed now. Because they are employed, they are less sensitive to the effect of travel time on their potential income; that is, the lost opportunity to see patients while they are driving around. This situation is going to change completely in the next couple of years because of the health reform act. There is going to be a lot more grouping of hospitals and doctors and a focus on serving a population. The urban hospitals are going to need some of the rural areas in their network.

GARBER: Are you talking about the accountable care organization (ACO) concept?

GREENAWALT: Yes.

GARBER: Which of the Washington providers are moving in that direction?

GREENAWALT: There was recently an agreement between Providence and Swedish,²⁰ which was a shock to everybody. Whether they become an actual ACO or not, they certainly see themselves as having a network that provides the whole spectrum of care for a number of geographic areas. I would say they're probably at the forefront among the traditional systems. Group Health has always functioned in that way, where it takes the whole population and treats every part of it. There is a lot of merger conversation going on, and it's all related to positioning for what comes next. Whether it's an "ACO" exactly, as described in the legislation, nobody seems to be sure, because people are unsure of what ACO means. But they are pretty sure that they will be expected to take some form of risk and to cover broader populations. A lot of it goes back to the things Bob Sigmond talked about in the '60s, about how the health care system ought to be divided. Now there's a conversation about caring for the health of the population and caring for an area, as opposed to whoever just walks in the door.

GARBER: Could you elaborate about what you mean by caring for an area?

GREENAWALT: Bob Sigmond used to envision this as dividing a pie. There ought to be part of the pie (the community) cared for by a hospital or group of physicians and insurance companies and pharmacies and others. There wouldn't be so much competing around the whole city.

GARBER: Would that pie be divided geographically?

GREENAWALT: Yes.

GARBER: So, there's a specified service area that this group of providers would care for.

GREENAWALT: That was Bob's idea back in the '60s. There is some movement in population-based care developing now, where people are looking at much larger populations and looking at health care more broadly, because they don't know how to deal with some of the chronic illnesses unless they start treating much broader than when patients just walk in sick.

GARBER: Would you talk about the relationship between the hospitals and the physicians?

GREENAWALT: Washington may be one of the only states where a past president of the state medical association has always sat on our hospital association board. Conversely, for the last ten years, a member of our board has held a position on the medical association board. We've always figured that we had to find a way to work with each other. I learned the need for cooperation the hard way in the early years. More than once the hospital association tried to move legislation and it just wouldn't go anywhere. I learned that attempts to enact legislation without the

²⁰ Providence Health & Services (Renton, Washington) and Swedish Health Services (Seattle) announced the intention to affiliate in October 2011. More information can be found here: www.providenceandswedish.org (accessed June 5, 2012)



Leo Greenawalt (left) at his first board meeting of the Washington State Hospital Association

support or neutrality of important groups were futile. I eventually concluded “This isn’t working.” So, I became a lot closer to the medical association and I worked hard on that relationship.

GARBER: During your tenure were there any larger-than-life physicians?

GREENAWALT: Almost all of the physicians who become president of the medical association are

larger than life, because to get elected in medical association politics one must be very assertive and articulate and passionate. A medical association meeting is like a New Hampshire town meeting with 200 people in the room, and anyone can speak on any subject. The meeting almost always includes a physician who is articulate or brilliant, or both, who gives an impassioned plea on some important topic. The group applauds loudly and pretty soon that person rises to become the president. It’s not quite that simple, but it’s close! Almost always, the physicians were real characters. They would be engaging, get angry, then be laughing – they would exhibit a whole range of emotions. I toured around the state with two of them during one of our malpractice crises. They’d say some things to people and I’d sit there and wonder, *how are we going to get away with this?* It was funny at times. However, these leaders were often so charismatic and engaging that the audience would forgive any outlandish statements.

GARBER: The third WSHA goal has to do with patient safety, with the objective to: “lead hospital, physician and health system efforts to achieve zero preventable deaths, injuries and infections.” That’s a tough mark to hit.

GREENAWALT: This goal came about because a number of our CEOs and physicians had gone to a meeting of the Institute for Health Improvement with Dr. Berwick,²¹ and had come back on fire with this issue of – why are we in this profession if we’re killing people? At one board retreat, out of nowhere, one of the physicians said, “We need to commit to the 100,000 Lives Campaign, and right off, we want to make sure that every hospital in this state is on board.”²² This was shocking for me, because we weren’t used to being a regulator of hospitals. They voted unanimously that they wanted to do it and they wanted everyone in.

²¹ Donald M. Berwick, M.D. is founder of The Institute for Health Improvement and served in the Obama Administration as administrator of the Centers for Medicare and Medicaid Services. More information can be found here: http://topics.nytimes.com/top/reference/timestopics/people/b/donald_m_berwick/index.html?inline=nyt-per (accessed June 5, 2012)

²² In late 2004, the Institute for Health Improvement initiated a campaign to enlist hospitals nationwide in an effort to avoid 100,000 unnecessary deaths. More information can be found here: <http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.295.3.324> (accessed June 5, 2012)

Once that began, the hospitals taxed themselves \$500,000 to set up a program to improve patient safety. The debate around it was: If we're killing people and causing harm, we shouldn't be, and this was the most important thing we could do. Then it came around to the question of what should the goal be? People were talking about a goal that would be reachable. But Dr. Vassall²³, a member of the WSHA Board and the long-time speaker of the house of the medical association, was clear. He said, "We can't commit to anything less than that no one should die in our place because of something we caused." That's how that came about. It was a member-developed idea, and there was an incredible passion around it by the members.

There were two people in particular – Diane Cecchetti²⁴, who is the CEO of MultiCare in Tacoma, and Dr. John Vassall, who was the president of the medical association, who were strong on this, and almost everybody agreed. There were some hospitals that didn't like being told what to do. In fact, the board even debated whether, if hospitals didn't join this, they would be permitted to be part of the organization anymore. However, they didn't do that.

GARBER: You mentioned that the hospitals voted to tax themselves half a million dollars. What was set up with that money?

GREENAWALT: We hired Carol Wagner, who came in and set up a program. We have a chief medical officer and group of physicians that meet regularly, a patient safety committee, and a number of other organizations who all worked on reducing these deaths. There are specific goals. We then received a grant from Premera²⁵ of \$1 million and we've had some other grants. Except for the last year, when he's been in his position in D.C., Dr. Berwick's been very active in traveling to Seattle or visiting with our committee by conference call. He always encouraged us to keep pushing onward. We've received a wonderful AHA award – the Dick Davidson Award – this year for that program.

GARBER: Congratulations. That's the first Davidson award?

GREENAWALT: First one, yes.

GARBER: What have been the results of the initiative?

GREENAWALT: Almost every measure is improving. Some things, like infection rates from intubation, have gone almost to zero. There were perhaps 13 or 14 deaths a year, and they're pretty much not happening any more. I think there are five different standards that the Institute for Healthcare Improvement suggested, and we decided to go forward with all of them. Carol Wagner keeps statistics on every hospital in the state. They have to report in. It's measured, has strict goals, and the members really like it.

²³ John H. Vassall II, M.D., is chief medical officer at Swedish Medical Center (Seattle). More information can be found here: <http://www.swedish.org/About/Overview/Leadership---Governance/Senior-Leadership/John-H--Vassall-II.-M-D-#axzz1wwIN9SjJ> (accessed June 5, 2012)

²⁴ Diane E. Cecchetti has been president and CEO at MultiCare Health System (Tacoma) since 1999. More information can be found here: <http://investing.businessweek.com/research/stocks/private/person.asp?personId=5966149&privcapId=4235275&previousCapId=753210&previousTitle=First%20Choice%20Health%20Network%20Inc> (accessed June 5, 2012)

²⁵ Premera is the Blue Cross plan serving Washington and Alaska. More information can be found here: <https://www.premera.com/stellent/groups/public/documents/xcpproject/home.asp> (accessed June 5, 2012)



Washington State Hospital Association board retreat

GARBER: I imagine it makes for wonderful positive publicity.

GREENAWALT: It's had a great impact in the legislature. There were things that the legislature wanted to regulate, and we have been able to show them that we take an issue on, we tell the truth, and we do it. We didn't do it for that purpose, but that's been the halo effect.

GARBER: I saw a news item about the flu vaccination campaign.

GREENAWALT: That was a similar thing. Flu is an infection. It doesn't seem right for our hospital caregivers to walk into hospitals and infect patients. First we met with the medical association, then with the nurses unions and others and tried to work out some kind of agreement on how we might do it. We couldn't get agreement. We were going to use legislation. Then the board voted to ask every hospital in the state to require immunization as a condition of employment. The number of people that are vaccinated has gone way up. We've got a couple hospitals that are at 90+ percent, up from 40 percent. I don't think any hospital has dropped as far as the vaccination rate. It's been a strong push. It was opposed by the unions as almost a civil rights issue. I think they were stuck in an awful bind where they had to speak up, but they knew they were on the wrong side of the issue. I think they were glad that we did it the way we did, and not through the legislature, because the first year they opposed it and got awful press for, "Why would you want to kill your patients?" When it came to pushing it the way we did, they backed off.

GARBER: That comment about unions leads us into the fourth goal, having to do with the workforce. The goal specifically reads: "to improve the availability of skilled, well-trained, diverse and productive health care professionals to serve the health care needs of our community." Are there enough physicians in practice in Washington State?

GREENAWALT: There are probably enough in total but the mix isn't right. People are saying at least 50 percent of physicians should be in primary care. While we're higher than most

states, we're not anywhere near that number. We have oversupply in some specialties and undersupply in others. There's a bad mixture.

Because of the recession, there is no nursing shortage. But there will be a horrible problem when the economy turns around. There aren't enough nurses for the care needed, not even close. The other problem is that the average age of a nurse in our state is 49, and 49-year-olds can't do what 24-year-olds can, like reading prescriptions without glasses or lifting patients. A lot of nurses have been retiring in their late 50s, as opposed to working until they're 70, because it's physically too hard.

GARBER: I would imagine that there are distribution issues. Physicians do not want to be out in the rural areas. They want to be in Seattle.

GREENAWALT: Yes, Seattle and Spokane are attractive.

GARBER: Where are the state's academic medical centers?

GREENAWALT: One thing we're really blessed with is that we only have one medical school. The University of Washington Medical School is the only medical school for Washington, Alaska, Montana, Idaho, and Wyoming. Oregon also has a medical school. We don't have the difficulty of competing medical schools producing the wrong kind of physicians. It's been this way for 40 years now.

GARBER: I would imagine that the UW medical school is pretty powerful then.

GREENAWALT: Yes, it's very powerful.

GARBER: That being the case, do you feel that the UW medical school is making correct decisions for the area?

GREENAWALT: Our medical school has three functions. They're one of the top, if not the top, research medical school in the country. They obtain lots of grants from the National Institutes of Health and other places, and they've always done that well. That goes way back to when we had a powerful senator, Warren Magnuson. He's the one that started the medical school. A lot of what they do is research, but they are also involved in teaching, of course, and they do some patient care delivery. Those three purposes sometimes don't have as much to do with the needs of the state of Washington as they have to do with how you produce researchers for the world.

GARBER: That's the classic model for an academic medical center, that it has those three components.

GREENAWALT: It's also what causes problems when hospitals are trying to say "You're not producing the right kind of doctors for us." The University of Washington is a great medical school. They get so much money from the federal government, they wouldn't survive without it. But it drives them to produce a certain kind of physician. Over the years, I've had the dean of the medical school in meetings with the hospital CEOs and others, and the conversation always returned to the "kind of physician we need and you're not producing." The dean's answer was, "The kind of physicians we're producing are for the future." There has always been tension.

But, the kind of physician that's needed for the future is the primary care physician. Under the fee-for-service system, specialists get paid more, and get paid by the amount of service they give. Many hospitals want to continue with their specialists, even though they know that when they look out five years, this model isn't going to work any longer. The medical school is often talking about the kind of specialists they produce around research or some issue like that, or maybe primary care. They're very good at primary care. But not what the hospital CEO back in Vancouver, Washington is saying that he needs next year or the next couple of years.

GARBER: You have to bring those doctors in from somewhere else. You have to attract them to Washington State. Has the state been successful in this?

GREENAWALT: Seattle is a magnet city, or it has been until the last couple of years. In fact much of the Western side of the state attracts many immigrants from other parts of the country...and the world. People from all over want to come there for their residencies and a fair number stay. There are strong residencies at Swedish and the University and Group Health and a number of others, and at the Tacoma hospitals, too.

GARBER: I wonder what impact television shows, like "Grey's Anatomy," have in drawing young people to Seattle.

GREENAWALT: I think "Grey's Anatomy" and "Northern Exposure" show the kookiness of Washington – it's a friendly, eccentric, earth-friendly place. A lot of people want to come here just because of that. Many come here during the summer, and it's the most beautiful city in the country in July and August, when it's not raining, and we have these long days. It's been easy to attract physicians.

GARBER: If we move along to the fifth goal, it is to "help members respond to new demands and opportunities to deliver reliable, patient-centered, high quality and cost-effective care." Do you have any comments about this goal? Was that goal member-driven?

GREENAWALT: Yes, it was member-driven. Members were looking at how and why, in a competitive market, it's been difficult for people to share information. This was a statement to each other of how to learn from each other and how to learn from people who go to national meetings. In essence, they were saying: we need to learn together, not compete. There is conversation about how hospital systems organize care, how they look at electronic medical records and other similar activities. Many would like to find ways together to adapt to the future.

I think what caused a change in attitude toward competition as much as anything was a sense that when health care grows into the middle years of health care reform, there is not going to be enough money. If there are ways of making the system more efficient, all hospitals might prosper, and if they don't do something together, they know there is going to be a continual arms race. It's all related to – is there some way we can work on some of this together, as opposed to killing each other off? That's a tough one. It's big and it's hard to do. One physician hospital CEO said to me, "It's so hard. We come into these meetings and we talk about how we're going to do things together and we really work hard on it and we really mean it. Then I go back to my office and we talk about how we can kill the guy down the street. How do we do that?" But they're talking, which I think is the important thing.

GARBER: The cooperation vs. competition problem has been an issue for years.

GREENAWALT: It has been, and I think the difference is that now people realize there is a finite amount of money. It used to be that leaders would come together because they ought to do it. I think now some of the CEOs see this as a survival question. If they don't find a way to dampen this rate of increase, there is going to be some other way of doing it. Most fear a governmental solution will damage much of what is good about American medicine.

GARBER: I also read this goal as having to do with the role of the state hospital association. At the American Hospital Association in the early '90s, there was a sea change when Dick Davidson came in. One previous function of the AHA, which had been to produce a lot of educational and operational support materials for the members, went away and the focus shifted to advocacy in Washington. How does WSHA balance those different activities?

GREENAWALT: About the same time, we eliminated much of the "helping the member" activity. The role became more of convening them and much more emphasis on advocacy. I was on the AHA board when Dick Davidson was CEO, so I was influenced some by that same movement, too. To survive we concluded we must retreat to activities that we really did well and were highly valued by the members.

GARBER: It's an interesting balance. There are members – maybe not at the CEO level, but at other levels of the hospital – who think, *Well, the American Hospital Association or WSHA should have something that's going to help me run my department better.*

GREENAWALT: Many hospital professional are just furious about the decision to pare back our services. In fact, you have described a most important issue for hospital associations. I knew that the members weren't willing to pay for it anymore, so I couldn't kid myself. There was no question we were doing a service because people were coming in and were getting something from it. The social workers used to come and meet, the CFOs did, public relations, the whole group, yet we just cut it out. The worst part about it for me was, when I talked to a member about what we did for them as an organization, they didn't even know their people were coming to a meeting and talking to peers. Since they didn't know, they assumed it wasn't worthwhile. That was a painful stretch.

GARBER: What is the relationship between the state hospital associations and the AHA?

GREENAWALT: It's been mixed. Carol McCarthy²⁶ had been a CEO of two different hospital associations. For some reason she took almost a hostile stance against state and metro hospital associations. Eventually the group turned against her. It was an awful thing to watch, but somehow we all survived it. Dick Davidson then was selected as CEO. He was clear from the beginning, together with Rick Pollack²⁷ that they viewed the state and metro associations as their partners, and wouldn't move forward without us. It's caused some difficult meetings sometimes because trying to bring the whole group together is not easy. When you seek consensus from states as diverse as Mississippi and Washington, for example, it is not easy. But at least for a while during the '90s, I'd say we were all on the same page most of the time.

²⁶ Carol M. McCarthy, Ph.D., was CEO of the American Hospital Association from 1986 to 1991.

²⁷ Richard J. Pollack is executive vice president, advocacy and public policy, at AHA.

As we got into the late '90s, some of the new CEOs of hospital associations didn't have the same background as the executives of my generation. Some didn't have a health care background, or they didn't have a hospital association background. They had backgrounds such as broader association executives or as advocates, and they were very good at their work, but they were harder for AHA to manage. A number of them did not feel the same allegiance to the American Hospital Association. Many were more likely to agree with the group only when the issue furthered the interest of their state. This differed from the earlier group that I was part of. I saw the success of the AHA as part of my job. Particularly people like Dick Davidson and Rich Umbdenstock,²⁸ whom I've known for a long time – if they wanted me to do something that wasn't in my best interest, I'd do it unless it was outrageous. Of course, that seldom was the case. Now the test always is: is this what our particular association wants to do vs. what AHA wants? I think that's much more difficult. The older group would stick with AHA through almost anything.

The current association executives are really good at association work. By that, I mean, they could run an association for anything. I don't think I could have gone to the real estate association, for example, or the truckers.

GARBER: The sixth and final WSHA goal is to “improve the health of the population while maintaining or reducing the cost per capita.” Bob Sigmond told me that you brought attention to the idea that Washington should be the healthiest state. Bob David, who is an AHA regional executive, told me about the West Coast mindset, which makes people out here more receptive than other parts of the country to wellness and preventive care. Have you seen any improvement in the overall health of Washington residents over the past decades?

GREENAWALT: There has been. As a state, about ten years ago we got active on the anti-smoking campaign. Our current governor, Christine Gregoire, was the lead attorney general who settled with the tobacco companies years ago, so it's been dear to her heart as well as to our health department as well as with the hospitals. Hospitals chose to become smoke-free campuses long before the rest of the country did.

We engaged with many of the hospitals on employee exercise health programs. It's been a big movement in our state. That's as much Washington as it is the Washington State Hospital Association. It's a phenomenon in the Northwest. I've been on the board of the Healthiest State in the Nation Campaign. One of the things that we look at is improving health care. Getting kids to the dentist is probably more important than half the other things we do. We have about ten different things we measure. The hospital part of these campaigns can be a very small part of improvement.

On the other hand, the hospital association members became very committed to improving health, not just hospital care. Much of that charge came from Don Berwick, who challenged all of us. It was a stretch goal that we knew we couldn't attain, but we always have it on the board looking at it – are we doing something to work on that side of it?

GARBER: You've mentioned Don Berwick a number of times. What a legacy he has of influencing so many people. You've met him?

²⁸ Richard J. Umbdenstock has been CEO of the AHA since 2007.

GREENAWALT: He and I were on the board at the same time at AHA.

GARBER: Could you draw us a picture of Don Berwick?

GREENAWALT: He's very quiet most of the time. He's not drawing attention to himself. Yet he's passionate. When it's time to speak, he's on it. When he's going to make a point, he does it as well as anybody I have met. When I was on the AHA board, he kept pushing for improved patient safety in American hospitals. Early on, there just was not much traction on that issue. One day he made a presentation to the group and everybody joined him with enthusiasm. He is like the Pied Piper in the best of sense. I do get attracted to that kind of person. I grew to like him, I think, the day I met him, and we did work on things at AHA together. Then when we started moving on to things on patient safety at WSHA, he's the first one we called to come out and help us out on it.

I'm just sick that he lost his position. He's the best we've ever had in that spot. He did not receive Senate confirmation for reasons that have nothing to do with who he was or what he believes in. It was pretty upsetting. If I had not met him, I would think he's this larger-than-life person. But he's one that when you sit down with him, he's interested in you, not in something else, and he's not full of himself or anything like that, but is inspirational, he believes we can do better.

GARBER: He's no longer head of the Centers for Medicare and Medicaid Services (CMS)?

GREENAWALT: He just left yesterday. He was appointed to the position 18 months ago, but if he wasn't voted on by November of this year by the full Senate, the position ended. They didn't vote on it. The Republicans made it clear that they wouldn't vote on it because he was for "socialized medicine" and he was for "killing old people." He had made a statement that England had done some really good things in health care. He said that every physician ought to be able to talk to patients about end-of-life activities, and it got twisted. A lot of it was anti-Obama, so it wasn't just him. But for those of us who knew him – we've never had someone in that position with the leadership and the knowledge – usually you have political appointees put in that position. Berwick entered the job knowing what he was talking about, substantively the best we've ever had. It was a big loss.

Who knows what he'll do? Some big organization is going to let him continue doing this, I think. He's had a big influence on our organization. Bob Sigmond has, too. I brought Sigmond out here every ten years or so. He managed a board meeting one year – gosh, he just upset them terribly at the moment, but at the end of it, he made some ridiculous statement, and everyone perked up. It was his typical way of getting them to think through what they were talking about.

GARBER: Do you remember what he was talking about?

GREENAWALT: Something to do with the relationship with Premera, our local Blue Cross Plan. We sued Premera. I don't remember what he said. I just remember that he said it in a very provocative way.

GARBER: Why did WSHA sue Premera?

GREENAWALT: They wanted to become a for-profit organization, and we, the hospitals, had formed Premera originally (it was a Blue Cross plan), and they were to be a not-for-profit, caring for people in the state of Washington. They wanted to go to be an investor-owned company, on the

New York Stock Exchange, and we blocked it.

They're still not-for-profit. When Blue Cross plans convert to for-profit status, often those executives make \$20 million or \$30 million during those transitions. It's a horrible incentive. Even though we sued Premera, the CEO of Premera and I kept the relationship intact the entire time. I worked on it really hard, as did he, to make sure that we didn't create an enemy, because I knew Premera is important in our lives and in some of the things we stood for.

GARBER: Who was that executive?

GREENAWALT: His name is Gubby Barlow.²⁹ Actually, after the lawsuit was over, Premera did grant us \$1 million on the patient safety campaign. So we kept the relationship strong.

GARBER: The last WSHA goal mentions bending the cost curve. That's a vitally important aspect. What is the financial health of hospitals in Washington State?

GREENAWALT: In 2011, they're still pretty healthy but declining. 2012 is going to be a miserable year. Hospitals will not be receiving updates on Medicare and Medicaid; the health plans are holding the cost down; the number of uninsured is rising. I think it's going to be a miserable three or four years for hospitals.

GARBER: What's the overall economy of the state like?

GREENAWALT: Washington goes into recessions worse than other states because we have Boeing and a couple of other very large employers that get hit hard. It's been very difficult – high unemployment, the state budget out of whack. The good news is that the state economy is poised to start growing again. Boeing is hiring people right now. Microsoft is going strong. So I think we're at the beginning stages of the coming out time. That usually is a six or seven-year period.

GARBER: What actions are the Washington state hospitals taking to try to bend the cost curve?

GREENAWALT: I think that's the goal we've had the least success on. When the members developed that as a goal, I think they really meant it. At the same time, competition started to heat up, and I think there has been very little movement on that goal in the last year. There is a lot more merger activity going on, but I don't know if that bends the cost curve or not. The main thing the hospitals are working on is the patient safety and quality side. But the dream that everyone had about really organizing better – I think they're now much more trying to position themselves for health care reform. The last 24 months has been the biggest building period that I can recall.

GARBER: As someone who has a passion for health policy, what are your views of the health reform law?

GREENAWALT: I'm glad it passed. I think we needed to have a stake in the ground so

²⁹ H.R. Brereton (Gubby) Barlow, is president and CEO of Premera Blue Cross. More information can be found here: <https://www.premera.com/stellent/groups/public/documents/xcpproject/executives.asp> (accessed June 5, 2012)

the country could move forward. It didn't do enough on reorganizing the health care system. But if it survives the Supreme Court test and this next stretch of time, I think it will set the stage where we start talking about the health of populations, as opposed to the sickness of them.

GARBER: During your long career at the Washington State Hospital Association were there members of the team that particularly influenced the successes?

GREENAWALT: Yes, I was blessed with outstanding leaders among the staff of the association. I believed that the single most important decisions I made were the selection of outstanding staff. Important, but not an easy task. I never felt confident that my interviewing skills were sufficient to find the best and the brightest. Also, I didn't trust letters of recommendation from people I did not know. So, rather than using search firms or advertising in national magazines, I almost exclusively relied on people I had met during my career to steer me toward the best. When it came time to recruit for a position, I always called on people I had known for a long time to help me find the right person. Often the person I selected had been described as one of the best my friends and colleagues had recommended.

For example, I received a call from the director of the University of Washington Program in Health Administration about Victoria Galanti. He said that Victoria was among the brightest and most organizationally savvy of any of his graduates, and he had been around for a long time. Victoria became the most senior vice president and COO of the organization. She seemed to be exceptionally strong in nearly every part of management in which I was weak. I can't imagine how the organization could have succeeded without her. My own career would not have moved forward without her.



Rural CEOs in a basketball skit

I received a similar call from a colleague in Washington DC about Claudia Sanders. Claudia established a policy program at WSHA that outsiders recognized as one of the strongest among all health organizations in our state and among her peers across the country. Claudia insisted on the highest quality in research and integrity. Policy leaders and other health organizations came to rely on her position papers and her considered judgment on a broad array of subjects.

Greg Vigdor came similarly recommended from Alex McMahon and the CEO of the New Mexico Hospital Association. Greg uncovered a spectacular number of grants and many other sources of funding. That funding saved at least a quarter of our rural hospitals from closing and helped many others to grow much stronger. Greg became president of the hospital association's foundation which eventually grew into the Washington Health Foundation.

Robb Menaul had joined the hospital association before I arrived and retired at the same time. We worked together for thirty years. Robb was simply the most versatile staff member I have

ever met. I can't remember any assignment he did not complete with superior results. A good writer, an excellent lobbyist, loved by the members and highly ethical. Not only that, Robb managed all of the WSHA shared services programs.

Of course, there were many others, but these four were at the forefront of nearly any accomplishments by the association. It was always difficult to have others give me credit for a particular activity when I knew one of these people had done most of the thinking and the work. However, I will take full credit for hiring them and keeping them for my entire time at WSHA.

GARBER: Would you like to talk about your family? How did you meet your wife?

GREENAWALT: Nancy and I have been married 46 years. She is from Erie, which is near Titusville. I was returning home from Notre Dame for Thanksgiving. A priest picked me up and wanted to know if I'd go with him to meet a family he planned to visit. It was Nancy's family and we just hit it off from the beginning. We started dating and got married three years later. My wife is one of the most reflective persons I've ever met. Her continual self examination has affected me deeply, causing me to re-think my behavior and pay attention to my sense of mission. Much of my success is related to the many long discussions, sometimes painful, that have defined our marriage.

Our daughter is a veterinarian and has a two-year old boy now. Our son is the lead designer for a very successful set of video games. He works for Microsoft and has four-year-old twins. Nancy and I love our children's spouses and they like us, too, which is great. You never know how that's going to work out! We're really lucky.

We are trying to figure out what we're going to do together in the next 20 or so years. It's been a wonderful stretch of time for the two of us. I'm trying to figure out what we have in common and what we can do together. People keep asking, is your wife really upset having you home? We just haven't had that struggle at all. We enjoy that time.

GARBER: Are there specific things that you've already identified that would like to do in retirement?

GREENAWALT: I joined the board of Group Health, which is the HMO. I had to run for that elected position. I didn't particularly want to face voters, but there was no other way. I think Group Health is the system of the future, and I wanted to go be part of the Group Health system. I've been a member of Group Health for a long time. I've also accepted a position at University of Washington in the health administration program. But, you know, a lot of what I want to do in retirement is rediscover what was me when I was young and in Titusville. This is going to involve more sports – I've been playing golf the last couple years.

I don't know whether I'll go on to another career or not. I'm trying to stay away from anything for six months or so, just so I don't jump right back in. When people have asked me to do something, I've said no because I'm afraid if I went right back in, I'd never break from the past, and I'm trying hard to do that. I'm also trying to make sure Bob Sigmond doesn't make me feel guilty, because he, of course, has the rest of my life planned out for me.

GARBER: What does Bob want you to do?

GREENAWALT: He wants me to write. He has been on my case for years for not writing enough, because as you know, he's a prolific writer. His topic of social movements and covering everyone – he's as passionate today as he was decades ago. He'd be damned mad if I didn't stick with that, because he feels he's invested in me.

GARBER: I'd also like to give you the opportunity to mention any other individuals who have been influential or who had been mentors.

GREENAWALT: One who has been a very good friend – I don't know that “mentor” is the word, but he is certainly the senior executive among our group is Duane Dauner³⁰ from California. He's been really helpful to me over the years. We went from being colleagues to being good friends, but part of that was because whenever I would call him for anything, he would help out. I learned from him. California is a wild state. Every social movement in the country goes through there at some time. Some come here to Washington and some don't. I've really learned a lot from him and been part of that.

GARBER: Do you have words of advice to young people who are considering a career in association work or in the hospital field?

GREENAWALT: Yes, I do. One thing I learned early on is that I am highly intuitive. On the Myers-Briggs, I score as highly intuitive, highly feeling and highly creative, whatever those things are. I learned early on that I had to find what my strengths and my passions were and stick to that, and not try to make myself into something I wasn't. If I would give advice to people, it is to find that part of themselves where the passion is and to nourish that passion, as opposed to where the career might take them, and to be careful to stick to their strengths. I find that where I'm weak, other people can do something in one hour that takes me eight hours to do, and where I'm strong, they can't do it. That's part of it.

Sy Gottlieb³¹ told me, “You need to have two or three things you believe in so much, you're willing to be fired over, because if you don't have that, you're not worth it to anyone. If you have more than four or five, you're such a pain in the ass, nobody wants you.” He said, “You better find those.” I think that's some of the best advice I've ever had, and I think I would give that to anyone. When I started out, I'd take on every issue. This was ineffective, and I see many young people doing that. They stand up for issues that they can't change, yet they don't have one issue that's central to their beliefs.



(L to R) WSHA CEO Scott Bond, Duane Dauner, Leo Greenawalt, and WSHA Chair Sara Patterson

³⁰ C. Duane Dauner is president/CEO of the California Hospital Association.

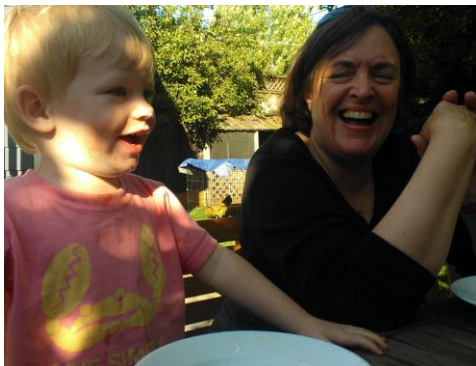
³¹ Symond R.V. Gottlieb was executive director of the Greater Detroit Area Health Council in the '80s. His oral history is: Weeks, L.E., editor. *Symond R.V. Gottlieb in First Person: An Oral History*. Chicago: American Hospital Association and the Hospital Research and Educational Trust, 1987. It is in the collection of the American Hospital Association Resource Center.

GARBER: What were those issues for you?

GREENAWALT: Covering the uninsured, particularly covering children, has been something that has driven me. I worked on it in Indian Health Service and other times. This came partly out of my family's union background, and growing up where I saw people that didn't have health insurance coverage. The other one has been improving the health delivery system. Every time we got into an issue, I asked myself, *is this going to make things better in ten years, or are we just paddling water?* If it was paddling water, I didn't want to get into it. Those were the two I stuck with the most.

GARBER: Thank you very much for your time today.

GREENAWALT: Thank you.



Grandson with Nancy Greenawalt



With son Dan



With daughter Jane, and Nancy Greenawalt (right)

CHRONOLOGY

- 1944 Born May 26, Titusville, PA
- 1966 University of Notre Dame (South Bend, IN)
Bachelor of Arts (Liberal Arts)
- 1967 Married to Nancy Bossart of Erie, PA
Children: Jane, Daniel
- 1967-1968 VA Medical Center (Pittsburgh, PA)
Administrative resident
- 1968 University of Pittsburgh
Masters in Health Services Administration
- 1968-1969 US Public Health Service Hospital (Washington, DC)
Medicare Grants Management Office
- 1969-1971 William W. Hastings Indian Hospital (Tahlequah, OK)
Executive director
- 1971-1973 Aspen Systems Corporation (Rockville, MD)
Research associate
- 1973-1975 Association of University Programs in Health Administration (Washington, DC)
Associate director
- 1974 University of Pittsburgh
J.D.
- 1975-1981 Michigan Hospital Association (Lansing, MI)
Vice president (government affairs)
- 1981-2011 Washington State Hospital Association (Seattle, WA)
President/CEO

MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives
Fellow

American Hospital Association
Committee member

American Red Cross
Member

Gonzaga University
Adjunct professor

Health Insights
Member

Hospital Executive Study Society
Member

Kid's Health, King County
Sponsor

King County Executive's Advisory Group on Improving Public Health
Member

Mayor's Committee on Uninsured
Member

Michigan Public Health Statute Revision Project
Member

Puget Sound Blood Center
Member

Rotary
Member

Seattle Chamber of Commerce
Member

State Hospital Association Executive Forum
Member

United Way of King County
Member

University of Michigan

Guest lecturer and preceptor

University of Washington
Adjunct professor

Washington Committee for Affordable Health Care
Member

Washington Governor's Commission on Health Insurance
Member

Washington Health Care Forum
Member

Washington Health Foundation
Member

Washington Health Reform Task Force
Member

AWARDS AND HONORS

Board of Trustees Award, American Hospital Association

Endowed Chair in Public Policy in name of Leo Greenawalt, University of Washington

Gold Medal Award, American College of Healthcare Executives

Healthcare Leadership Award, Washington Health Foundation

Leadership in Health Care, Group Health Foundation

Lifetime Achievement Award, Seattle Business Journal

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