



LOWELL C. KRUSE
In First Person: An Oral History

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LOWELL C. KRUSE

In First Person: An Oral History

**Interviewed by Kim M. Garber
On May 15, 2015**

Edited by Kim M. Garber

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EDITED TRANSCRIPT
Interviewed in St. Joseph, Missouri

KIM GARBER: Today is Friday, May 15th, 2015. My name is Kim Garber, and I'll be interviewing Lowell Kruse, who served for 25 years as the president and CEO of Heartland Health in St. Joseph, Missouri, and then transitioned to a new role as Senior Fellow for Healthy Communities with the Heartland Foundation. Lowell, it's great to have the opportunity to speak with you this afternoon. Let's talk about your childhood. Could you tell about your parents and how they ended up farming in Iowa?

KRUSE: My dad was born in Draper, South Dakota, but grew up in a farming family in Carroll County, Iowa. My great-grandmother, Minnie Kruse, and her husband came to Carroll County in the 1880s. Minnie was born in 1863, when Lincoln was president, and she was at our wedding in 1964! They bought the family farm from a Union soldier who had been given 160 acres for serving in the Civil War. That is our base farm and is where my cousin, Duane, lives. He farms all the land that is still in the Kruse family. There were four brothers who all farmed around Calhoun County and Carroll County. My two sisters and I still have some farmland in both Carroll County and Calhoun County that Duane farms. He's the last of our family to be farming.

GARBER: That's kind of sad.

KRUSE: Yes, but that's the way farming has gone. I grew up on 160 to 250 acres of land, and that took care of all of us. Now it's thousands of acres. Like everything, farming is changing dramatically.

GARBER: Was your family affected by the Dust Bowl during the '30s?

KRUSE: Not really. My dad lost a lot of money during the Depression. When you grow up with parents who were farming and lost everything, you always hear about that. It made them conservative in terms of banking. They never bought anything unless they had the money, except for large purchases of farmland. The Dust Bowl wasn't such an issue. It was more the Depression that got them.

GARBER: Did those values pass along to you?

KRUSE: Absolutely. When I was young, our farm didn't have running water in the house. I went to a one-room schoolhouse. There were two other kids in my class – it was like a group of families that got together and home-schooled. We had 14 or 15 kids in the school, and Margaret Ann Halvorsen was our teacher. I grew up on a typical farm, and we didn't know any different. We didn't have a lot, but we didn't think we didn't. It never came up because everyone was like that.

Growing up on the farm, particularly with parents who had been through the Depression, everything was about work, being responsible, taking care of the land and taking care of your animals. Going to school wasn't a big priority, but we needed to do that. My parents had an eighth grade education. In my parents' generation, they weren't encouraged to go beyond the eighth grade because they had to go to work. I had one uncle who wouldn't let his kids go beyond the eighth grade.

Being responsible is a great way to grow up. I think about that many times in terms of children today growing up in large communities like Minneapolis and Rochester. They don't have quite the

same opportunities that farm kids do. You still see the difference in some of the kids who grow up on farms here in northwest Missouri and Iowa. It's a unique environment to grow up. There are few people who can do that anymore.

GARBER: That's an interesting observation in that many people would look at it the other way around – that children who grow up in the large urban areas have more opportunities than those who grow up in farming areas.

KRUSE: In urban areas they have more opportunities for more exposure, but I think that the opportunity to grow up on a farm teaches responsibility in a different way. Usually, you're started to work young, but you don't even know that you're working – you're expected to do whatever you can at whatever age it is. You learn how to drive early, and you learn how to take care of animals. There is no messing around. When work has to be done, it has to be done. You're not influenced by a lot of other behaviors. Everyone does the same thing. It's one of those things that gets ingrained into you – that you're responsible. You've got to milk the cows twice a day. You've got to feed everything. You've got to plant. You've got to do whatever needs to be done at the time.

Then, if it doesn't rain, or it rains too much, you live or die by that economically. Without even knowing it, you become attuned to the cycle of life, how everything is connected, what your role in it is and that you're responsible. That doesn't mean that all of us who grew up on the farm were always responsible while we were growing up. Sometimes you wanted to go off and cut up a little bit, which we all did. I'd have to admit to that without telling you exactly what I did! I do remember coming home a couple times early in the morning and having to go right back out into the field without going to bed. I think my dad was waiting for me. When you spend all night doing something you shouldn't, and then all day on a tractor, you decide you don't want to do that too much.

Growing up on a farm and the responsibility that we learned led me to be grateful for what I have, to be accountable, and to be conservative financially. I don't like to borrow a lot of money. I don't like to buy things that I can't pay for. If I decide to borrow money to buy something, it's because it's a better way of using the money. My parents didn't trust the banks. Our cash reserves were in the false bottom of a cupboard. We all knew where the cash was, but no one else did. You had to know how to lift up the bottom of the cupboard to get at the cash.

GARBER: And the cupboard wasn't fireproof.

KRUSE: No. In fact, we heated the house with a wood-burning stove and cooked with corncobs. The corn would be shelled, then we would take the cobs and put them in the cob house, which was right next to the house. One of my jobs was to make sure that the cob basket was always filled so that my mother could cook. We milked our own cows and had our own chickens and slaughtered our own hogs. That was growing up.

GARBER: Those values are going to come back later in your life with what you are doing today and your thoughts about community. There's going to be a tie-in that's going to come along.

KRUSE: Absolutely. You end up getting a lot of exposure to responsibility and how the world works and how everything is connected to everything. When you stop paying attention to that, then things don't go well with the land. What you don't get growing up on the farm is the exposure to the bigger world. When you get a farm kid off the farm, going into the service or going off to

college, there is an orientation time needed to get used to all this. When I went off to college, I was absolutely stunned by the lack of accountability that some other kids had. I couldn't believe it. Obviously they weren't paying their own way to college, because they weren't studying, or they were out partying all night. I was still trying to get to bed by 9:30 or 10 at night.

GARBER: We'll get to your college years in a little bit, but I'd like to back up and talk about Lake City, Iowa, and particularly the interesting medical establishment there because I think it may have been typical of other small rural towns at the time.

KRUSE: I think it probably was.

GARBER: There were a couple of families of physicians – the McCrarys¹ and the McVays.² Do you remember them?

KRUSE: I remember the doctors. They each had a little hospital. However, I was born in Carroll County – because they didn't deliver babies in Lake City.

GARBER: Lake City was a town of 2,000 or so when you were born.

KRUSE: Less than that – I would say 1,200 to 1,300. Babies weren't born at those hospitals in Lake City, so Mother went down to the Carroll hospital.³ I remember her stories and don't think that there was much prenatal care. When she thought it was time to deliver, she would let the doctor know she was going to show up in a couple weeks at the hospital.

There wasn't much to the Lake City hospitals. It was the doctor's place to put his patients when they needed to go in the hospital. I went into one of the little hospitals in Lake City with an appendicitis attack, but they didn't take it out. There probably would have been a surgeon there if I'd needed it, but that didn't happen. I still know where the building is – it's now apartments.

The Stewart family contributed something like \$50,000 to help build the new Stewart Memorial Community Hospital in Lake City. That has become quite a nice facility. I think the reason that Lake City stabilized and continued to grow is that they made a decision to put the hospital there, and that attracted the doctors, who attracted the patients. The small communities around Lake City didn't fare as well. Wherever the hospital was and the doctors were, other things seemed to happen as well. It became a tourist attraction, if you will, to have a hospital there.

GARBER: I'd like to explore this model a little bit further. There would be a general practitioner, a GP, usually.

KRUSE: Yes.

GARBER: Were these physicians both owners and also administrators of these small

¹ Watters, E. (1982, Sept. 8). Peeking into Lake City's past: McCrary clan is practicing today. *Lake City Graphic*. Retrieved from <http://iagenweb.org/calhoun/records/histories/lake-city-past/mccrary-2.php>.

² Watters, E. (1983, Aug. 25). Peeking into Lake City's past: More about Dr. McVay and his descendants. *Lake City Graphic*. Retrieved from <http://iagenweb.org/calhoun/records/histories/lake-city-past/mcvay-2.php>

³ St. Anthony Hospital (Carroll, Iowa) was a community hospital with about 100 beds at the time. [American Hospital Association. (1945). *American Hospital Directory 1945*.]

hospitals?

KRUSE: Yes, unless they had a head nurse of some sort who took over most of the things. Some of them may have done some minor surgery, too. I don't know whether there was a traveling surgeon. I can't remember if there was a surgeon in Lake City.

GARBER: A circuit rider.

KRUSE: I don't know.

GARBER: That did happen in rural areas – that you'd have specialists who were circuit riders who would go around from hospital to hospital.

KRUSE: Absolutely, and do surgery on certain days, yes. If a broken bone needed to be set, though, my guess is that they would stabilize and transport the patient to a larger facility, maybe to Carroll, or to larger facilities in Ames or Iowa City or Des Moines. Back in the '40s and '50s, there wasn't much. The whole purpose of the Hill-Burton Act⁴ was to start building hospitals, particularly in small communities, because money during the war had been diverted from anything domestic – roads, bridges, hospitals, schools, you name it. The Hill-Burton Act came along to start populating small towns around the United States with hospitals.

Up until then, it had been pretty standard in small towns for the physician to own the hospital. If not, it was often the church or the sisters that owned the hospital. Hospitals were, for the most part, for poor people – where they went to die. Wealthier people were treated primarily at home. During the Depression, a lot of the nurses went to work for the hospital because they had no place else to go. It started to move people into the hospitals. We were not very sophisticated until after they began investing in building hospitals through Hill-Burton, and then Medicare. The money that came from Medicare was the fuel of rapid expansion of everything.

GARBER: You described what is known as the hub-and-spoke model, where you have a group of primary care and secondary care facilities that refer into a more specialized regional tertiary care center. I'm intrigued by your comment about how when a hospital comes to town, it pulls in more resources and becomes a destination.

KRUSE: Back then I don't think they thought about a hub-and-spoke model. That's pretty recent – in the last 20 years or so – with the systems that have been built – when we began talking about competition in health care, “We want to be like the big guys,” and, “We're not really health care organizations. We're selling commodity products.” For the most part, it was just people in their communities who built hospitals to take care of people.

I'm fascinated by how insurance began, starting back in the mid-'30s with the first Blue Cross

⁴ The Hospital Survey and Construction Act (P.L. 79-725), enacted in 1946, is more commonly known as the Hill-Burton Act after sponsoring senators Lister Hill, D-Ala., and Harold Burton, R-Ohio. The legislation provided capital funding to help modernize hospitals nationwide in exchange for the provision of uncompensated care in the future. [U.S. Department of Health and Human Services, Health Resources and Services Administration. *Hill-Burton Facilities Compliance & Recovery*. Retrieved from <http://www.hrsa.gov/getthehealthcare/affordable/hillburton/compliance.html>]

plan established by Justin Ford Kimball⁵ in Dallas. He was a schoolteacher who became a hospital administrator, and he noticed that a lot of schoolteachers came to the hospital and couldn't pay. He came up with the idea of an insurance plan where you pay 50 cents a month. I remember reading about this because I received the award from the American Hospital Association named after him. That's when I learned what it was about. He was the originator of the first Blue Cross plan. The first idea about insurance came from a hospital administrator in Texas as a way of helping his former colleague schoolteachers afford to use the hospital.

It took off where hospital CEOs formed groups to figure out a way to help their patients pay for care – that's why hospitals got the idea of integrating themselves with financing, because it made common sense. Then we separated insurance from delivery and cut out the alignment of incentives. If you have the physicians separate from the hospitals, separate from the financing – you can't come up with a more disconnected system and then expect it somehow to be efficient. The theory of all of this is that every system is designed to get precisely the results it gets. All along the way, no matter what the system was, it was perfectly designed to get the result that it got.

Back when I was born, the system was that the doctor owned the hospital and there wasn't a lot of insurance. That was designed to work for them. As more hospitals were built, and we needed Medicare and Medicaid because we had too many people in poverty and elderly people weren't covered – however the system was designed, the result was exactly what that system was designed to do, whether we intended that or not. If something is working, it's because it had the right design. If it's not working, it was because it was designed poorly. Our health care system was designed from the get-go very poorly to get the result we all want, which is a healthier population with a lot less cost. It was designed pretty well to encourage the expansion of specialty services. The fuel is the money.

In 1965, when I started in graduate school, the Medicare bill was passed, and we were spending 4 percent of the gross domestic product on health care. Now we're at 19 percent, or closing in on that. Yet, we rank somewhere around 37th or 38th in the world in terms of health status. Is that a well-designed system? The answer would be no. All those are the things that cause me to start to worry about almost everything, as I learn more about health care and learn more about what was going on in the community.

Well-intended people are always trying to improve things. For the most part, business leaders, community leaders, health care leaders, school leaders are always trying to do things that they believe to be in the best interest of everybody. It just doesn't always work out that way.

GARBER: Yes, I believe that to be true, too. Let's go back to what got you off the farm. I read that you had a life-changing encounter with a local banker who came out to the farm to visit your dad. At the time, you were yourself a hog farmer.

KRUSE: Right.

GARBER: You were also responsible for cultivating corn and soybeans.

⁵ Justin Ford Kimball (1872-1956) was an educator and administrator in Texas who, in his role as a vice president at Baylor University, in 1929 created a hospital prepayment plan for Dallas schoolteachers. [Texas State Historical Association. (2010, June 15). Kimball, Justin Ford. *Handbook of Texas Online*. Retrieved from <https://tshaonline.org/handbook/online/articles/fki09>]

KRUSE: I had graduated from high school in May 1961. I had never thought about going to college. We didn't do that in our family. My older sister had gone to an LPN nursing school. I had begun to raise hogs when I was in high school as part of an FFA project – Future Farmers of America. I had six hogs, and I would raise little pigs, and I would feed them and take care of them, sell them, and that was all part of my responsibility building. I didn't know all this was what it was, but that's what it was.

We bought another farm when I was a junior in high school, believing that ultimately I would be farming with my dad. Then I also got a job with the local veterinarian, Dr. Bowie, who had invented this fiberglass truck box to go on the backs of pickup trucks that veterinarians used to go around to the farms with all their equipment in it. I was going to be working for Doc Bowie when I wasn't farming, raising hogs, and that's as far as my thought process had ever gone.

This must have been about June, or maybe a month later, soy beans would be up. I was out cultivating. There was a 120-acre field of soybeans, and I had a little "B" John Deere tractor with a two-row cultivator on it, so I could cultivate two rows at a time. I don't know if you know how much 120 acres is? It's a lot. You spend a few days going across this field back and forth, back and forth. That's an interesting part of the story.

I was making a turn at the road when our local banker stopped at the farm looking for my dad. He asked me what I was going to do that fall. I told him I was going to farm and work for Doc Bowie. He said, "Have you thought about going to college?" I told him, "No." He said, "You've got enough money in the bank from raising hogs to go to college, at least for a couple years. If you don't like it, you wouldn't have to stay. You could come home." That was it, the sum total of the entire conversation.

I got back on the tractor and made a few more rounds, and I realized that I had another 100 acres left. I said, "Maybe I ought to go to college," because I was thinking, "Do I want to do this all my life?" Growing up, I was a daydreamer. I wasn't particularly enamored with farming, but it was what I knew and all of my family did it. I drove the tractor up to the house, and my mother came out. It was the middle of the afternoon. She said, "What's going on?" I said, "I think I've decided to go to college." She said, "We better get your dad." He came over, and she said, "He thinks he wants to go to college. Where would you want to go to college?" In retrospect, I think my parents thought, "This might not be a bad idea, because he may not be a really good farmer. He thinks about other things – doesn't pay attention like he ought to, maybe."

We went up to the library on the third floor at the high school. Emma Johnson, who was the retired school superintendent, was there. We walked into the library, and she asked why we were there. My parents said, "He wants to go to college, but he doesn't know where colleges are. We thought you would know where he ought to go to college." She said, "Well, you're a good Lutheran, so you probably ought to go to Augustana College in Sioux Falls, South Dakota." That was it.

A week or so later, we drove up to Sioux Falls and walked into the admissions office at Augustana. The receptionist said, "Can I help you?" I said, "I'm here to go to college." She said, "Do you have an appointment?" She was looking for my file. I said, "No, no, I was out cultivating, and our banker came by, and he said, 'You ought to go to college,' and I went to see Emma, and she said 'Augustana,' and that's it. That's how we got here." She said, "Well, okay!" We put it all together, and that August I showed up in Sioux Falls to go to college. There was never any big college plan.

There wasn't any big strategy or vision of higher education. That's exactly how it happened.

To finish this part of the story, the receptionist asked me what I wanted to major in. I said, "What do you mean?" She said, "What do you want to do when you graduate from Augustana?" I said, "I'd like to be a hospital administrator." The reason I said that was that I used to usher in our little Lutheran church in Lake City, and the hospital administrator there had a really nice looking wife. I was thinking, "You know, if I'm going to get a good-looking woman like that, I'm going to have to be a hospital administrator." That's the only time I ever thought about it. No one had ever asked me what I wanted to do when I got out of college because I had never thought about going to college. It was the only thing I could come up with when she asked me. She said, "We don't have health care administration." I said, "Whatever's close." She said, "Business," so I majored in business. That's how I got there. It was that simple.

I've had those things happen to me throughout my life, and I recognize them for what they are. If you are constantly watching what's going on and paying attention to all the events and all the people who are trying to help you along the way – if you are really paying attention – it's amazing what opportunities you have. Some are coincidence. I'm not a big believer in predestination, that's not what I'm talking about. I'm talking about being thoughtful about your surroundings. Growing up on a farm, you pay attention to your environment. You see how the weather is. Are we getting enough rain or not getting enough rain? Over time, if we don't get enough rain, then we have to change the kind of crops that we plant.

You have to pay attention, but good things can happen to you if you're not oblivious to what's going on around you. You have to be thinking all the time in order to take advantage of everything that presents itself, whether by accident or if someone does you a favor. That's been the story of my life.

GARBER: It sounds a little like the concepts of mindfulness.

KRUSE: Yes, I think so.

GARBER: I see by the picture of your wife behind you there, that the choice of hospital administrator was a successful strategy.

KRUSE: Yes, we will be married 51 years in August.

GARBER: After graduating from Augustana, you went right on to grad school, and you went to a famous program.

KRUSE: Yes.

GARBER: The University of Minnesota program had been started after World War II by James Hamilton,⁶ who was quite a personality.

⁶ James A. Hamilton (1899-1985) was director of the Program in Hospital Administration at the University of Minnesota from 1946 to 1966. His oral history: Weeks, L.E., (Ed.). (1983). *James A. Hamilton in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

KRUSE: Yes, he was.

GARBER: You came in the last year that he was there.

KRUSE: Yes.

GARBER: Tell about your experiences with Professor Hamilton.

KRUSE: Jim Hamilton scared the bejeebers out of you. I was young and naïve. I had turned 21 in February of the year that I got there. I was very young when I got married, very young when I



Professor James A. Hamilton photographed at a convention of the American Hospital Association in 1956 or earlier. Photography courtesy of Cristof Studio, San Francisco.

I got into the program. I remember sitting in the front row in the first class that Jim spoke at, and he asked some question. I answered, “Well, I assume ...” and he went all over me about the word “assume,” and never to assume. It was humbling. Jim was vibrant, animated. He was a short guy, with big bushy eyebrows, a mustache, an east coast accent. He was an interesting character and commanded the room – no question about it – commanded the students.

He and George Bugbee⁷ and Ray Brown⁸ started the first programs. They had this idea that hospitals were getting to the point where they needed more sophisticated management and leadership. The idea of the doctor who appoints a head nurse to run the hospital didn’t work anymore. At that time, particularly at Minnesota, it was a professional school more than a part of the graduate program. Jim Hamilton said, “We’re going to teach you how to run hospitals, be hospital administrators.” We were in class 44 hours a week. We all wore suits and ties. It was a business school. He believed in the case study process. There were 14 steps of problem solving, and we did a lot of work on case studies and preparing for case studies.

Of course, we got classes on public health and statistics and all the normal things, but it certainly was not a business school curriculum. It was a health care leadership and administration school in the School of Public Health. We had a much greater emphasis on public health, I think, than the schools

⁷ George Bugbee (1904-1995) served as the executive director of the American Hospital Association from 1943 to 1954, later becoming director of the Graduate Program in Hospital Administration at the University of Chicago from 1962 to 1970. His oral history: Weeks, L.E., (Ed.). (1983). *George Bugbee in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

⁸Ray E. Brown (1913-1974) served as a hospital administrator at the University of Chicago Clinics and Hospitals as well as director of the Graduate Program in Hospital Administration at the university from 1951 to 1962. [The American Hospital Association’s 1963 Distinguished Service Award to: Ray E. Brown. (1963, May 1). *Hospitals, J.A.H.A.*, 37(9), 44-49.

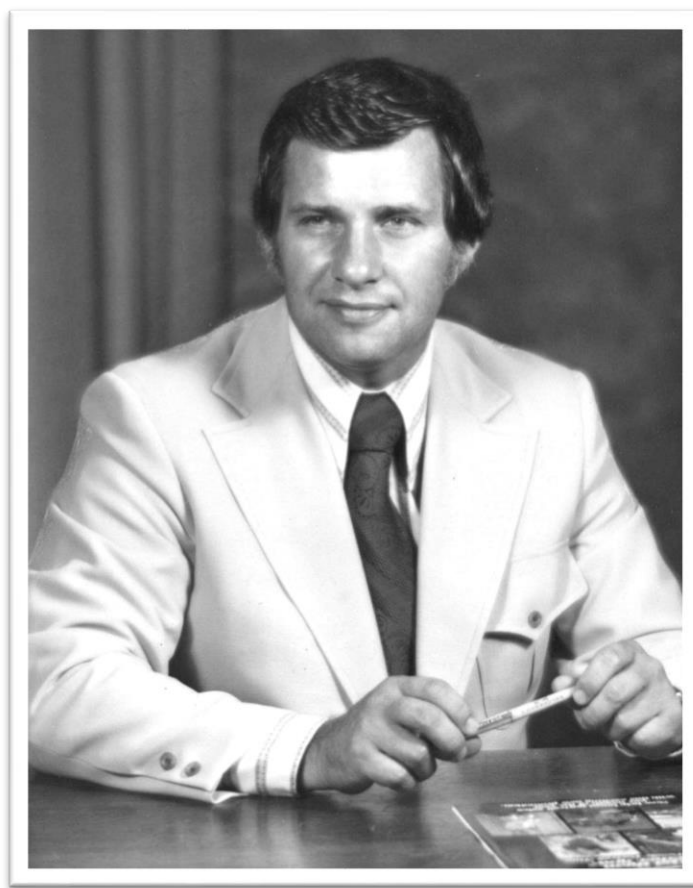
that were built in the business schools. I believe, again, by fate, that's where I went because it really helped shape my whole career and how I thought about things.

Jim Hamilton was a character. We would have social functions to teach us how to be socially engaged. I remember him teaching us how to order expensive scotch. He and his wife, Edith, would have functions at their home and teach us to be well-mannered at social events. They were trying to model the social experience. Edith would have discussions with all the spouses. My whole class was male, except for the two nuns, Sister Ann Marita and Sister Barbara McCool. Sister Barbara McCool became Mrs. Montague Brown.⁹ That is how I got to know Monty.

Edith would tell the women what they had to do to help their husbands survive and thrive in the business. She said that the wives could make or break their husbands by how they conducted themselves. They had an important part, so they learned how to entertain. My wife was even younger than I was – she was 18 and I was 20 when we got married. Talk about two young people, right off the farm, not experienced. I was the youngest in our class. We absorbed everything because it was all new to us.

When I was at Augustana, I got all the courses I needed for my major in Business by the early part of my junior year. Then I also got a major in Psychology and a minor in Economics, and a minor in Sociology, because I kept being interested in different things. The more I learned, the more I got interested in other things. At one point, I thought I was going to get a Ph.D. in Clinical Psychology and have a clinical practice.

By a stroke of luck, I had to write a paper for an English class my freshman year, and I decided to write it on hospital administration. I went to interview Lyle Schroeder¹⁰ at Sioux Valley Hospital. Lyle was a young new graduate of the Minnesota program. He had grown up



Lyle Schroeder, pictured here in a 1974 photograph, served as the CEO of Sioux Valley Hospital (Sioux Falls, South Dakota) for 36 years.

⁹ Barbara P. McCool went on to receive her Ph.D. from Ohio State. She and her husband, Montague Brown established the consulting firm Strategic Management Services, specializing in the developing trend toward the formation of multihospital systems. [Brown, M. (1986, Winter). HCMR interview: Barbara P. McCool. *Health Care Management Review*, 11(1), 89-96.]

¹⁰ Lyle E. Schroeder served as the CEO of Sioux Valley Hospital (Sioux Falls, S.D.) for 36 years. [Olson, V. (2015, Feb. 16). Whatever happened to Lyle Schroeder. *Argus Leader*. Retrieved from <http://www.argusleader.com/story/life/2015/02/13/whatever-happened-lyle-schroeder/23397783/>]

in Sioux Falls, gone to Augustana and worked at Sioux Valley Hospital. He went back there as assistant administrator. I went to interview him about what it was like to be a hospital administrator, and that was my first exposure to it. Lyle and I got to know one another, and I relied on him over the time I was at Augustana to tell me about what it was like being a hospital administrator. When I got back to Sioux Falls periodically, we would have dinner together. He remembers me as a pest, asking way too many questions all the time. I don't remember it quite that way, but he always buys dinner, so that's okay.

During my senior year at Augustana, I was thinking about getting a Ph.D. I was interested in state psychiatric hospitals. I thought maybe I could do both by becoming an administrator in a state psychiatric hospital. Then I went to visit a couple, and it was so difficult to go into these state hospitals. Then Lyle said to me, "Have you thought about going to Minnesota? I'd be glad to help you get in." I applied to Minnesota, used him as a reference and was accepted.

At the end of our first year of didactics, we would all be assigned to a residency. We would go to Jim and Edith's house for a social event, and then he would take each couple into his office and tell us where our residency was going to be. We had had a chance to rank our top three choices, of which I got none. I was assigned to Frank Walter at St. Barnabas Hospital.¹¹ I said, "I'm curious about why I'm going to St. Barnabas. I don't know anything about it." He said, "Frank Walter was a young administrator at one time, and he will understand what it's like to be a really young guy in need of a lot of mentoring. By the way, he's here in Minneapolis, so you can be close and you'll have somebody who understands your situation. That's where I'm sending you."

Jim Hamilton then said, "Any other questions?" I said, "Yes, why did you ever accept me into this program to begin with?" After I had been there a couple of months, I didn't think there was a fit. Not that I didn't enjoy what I was doing, but in terms of my lack of experience about almost anything. He said, "You've worked all your life on the farm and grew up learning those values. You paid your own way through college, and you worked all through college. That creates a value system and character that I like. Also, Lyle Schroeder recommended you very highly, and we trust our alums to be good judges of character."

GARBER: Do you recall what your three choices were, none of which you got?

KRUSE: One was Stormont-Vail in Topeka, Kansas. I do remember that, but I can't remember what the other two were.

GARBER: That must have been fun for Professor Hamilton to go through that process every year of pairing up students with their administrative residencies.

KRUSE: I've had a bit of a similar experience. We have six Kruse Scholars now at the University of Minnesota and six at Augustana. We started that a year ago. I go to each campus in the fall and the spring and meet with those students. I'm not faculty – I'm not doing what Jim did – but it is intriguing to watch the students and stay in touch with them. I get a kick out of working with young people. I understand why he got enjoyment from that.

¹¹ Frank S. Walter was director of St. Barnabas Hospital, which later merged to become Metropolitan Medical Center (Minneapolis), from 1963 to 1982. [American Hospital Association. (1983 and earlier years). *American Hospital Association Guide to the Health Care Field*. Chicago: AHA.]

GARBER: There was the drama, too, of having the party and bringing each couple into the office.

KRUSE: It was quite an experience. How fortunate it was to be in the final stages of the career of someone who was so well-known in our industry and who was part of the beginning of creating this as a profession. Then you add his personality. He was aggressive. He was entertaining. He was smart. He was good at teaching. He didn't mince words if you were not doing well. Yet, he never made you feel bad about yourself, because there was always a little humor.

I thought it was a great experience. This was an emerging profession. I was in the Class of '67. The early graduates were '49 and '50, so it was only about 15 years after Jim Hamilton had started trying to figure out how to teach health care administration. But with 15 years under his belt, he'd worked the kinks out of the process and was feeling confident in himself. His graduates were doing well in the industry. He was in a good spot. It was fun for the students. We all had the same reaction to him, I think, in terms of his approach and style and behavior and all that. We all have fond memories. He was quite a guy.

GARBER: Professor Hamilton had considered the idea of a Ph.D. in Hospital Administration, but decided that he was not in favor of that. What are your thoughts about the value of a Ph.D. in this field?

KRUSE: To prepare people to do research and to teach, I think there would be some value in that, but I don't see the value of a Ph.D. in preparing people to lead in the area of health care administration, as a practitioner. Many of the things we do in leading health care institutions and health care systems ought to have more research applied to it. Take a look at how we've built this health care system. It's not working so well. We ought to be having someone raise some questions. When you've got a bunch of practitioners out there all trying to make sure their institutions are successful, there's got to be someone stepping back and saying, "Wait a minute. What's working? What isn't working?" That's where I think Ph.D.'s can make a major contribution.

If you're going to get into a policy discussion about how you might shape and reshape the field, it's a combination of the academically-trained Ph.D.'s and the practitioners coming together. Policy drives everything. Every system is designed to get the exact results it gets. Policies shape all of that. Our reimbursement policy shapes the result that we get.

GARBER: Your graduate program was set up so that you had one year of classroom teaching and then a one-year residency. Do you think that that's still a good model today?

KRUSE: Two years of didactics followed by a year of fellowship, particularly for young people, is probably right – there's so much to know. For people in their early 20s, a year of didactics, then a summer residency, another year of didactics followed by a fellowship would be best. If you came out of industry – let's say you were a pharmacist – and you wanted to get into health care administration, I don't know that you need the fellowship.

In these fellowships and residencies, you're still a student and people will tell you all kinds of things. Once you're in a suit, they don't talk to you anymore. The purpose of the residency is to get exposure to all these people and ask them questions, and they'll be very honest with you. It's very helpful. The residency year was good for me.

GARBER: That's interesting, the way that communication changes.

KRUSE: People really do want to help students, and you can ask a lot of stupid questions.

GARBER: Let's move on to your residency, which was at St. Barnabas, as you mentioned. While you were there, the hospital was going through a merger, or had it already happened?

KRUSE: It had not happened, no. Swedish and St. Barnabas were separate.

GARBER: Could you tell a little bit about St. Barnabas and the Swedish Hospital and how they decided to consolidate?

KRUSE: Swedish and St. Barnabas were across the street from one another. They were competitors. St. Barnabas was Episcopal and Swedish was Lutheran. St. Barnabas was maybe a little bit more blue blood – I had that impression. I was there in the mid-'60s. Remember the way Medicare was then? It was the more you spent, the more you got paid. It was Katy-bar-the-door in terms of building hospitals, because if you could build a hospital, you'd get paid for it. Hospitals were expanding and building all over the Twin Cities.

There was some sense that there were getting to be too many hospital beds. With Swedish and St. Barnabas across the street from one another, there was a sense that maybe we ought to be collaborating. Carl Platou¹² was starting to build a suburban hospital – Fairview Southdale.¹³ Bob Van Hauer¹⁴ up at Health Central in the northern part of Minneapolis was putting a system together of acute and long-term care facilities. Everybody was trying to do something unique.

Frank Walter and Les Johnson,¹⁵ who ran Swedish Hospital, were starting to talk about what they ought to do together. Ultimately, they decided to build a combined facility that connected the two hospitals. They hired David Bjornson,¹⁶ who was at Swedish, to run the combined facility.

¹² Carl N. Platou (1923-2012) attended the graduate hospital administration program at the University of Minnesota, earning his degree in 1951. Platou went on to a leadership role in creating Fairview Health Services (Minneapolis). His oral history: *Carl N. Platou in first person: An oral history*. (1993). Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center. [Obituary: hospital visionary Carl Platou transformed Fairview. (2012, May 31). *Minneapolis Star Tribune*. Retrieved from <http://www.startribune.com/local/155858835.html>]

¹³ Fairview Southdale Hospital (Edina, MN), a new hospital built on a greenfield site donated by the Dayton Corporation, was completed in 1965. It is credited as being the first full-service satellite hospital in the United States. [Sullivan, J. (2008, Winter). A tale of two hospitals: Fairview story began in 1906. *About Town* [City of Edina]. Retrieved from http://edinamn.gov/edinamn.gov/edinamn.gov/files/News_Publications/About_Town/L4-91_AboutTown_2008Winter.pdf; and, Fairview Health Services. (2012). *Honoring the legacy of a visionary: Carl N. Platou (1923-2012)*. Retrieved from <https://www.fairview.org/emergencycenter/LearnMore/AboutCarlN.Platou/index.htm>]

¹⁴ Robert Van Hauer (1910-2007) became administrator at Glenwood Hills Hospital (Minneapolis) after World War II and later presided over the formation of the Health Central system with hospitals in the Twin Cities metropolitan area. [Cohen, B. (2007, Dec. 17). Robert Van Hauer, who led Health Central. *Minneapolis Star Tribune*. Retrieved from <http://m.startribune.com/obituaries/11604701.html>]

¹⁵ Lester G. Johnson (1914-1986) served as administrator of Swedish Hospital (Minneapolis) from 1965 to 1971. He then became executive vice president at Metropolitan Medical Center, which resulted from the merger of Swedish and St. Barnabas hospitals. [American College of Hospital Administrators. (1977). *1977 Directory*. Chicago: ACHA.]

¹⁶ David L. Bjornson was associate administrator at Metropolitan Medical Center from 1967 to 1970. [American College of Healthcare Executives. (1990). *1990 Directory*. Chicago: ACHE.]

Between the two hospitals was built rehabilitation, long-term care, nonacute services. When you added Swedish and St. Barnabas in a combined facility, we had about 900 beds in downtown Minneapolis. Building the combined facility ultimately led to the merger, in my view.

GARBER: The combined facility – was this a total replacement hospital?

KRUSE: No, Swedish Hospital is on one side of the street, St. Barnabas is on the other. We built a building in the street called the combined facility, which connected the two hospitals. David Bjornson reported both to Les and to Frank. The whole thing became known as Metropolitan Medical Center when the merger happened in the early '70s.

GARBER: That's interesting, that the street was closed and a new building was put there.

KRUSE: Yes.

GARBER: Did they ever build a total replacement hospital?

KRUSE: No. Swedish and St. Barnabas merging to form Metropolitan Medical Center was one of the early mergers anywhere. There were more experiences of hospitals like Fairview building Fairview Southdale – or systems planting new hospitals – but not the idea of mergers. I know that we were not merged when we built the combined facility. There would have been no need to build a combined facility. The building of the combined facility ultimately led to the merger. Frank became the president and Les became executive vice president, and we had to merge the board.

Swedish-St. Barnabas was my first experience of merging and of bringing two health administrative groups together that had been used to competing with one another. Before that we had done some things together. One of the things I've learned is that until you're totally merged, you don't ever tell the truth to each other. If you're working together collaboratively, but you're still two competing hospitals, there is never full disclosure. There is always jockeying for position. In a collaboration, while it's very important for people to work together, there is something totally different once you're in one organization and all have the same balance sheet. I learned over time that you behave differently when you're in one organization than when you're in two trying to work together.

GARBER: Do you mean intentionally or unintentionally?

KRUSE: Intentionally. When you're part of one organization, you're all in. You throw in everything. Everyone's help is needed. By the way, if you're not participating fully, then you don't need to be on that team. When you're two separate organizations working together, there is always a little bit of positioning. It's hard to describe. Now as I look back, I can see differences in how the two groups worked together when collaborating, and then how they worked together when they were all one team.

It's human nature. Remember, they're still CEOs of their own hospitals. David Bjornson wasn't running the parent organization over the two hospital administrators. It was the other way around. With the combined facility, David Bjornson reported to two people.

People don't always do the right thing. They try hard. That doesn't mean they're bad people. My experiences tell me that when you're collaborating and working together, as good as you are, there is still a little held back, still a little bit of reservation.

What if you're sitting in a joint meeting and you get an idea, it would be better to have, let's say, one operating suite? Are you going to propose that? Probably not, but if you're all in one organization, at some point, you say, "Shouldn't we put all the acute care here?" I can assure you that it doesn't happen when you're collaborating and working together, despite all the outward signs that you're doing everything in the best interest of all.

GARBER: That must be a dicey thing for the CEOs to manage. It's human nature for people to talk and gossip about this and that, but now you have to control communication all through the organization so that inappropriate things aren't being said.

KRUSE: It's dicey. A lot of good things can happen through collaboration of well-intended people trying to work together, but are you going to do your best most creative thinking? Not that I've ever seen. Do you get some good things done? Yes. Can you make some progress? Yes. Are they intentionally dishonest and trying to thwart? No, I probably wouldn't go that far. You're not going to get your best work out of a team that isn't a well-oiled team of people who work together, know each other, trust each other, and have some history together. That's all I'm saying. You have to start someplace, though. None of this is good or bad. It just is.

GARBER: You were offered a permanent position at the hospital after you graduated.

KRUSE: Yes.

GARBER: What did you do there?

KRUSE: Administrative assistant was my first title. Frank offered me the job because he didn't feel that I had finished my residency yet. We liked each other and he had been good to me. Frank was still a young guy. He was still probably in his late-30s when I graduated. I had three departments – social service, housekeeping and dietary, or maybe maintenance. He said, "Don't make any decision until you check with me first!"

One of my observations about personal development is that it takes about 20 years to produce an entry-level young adult. It takes another 20 years to produce an entry-level young leader. Everything has to go right in that time period. You can't plant corn in August and expect to have a crop in October. You can't have an entry-level young adult proficient in doing well in college or in a first job if you don't start back in early childhood. If we're going to produce these young 20-year-olds who are doing well in college and who are going to run this country, then we better all get together from birth through that first 20 years.

After age 20, they've had some experience. They're finishing their college, they're finishing service, they're getting their first jobs. Some doctors aren't even finishing their fellowships until they're in their early 30s. If you're going to get an experienced, mature leader of you-name-it, they don't get the experience until 15 or 20 years out. They haven't matured. They don't have the multiple experiences. I think of that first 40 years of a person's life as part of their developmental process. The balance of life is when they're leading, responsible, and they have to circle back and make sure that the early childhood development is happening in their community.

Leaders of any organization who complain that the people they're hiring don't have the skills, that they don't know how to work as teams, is because we don't have a strategy as a country in terms of how we produce these workers over and over. There are about four million babies born in the

United States every year. We've got four million opportunities to start over every year, but we don't do it very well because the span from birth to 20 or 25 years old is so long. If you're going to have a big crop in October, you've got to start way back.

Sometimes people say that in their company, they're going to grow their own workforce. How are they going to do that? They will take high performers and give them internships. Where do those high performers come from? They come from parents who started reading to them when they were one and two years old. The companies don't grow their own. They take advantage of what parents and school systems do from early on to produce the students that can do the whatever – right?

I've been a CEO since I was 33. I was a CEO for seven years in Rochester, New York, before I came here when I was 40. The seven years in Rochester helped prepare me to become a CEO. You can't practice being a CEO. You can think about it. You can study for it. You can prepare for it, but you can't be one until you are one. You aren't really a good one until you've done it for a number of years. We have to be mindful of this preparation time for students and leaders.

GARBER: That's what you're working on now, in part.

KRUSE: That's what I've been working on for a long time, yes.

GARBER: Do you have anything else that you want to say about Metropolitan Medical Center before we move on to Rochester?

KRUSE: I did that internal work, the departments, for maybe three years. Interestingly, I learned that I didn't really like doing it. I didn't like day-to-day operations very much. At that time, in 1968, I joined the Minneapolis Jaycees. A friend called and asked if I wanted to join the Jaycees, and I said, "What do you do?" He said, "Well, this is about leadership development through community service." My biggest concern about myself at the time was lack of leadership capability. I truly didn't know what it meant to be an administrator. Jim Hamilton had said to us, "You're going to be running these places. You're going to be the leaders."

I didn't have leadership experience in high school. When I got to high school, it was my first experience of being with a huge class of 58 students. I knew I didn't know how to lead, and I wasn't good at it. I couldn't speak in front of groups. There were all kinds of things. The Jaycees were formed for the new generation to practice being leaders. I joined the Jaycees and learned how to lead volunteer projects and community groups.

That's when I began to really learn about the community. I became very active in it, and became president of the Minneapolis Jaycees, and then went on to become a national officer for four years. I traveled all over the country and had responsibility for Jaycee development in all the metropolitan areas of the United States with over 100,000 people. There were 160 communities of that size at the time. I traveled to all 50 states. Every weekend I was off to some other community teaching young people. I was in my late 20s. We were helping each other grow and trying to encourage.

That experience of experiencing community leadership as a volunteer on a committee, seeing someone a few years older than me leading something, leading a committee, going on to the board and then being chairman of the board – all of those experiences were designed to prepare me to be the best I could be. That's when I began to realize that not only do we need a very purposeful

development strategy in the first 20 years, we need a very purposeful development strategy for people in the next 20 years. That's where we're getting our city council members and our school board members. We're not thinking about this well enough as a country.

People knew that 4H and FFA and Girl Scouts and Boy Scouts and sports were all experiences that children need to learn how to work in teams and how to be leaders. Jaycees was designed to give young people who wouldn't normally have a chance to lead in their organizations a chance to lead in the community. We didn't work with wealthy kids. We worked with poor kids and with sick kids and with drug-addicted kids. I realized that the Jaycee community projects were more interesting to me than what I was doing at the hospital.

I moved from an internal operations job to a marketing and community relations job – in which I was working out in the community. At that time, hospitals were starting to market themselves. Frank asked me to do work outside in the community because I was doing it anyway with the Jaycees, and I liked it. Frank came out of the business school at the University of Chicago. He was more of a business-oriented person in running the facility, and I was finding I didn't like running the facility. I liked the connecting to the community.

My job became figuring out how do we go out in the community and recruit more patients. There are two ways to recruit patients. You can build relationships with groups of patients, or you can recruit doctors who bring the patients. To recruit doctors, you have to buy technology for them. Talk about a medical arms race – that's where it all comes from. I had been there a few years. My office window faced Elliot Park in downtown Minneapolis. As I was looking out across this park, I could see that it was filled with Native Americans with their kids, sleeping on the benches. I could see this poverty, and yet I saw our hospital spending money to recruit doctors because we wanted them to refer patients because we were building too many beds. It didn't make sense to me that we should be building all those beds while I was looking out in the park and seeing that we were not doing anything for that population. I was beginning to realize that the financial incentives were: the more you spent, the more you got paid. What a great country, right? I don't think I thought about it in this way from a policy perspective. When you grow up on a farm, you have to make common sense of what you're doing and be thoughtful about all these things.

Now I was a community leader, a young Jaycee. I was also on the Chamber of Commerce and was starting to meet with all these Chamber people. I had been making an argument to them that they ought to take young people and put them on boards so that they could experience being on boards. When I made that argument, they invited me to go on their board. I thought, "I need this kind of experience."

I was getting exposure to community leadership because I began to think that's what hospital administrators ought to be doing – engaging and collaborating with other parts of the community to improve the health of the community. The operation of the hospital would be taken care of by somebody interested in doing that, but that wasn't me. It occurred to me very early on that the best job to have was the CEO's job, because you could look at which initiatives worked and which didn't, and you could allocate resources where you wanted.

These were all early thoughts in those first 10 years. That first 10 years of my Metropolitan Medical Center experience was a continuation of my residency. I was learning about the community, about the hospital, about how you merge, about what works and what doesn't work. It was one big

educational experience for that first 10 years. That's the way I view it in retrospect. Even while I was there, I realized, "I'm learning so much. I have no idea what's going on. I'm going to absorb it all."

Because of the Jaycees' focus on leadership development, we heard from great motivational leaders and met all the great motivational speakers of the day. They would fill you with ideas of how important it is to be a good leader and to develop the characteristics of leadership. I began to think that leaders in health care, particularly, have to be thinking about the community, have to be thinking about our own leadership capability. I became a student of leadership. As a resident, I was worried about not being able to be a good leader. Fear of failure was one of the most important drivers for me during my entire career – not knowing enough, not being good enough, offending people, leaving somebody out. I've been sensitive about that. I wanted to know as much as I possibly could about whatever the task was.

I watched people. I would go into board meetings and see how successful people conducted themselves. I remember some young up-and-comers in the corporate world who were nasty. They would ask questions at board meetings that made them look smart, or that they thought made them look smart, but it was a "gotcha" question. I would hear others – the chairman of Lutheran Brotherhood or the chairman of Land O' Lakes – who were confident of themselves and always kind. They would walk into the Minneapolis Club and they would ask the guy behind the counter checking coats, "Bill, it's good to see you again. How are the kids?"

I thought about this. Here is a guy on top of the world, and he's kind and humble. Here's the young up-and-comer who is brash and trying to impress everybody. I have thought about that all of my life. I wanted to be a good leader, and I was looking for all those characteristics. Then I was exposed to the Jaycee organization, whose total existence is to teach leadership through community service. I was driven to look constantly at my leadership style and others', and looking at a community and realizing: we're not doing a good job as citizens in running our communities. We're doing a terrible job.

Those were all the ideas that were forming in that first 10 years. I said, "I'm going to be a CEO by the time I'm 30, and the reason that I'm going to be a CEO is because I don't like the way we're doing it now, and I want to do it differently." Can you imagine? I didn't even know how to do it, but that's what drove me: you see something, but you can't do anything about it because you're not in a position to do anything about it.

Even though I had the goal of being a CEO by the time I was 30, I was on the national Jaycee officer track, which was one year after the next. I became a national vice president, which was a very good learning experience – I traveled all over the world doing that. When I was 31 or 32, I said, "I'll start looking for that other CEO job." When I was finished being national vice president, then someone asked me to run his campaign for the president of the United States Jaycees, which was running a national election. I thought that was a pretty good deal. By this time, I knew Hubert Humphrey and Walter Mondale, our senators who had both gone on to be vice president. Because I was a leader in the Jaycees, I also knew them in their roles as vice president. I was starting to see the power of those positions, so I wanted to play that out.

As that campaign was winding down, Frank Walter said, "Lowell, I know that you want my job, but I'm not going anywhere. You need to be a CEO. The way you think, what you worry about, what you're preparing yourself to do, you need to be a CEO, and I'll help you." I'm pretty sure that

Frank knew I didn't know how to be a CEO. I'm pretty sure that I knew, too, but I didn't admit it. The fact was that I didn't know how to be a CEO because I didn't have the maturity, and I didn't have the experience. Looking back at that first stint of being a CEO, is what leads me to believe that it takes a long time to prepare someone to be a leader – not necessarily the CEO, but to be a leader.

Some years later, when I was 40 and came to St. Joseph, I thought I was pretty good – I mean, truly. I knew I'd been through two or three mergers or consolidations, had seen things that worked or didn't work, and had had a lot of different leadership experiences in the community and the state and the nation. I really had had an intensive learning experience for 40 years. Now I talk about that to everybody. We have got to be intentional about growing the kind of leaders we want over this entire spectrum of time, or our system will be designed to get exactly the results we get, which we won't be very happy with as a country.

GARBER: We're at a point in your career where you are going to make another move. You and your young family moved to Rochester, New York. How did this opportunity come about?

KRUSE: I had made the decision that I wanted to become a CEO. I envisioned myself running a large organization like Metropolitan Medical Center because that's the only place that I had worked. St. Barnabas was about 300 beds, and Swedish was maybe 350 or so. The consolidated Metropolitan Medical Center was a big organization. That's what I thought I wanted. Frank introduced me to a recruiter friend out of Chicago who interviewed me and said, "I've got a good opportunity for you in Rochester, New York."

I went out to interview at Park Ridge Hospital, to be administrator of a 200-bed hospital on the west side of Rochester in Greece, New York. I met the chairman of the board, a gentleman in his mid-'80s. This was their brand new hospital. They had employed a lot of politics to get their new hospital built and they were proud of it. They had 150 acres of land, give or take. They felt they were in good shape. There was no big issue other than running the hospital. That was not really what I had in mind.

When I came home, the recruiter called me and said, "What did you think?" I said, "I'm not interested in that. There's not enough going on in terms of what I want to do." He said, "Did you meet Tom Riley?" – who was the incoming chairman of that board. Now this is an example of what I was talking about before where "you don't ever want this stuff to get out" kind of thing. I said, "No, I didn't meet Tom Riley. Why?" He said, "What they're looking for is somebody with collaboration experience, because Park Ridge wants to take the lead in bringing together Highland, St. Mary's and Park Ridge into a group."¹⁷

The leadership of the Rochester hospital community had worked well together over the years. Rochester is known for collaboration and working together on the part of its business community in terms of supporting the arts, the United Way, education, whatever it is. Kodak and others took the position that if we're going to build the kind of community that supports our leaders and our employees, then we've got to worry about all of these things. They had that sense.

¹⁷ In 1977, the three Rochester hospitals exploring collaboration included Rochester St. Mary's Hospital of the Sisters of Charity, a 298-bed major teaching hospital; Highland Hospital of Rochester, a 274-bed teaching hospital; and Park Ridge Hospital, a 194-bed nonteaching hospital. [American Hospital Association (1978). *Guide to the Health Care Field* (1978 ed.). Chicago: American Hospital Association.]

Through the Rochester Hospital Association, the CEOs of all seven hospitals would go out on retreats. During one retreat in 1975 or 1976, they got to talking about what would be the ideal health care system for Rochester. They said, “We’ve got Rochester General at the north, and Strong Memorial to the south side of the community. We’ve got Genesee, the blue-blood hospital, on the east side.¹⁸ It would make common sense if we restructured and had Park, St. Mary’s and Highland together. That was their thinking out of the box. Let’s go with four organizations rather than seven. The board at Park Ridge decided this was a pretty good plan, thinking that if the hospitals merged and the number of hospitals was reduced, those beds would end up on the Park Ridge campus. They wanted to take leadership in building this multi-hospital system.

When I met with the young incoming chairman, I said, “I’m interested in that! I’m interested in something that’s bigger, that’s designed to do the right thing for the community, that’s complicated. That’s something I’d be very interested in doing.” I took the job at Park Ridge. There wasn’t any question. When I took the job at Park Ridge, no one knew what the plan was except me and the couple of board members who told me what they wanted me to do. Not all the board members knew it. Certainly the staff didn’t know that’s why I was there, and I never told anybody that. I knew in the back of my mind that I would begin to work together with the CEOs of the other hospitals, starting to play out this plan that had come together a year earlier. I didn’t go there with the intention of ever running Park Ridge.

I began to think about how you would do that and how you would build the relationships. There was a small group of board members from each of the hospitals who were also involved in this discussion. For the most part, people didn’t know that this was a primary motivator for me to come out there, or that that was what I considered to be my key job.

Once I had been recruited there and we were wrapping up, the recruiter said something to me that really caught my attention. He said, “Lowell, you’re the finest candidate I’ve ever placed in a position like this.” I thought that a strange comment, because I knew that I wasn’t. I knew I had never been a CEO, and I wasn’t quite sure what he was referring to.

I began thinking about what would cause him to say that. I never asked him that because I hadn’t run a hospital before. I hadn’t been the CEO when a merger happened. The only thing I could think of was what I had described to the board and to the recruiter as the kinds of things I’m interested in – engaging the community and making the health system work together to serve the interests of the community. I believe that there are three systems that exist to serve the public interest – health, education and government. Collectively we have to work together to serve the public interest. It’s not pure, but that’s the main driver.

The things that must have driven the recruiter’s comment were the direction that I wanted to take the organization, the way I wanted to take my career and the fact that I had other leadership experience in the community, particularly my national work with the Jaycees. I was confident that I wanted to do these things, but I was pretty sure I didn’t know how to do them.

Why would he say that? It’s been on my mind for a long time. I think about it even now.

¹⁸ Also in 1977, the other hospitals mentioned included Rochester General Hospital, a 543-bed major teaching hospital; Strong Memorial Hospital of the University of Rochester, a 722-bed major teaching hospital; and Genesee Hospital, a 424-bed major teaching hospital. [American Hospital Association (1978). *Guide to the Health Care Field* (1978 ed.). Chicago: American Hospital Association.]

What is it that would cause people to say, “You’re an outstanding leader”? What is that? And I never completely answered that. I keep it an open question because we have to keep questioning ourselves in terms of what we’re doing and are we contributing to advancing the common good.

When I went to Rochester, I had the job of being president of that hospital, and I had to do what I had to do. I said to the staff, “Keep doing what you’re doing. You obviously are running a successful organization. I don’t have a lot of big plans to change anything. You’re a new hospital and a good group, let me catch up with you.” They seemed to be thinking, “That seems a little strange that this guy would come in and not have his plans all worked out and what he wants to do.” I thought, “Let’s just keep going.” I wanted to devote more of my time to figuring out St. Mary’s and Highland.

Eighteen months later, we had brought the board members together and led a process administratively that included board leadership from each of the three hospitals to form Upstate Health System. I had brought them back to Minneapolis a time or two and showed them other hospital systems that had formed, and how they were doing that. We put together Upstate Health System, and I became president. Tim McCormack,¹⁹ who was the associate administrator – he was a little bit younger than I was – became the president of Park Ridge, and Sister Ann William²⁰ was at St. Mary’s and Mike Weidner²¹ was at Highland. They stayed in those positions. John Stevens²² was another administrator at Highland Hospital who was also engaged in the idea of forming Upstate Health System. John was very helpful in the process. The reason I was in Rochester was because I wanted to be a CEO by the time I was 30, and it didn’t make any difference to me where. I ended up there because Frank had introduced me to this particular recruiter, and I went, not to run Park Ridge, but to figure out what we could put together.

I spent most of my time trying to figure out how to build the three-hospital system and maybe a third of my time on what the future of Park Ridge should be. For the most part, I stayed out of too much of the day-to-day operations. I did meetings with employees – all of the things you’re supposed to do, but my heart wasn’t in that. My heart was in the bigger question of how do those three hospitals come together?

New York State was on the verge of bankruptcy in the mid-‘70s. When a state is on the verge of bankruptcy, the schools are in trouble, the health care system, everything is in trouble. Because Blue Cross reimbursement was tied to Medicaid reimbursement in terms of a ratio, hospitals were

¹⁹ Timothy R. McCormick served as president and CEO of Park Ridge Hospital and Park Ridge Health System from 1979 to 1997. At that time, Park Ridge consolidated with St. Mary’s Hospital to create Unity Health System. Mr. McCormick served as president and CEO of Unity until his retirement in 2009. [Unity Health System. Unity Health System President & CEO Tim McCormick to retire. *Press Release*. Retrieved from <http://m.unityhealth.org/News/News-Article.aspx?nid=283>

²⁰ Sr. Ann William Bradley (1940-1984) served as president of St. Mary’s Hospital (Rochester, N.Y.) from 1978 to 1984. [Sister Ann William Bradley DC, led St. Mary’s modernization. (1985, Jan. 2). *Courier-Journal*, 16. Retrieved from <http://lib.catholiccourier.com/1985-courier-journal/courier-journal-1985%20-%200016.pdf>]

²¹ Michael J. Weidner served as president and CEO of Highland Hospital from 1978 to 1998, during which time it was transformed into Highland Health System, and later merged into the University of Rochester Medical Center. [Lehman Brothers, and Citigroup. (2003, Oct. 29). *University of Rochester revenue bonds, series 2003*. Retrieved from http://www.dasny.org/Libraries/Documents - About/University_of_Rochester_2003_A-C_Official_Statement.pdf]

²² John B. Stevens, Jr., served in administration at Highland Hospital of Rochester from 1967 to 1979. [American College of Healthcare Executives. (2000). *2000 Directory*. Chicago: ACHE, 1397.]

operating with no cash, one day's cash, less than a day's cash. I knew that New York State was in trouble. I remember asking the finance officer at Park Ridge, "How do you run a hospital when you have no balance sheet, when you have no cash?" They were borrowing money on pledges to their foundation to make the payroll, and they had to keep borrowing money to generate enough cash to stay in business. I remember our finance officer saying, "In New York, you just do. You figure it out." Everybody knew the hospitals had to be there. When things got too bad, they'd come up with some kind of other strategy.

Rochester had a history of always working together when there was a crisis of any sort. In 1975 or 1976, they might have thought, "Maybe the next step for us is to bring Highland, St. Mary's and Park together." By the time I got there, we began thinking about bringing all the hospitals together because reimbursement was so terrible. We formed the Rochester Area Hospitals Corporation.²³ I was working on trying to get these three hospitals together, but then all of us collectively began working to form the Rochester Area Hospitals Corporation that would be more than a hospital association. We didn't know exactly what it was going to be, but it brought in the leaders of the industry, the doctors, certainly David Stewart from Blue Cross.²⁴

Out of the Rochester Area Hospitals Corporation came the HEPP experiment – the Hospital Experimental Payment Program.²⁵ Jim Block²⁶ was the CEO. He was a physician. Over time, all of the hospitals, the doctors from the hospitals, and business leaders, like the treasurer at Kodak and people from Xerox and other companies, worked together because we knew our very survival was at stake. The hospitals were losing money. We came up with this idea, the HEPP experiment, where we would put together a global budget for the community, which was what all the hospitals had spent the year before. This is a very simplified explanation, and it's roughly right, but it's not the exact formula of the HEPP experiment.

We went to Medicare, Medicaid and Blue Cross and got exceptions or some kind of experimental pilot status, where all the money that they had paid us last year – or for some period of time – would go into a global cap. Every hospital would get a weekly check for what their revenue was the prior year, regardless of volume. If our volume went up and our expenses went up along with it, it would be a variable cost add-on for anything over 10 percent off of that average. If it went below

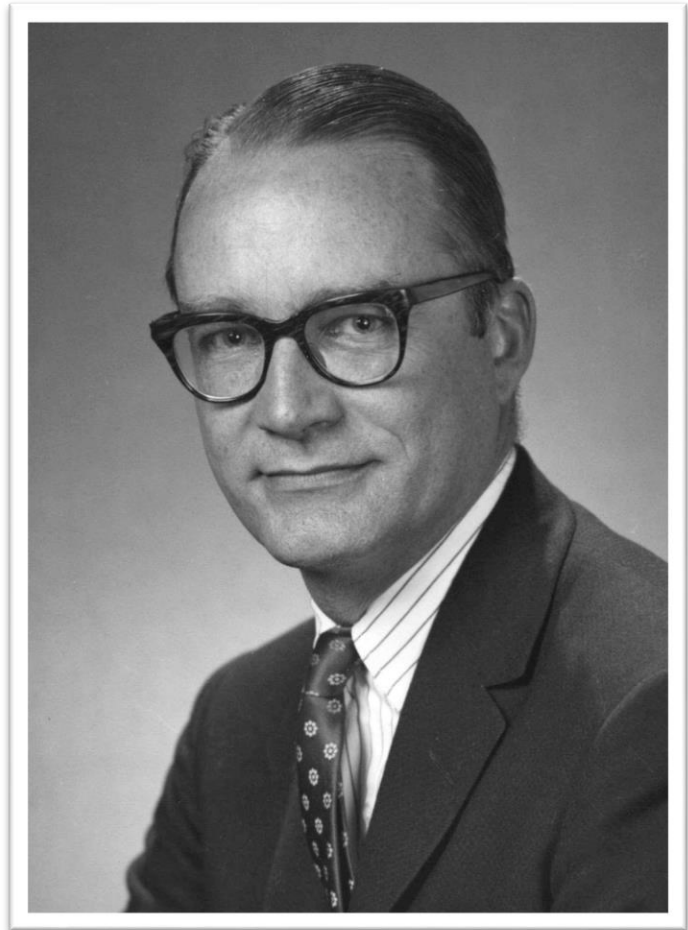
²³ The Rochester Area Hospitals Corporation was incorporated in 1978 as a not-for-profit corporation with nine participating hospitals. [Green Mountain Care Board. (2012, Jan. 3). *Hospital Experimental Payment Program (HEPP): Rochester, New York 1980-1990*. Retrieved from http://gmcboard.vermont.gov/sites/gmcboard/files/Charbonneau_010312.pdf]

²⁴ David W. Stewart began his career with Blue Cross of the Rochester Area in 1949, retiring as Chairman of Blue Cross and Blue Shield of the Rochester Area in 1985. His oral history: Weeks, L.E., (Ed.). (1987). *David W. Stewart in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

²⁵ The Hospital Experimental Payment Program, which established a revenue cap for hospital inpatient and outpatient services, was in force during the 1980s in the Rochester area. [U.S. General Accounting Office. (1993, Jan.). *Health care: Rochester's community approach yields better access, lower costs*. Washington, D.C.: GAO. Retrieved from <http://www.gao.gov/assets/220/217472.pdf>; and, Friedman, B., and Wong, H.S. (1995, Summer). Impacts of hospital budget limits in Rochester, New York. *Health Care Financing Review*, 16(4), 201-219. Retrieved from <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/CMS1191383dl.pdf>]

²⁶ James A. Block, M.D., served as president of the Rochester Area Hospitals Corporation and then went on to become president and CEO of the University Hospitals of Cleveland and, later, of the Johns Hopkins Health System. Partnership for Palliative Care. *James A. Block, M.D.* Retrieved from <http://restoringqualityoflife.org/about-us/our-leadership/6-james-a-block-md>]

it by 10 percent, then there would be a takeaway, based on variable costs. Because, remember, you still have your fixed cost. Blue Cross had 90 percent of the third-party market, other than Medicare and Medicaid, so Blue Cross knew exactly what was driving cost. As a result of all the hospitals working together, we were looking at all of the data that Blue Cross had. At the same time, David Stewart was controlling the size of the hospital system by the way he would reimburse. At Park Ridge, I wanted to build a new drug rehab center for treating alcoholics because we were sending all of our patients from Rochester, New York, either to Hazelden in Minneapolis or Chit Chat Farms in Pennsylvania. I said, "There are enough alcoholics here so we'll build that on our campus." David Stewart said, "You can build it, but I'm not going to pay for it." It really irritated me. Now I appreciated the way it had been in Minneapolis, where we could compete and do all these things and get paid for them. In Rochester, I was saying, "You can't tell me what I can build here or not." He said, "Oh, yes, I can, and I'm going to."



David W. Stewart photographed around 1970

Then I said, "I think I'm going to pull out of Blue Cross. I'm going to take our employees and I'm going to pull out of Blue Cross." I got a call from one of the other presidents of one of the hospitals, and he said, "Lowell, you're not going to do that." I said, "Yes, I am." He said, "No, you're not." Pretty soon, some of my board members called and said, "You're not going to do that." I said, "Okay."

I realized that the business community had their leaders on the boards of the hospitals and on the board of Blue Cross. Blue Cross had become the means for the business community to control the expansion of the health care system and to keep costs in line. The business community had decided that they would use community rating, which means everybody pays the same. Kodak, with 60,000 employees, pays the same premium as a little gas station with six employees. They used community rating. They controlled the expansion of hospitals. All of that was controlled by business leaders working through Blue Cross. David Stewart was a very creative guy.

I was trying to figure my way through all of this. I got a call one day asking if I'd like to be on the Blue Cross board. They always had one hospital CEO on the board. I did go on the Blue Cross board, and I began to realize the power of that Blue Cross database – who the high-performing docs were, where the costs in hospitalization were going. I had no idea.

Remember, I was in my 30s and learning. I was learning about the politics of a community. I was learning how to develop a health care system in an environment that was almost bankrupt. I was watching situations when people worked well together and when they didn't work well together. Everything was a learning experience.

When the experimental payment program came along, we were in such a critical situation financially, by looking at the Blue Cross data and having each of us in the rooms with our board members and our doctors meeting every Friday, we came up with all kinds of ways we could save money.

Pretty soon, the hospitals were profitable. All of them were profitable. I remember after about three or four years, somebody said, "You know, we're going to have to give some of this money back, and we don't want to embarrass the Governor. Here we've got this oasis – Rochester, New York – where the hospitals are healthy and making money, but the rest of the state's not doing well. What did I learn in all of that? I learned that if you collaborate, and if you're open and transparent and you work together, and if the stakes are high enough, it's amazing what well-intentioned creative people can do.

The three hospitals that we put together in Upstate Health System had almost become irrelevant in the context of the HEPP experiment, with the exception that I felt that Rochester was overbuilt in terms of beds. I felt that here was Park Ridge, a 200-bed hospital on the west side of town with no teaching programs, no OB, and that maybe what we ought to do would be to take the Highland beds and move them over to the west side of town. What I hadn't done when we formed Upstate Health System was to consolidate the balance sheet, so we didn't have asset control.

There was an article that Sister Ann William and I wrote on the split management system, because people kept saying, "How are you doing this?"²⁷ We had a parent organization that did strategic planning and strategic thinking, but each of the hospitals had their own CEOs with their own boards operating that facility. That seemed to make sense at the time, and it allowed us to get Upstate Health System together quickly. If we had had to go through the discussion of merging assets, I don't think it would have happened that quickly, or it might never have happened, because except for Park Ridge, the individual hospitals were saying, "This is the way for us to survive – to join forces and then we can compete with the big guys. Park Ridge was thinking, "Maybe it's a way for us to take out some capacity and move hospital beds around.

Later on, when I said, "Let's start thinking about moving some hospitals around," then the individual administrators of the hospitals said, "No, no, no. That's not why we're in this deal. We're not going to merge the assets." For two or three years, I kept thinking, "How do we do the right thing of merging these hospitals together, like we did with Swedish and St. Barnabas, figuring out ultimately how to consolidate services?" Finally, some of my board members and I said, "We're going to have to make the decision to consolidate assets or we're not ever going to get anything done." I felt that we would never get that approval. The hospitals were now healthy enough.

My wife, Leslie, did not do well in high school, graduating at the bottom of her class of 600 students in Sioux Falls, South Dakota. When we moved out to Rochester, the youngest of our three

²⁷ Bradley, A.W., and Kruse, L.C. (1980, Mar.). Split management corporation balances central authority, autonomy. *Hospital Progress*, 61(3), 64-66.

kids was starting kindergarten. Leslie decided to start college. She said, “If something ever happened to you, I could never support these kids.” She started at a community college and went on to get her master’s degree in speech pathology.

The reason that’s important is that I knew that once we called the vote on consolidating the assets, that the vote would be “no,” and that I would have to leave – because I couldn’t recommend something, have it turned down and then stay. We delayed the vote until the early part of 1984, because Leslie was finishing up her master’s degree then. She had said to me, “I’ll go anywhere you want to go, but if we leave before I finish my master’s program, I probably won’t start it up again. If we can time this so that I can finish in Rochester, I’d appreciate it.” I said, “Sounds good to me.”

We studied it for a few more months and took a vote in January of ’84. The vote was no. The next month I showed up in Chicago at the American College of Hospital Administrators, and ran into Montague Brown in an elevator. I hadn’t seen Monty for years. I told him my story. I said, “Here’s what I’ve been trying to do. I didn’t get it done. I need to leave and we want to get back to the Midwest, because my parents are still living on our farm, and they are aging.” I had been looking at a position in Chicago with a large system. I had talked with the people at Group Health in Puget Sound. They were looking for a new CEO.

Monty said, “Do I have a deal for you!” He told me about Heartland Health in St. Joseph, Missouri. I said, “The last place I would go would be St. Joseph, Missouri.” We used to deliver hogs here when I was growing up. I knew that it was an old river town, the same size now as it was 100 years ago – about 75,000. This wasn’t even close to anything that I could imagine doing in my career. I always thought I would be in Chicago or Minneapolis or Dallas in a big system.

Monty said, “You really ought to come and talk to these people. They’ve merged – they’re in the process of bringing the two hospitals together. They’ve formed a parent, Heartland Health, but they haven’t merged the hospitals yet. They’re intending to. The administrator of one of the two hospitals has left, and they’ve decided that they want to look outside of the community to bring in a new CEO to merge the hospitals.”

I said, “Monty, no.” I truly knew that I would never go to St. Joseph. I’ve never been more certain about anything in my life. Then Monty’s wife, Barbara (my classmate), called me. She said, “Lowell, you would be ideal for this. You’d be perfect. We’d love to have you come in.” I said, “Okay, I’ll come out and interview.” I knew it would be a great interviewing experience. Then the hospital called and said, “We’d like to have your wife come with you.” I thought that was strange. Why would you do that on the first interview? I thought, “It’s your money. Leslie, if you want to fly out there with me, great.”

We came out here, and during the interview, I was looking around and I was thinking, “This is not the place I want to go. I’m not interested.” They asked me questions about my philosophy, and I was more than happy to wax eloquently on everything I think about and believe. In the meantime, they were all over Leslie, telling her what a wonderful community this is. The night before we left, we were all at the country club for dinner with board members. I noticed that all of the conversation was directed at her like there was a spotlight on her. I thought that was funny, but since I was not going to go there anyway, it didn’t matter.

We got on the plane to go home. I said, “That was interesting, wasn’t it?” She said, “I thought

that was pretty good. I think we're going to go to St. Joe." I said, "No, we are not going to St. Joe." She said, "We're going to go to St. Joe." I said, "No, we're not going." We got back home, and she said, "Look, we need to finish raising our kids in a small town. You're gone all the time. You're on the fast track. We're going to go to St. Joe and finish raising the kids, and then you can go do what you want to do. That's where we're going." I said, "Okay."

I called them back. I said, "What do you want to do with this thing?" They said, "We want to put the hospitals together, and we want to do the right thing for the community." I said, "Do you have any covenants where we've got to do this versus that?" They said, "No. We want to build the right health care system to serve St. Joseph and northwest Missouri." I wrote that down. "We want the CEO of Heartland to participate in the economic revitalization of northwest Missouri." They had been hit hard in northwest Missouri by the farm crisis and other things, plus there was a very low educational attainment. Heartland was going to be the largest employer, and they wanted their CEO to be engaged in that activity. I said, "I honestly don't have an interest in running a hospital on a day-to-day basis." Even though the combined bed capacity of the two hospitals was around 800 beds – it was a big organization – I said, "It's not what I want to do." I wasn't trying to sell myself here because I wasn't coming here, right?

However, I thought, "That's what health care leaders ought to be doing." The economy and educational attainment lead to health. They want to build a health care system to meet the needs of the region and participate in the economic vitality. Then there was this catch-all, "We want to do the right thing. We don't know what that is, but we want to do the right thing, and we want a CEO who can take us there."

Then I got to thinking, "Monty has put them up to this, because he knows how I think. He is the one who told them what to say." I admit that I talked to a couple of people who had been at the interview, and I said, "Now tell me the truth." They said, "No, no, no! That is what we want. That's what we think – we shouldn't be competing. There's not enough room for that. We need to do the right thing for the community." Remember, too, Leslie had said, "That's where we're going."

It was worse than I thought when I got here. Trucks wouldn't unload unless we gave them a cashier's check. When I looked at the balance sheet and saw that we had \$17 million, I said, "We've got cash!" The finance department said, "That's encumbered because of our \$50 million debt." I hadn't asked about the rating, but we were BBB+ rating, which is the lowest level you can have above a junk bond.

The history of the hospitals in St. Joseph was that there had been a Daughters of Charity hospital officially named St. Joseph Hospital, but that was known as the "Sisters Hospital." It was located on the north side of downtown. The Daughters of Charity decided that they were going to get out of the hospital business and left the hospital to the community. People at the other hospital in town, Methodist Medical Center, believed that the Sisters Hospital would fold. Methodist built a new long-term care facility, to acute care standards, so that when Sisters folded, that's how they would be ready to merge.

Several of the Sisters employees went to business and community leaders and got them to form a board, and that board ended up building a new hospital on the east side of town. What started out with the Methodist strategy to merge everything didn't seem to be working so well. Instead, there was a new 200-bed St. Joseph (Sisters Hospital) on the east side of town that opened in 1982. In 1983,

the new hospital was approached by one of the for-profit organizations with a buy-out offer. St. Joseph said, “No, we’re not interested in selling to a for-profit chain.” That got some of the board members at St. Joseph Hospital to thinking that the chain might approach Methodist next, and Methodist might say yes because St. Joseph Hospital was doing well with the brand new hospital that was taking all the paying patients. Methodist didn’t have a pediatric unit. They didn’t have an OB unit. All of the non-pays were coming to the Methodist facility, and it seemed like Methodist was on the ropes. The board members thought, “If the chain doesn’t get us, they might get Methodist. We don’t want that.”

The two boards started talking to each other, and they put a parent board together in ’83, I think. The administrator of Methodist Medical Center, Joel Allison,²⁸ became the CEO of the parent and CEO of Methodist, and Tom Hesselman,²⁹ who was the CEO of St. Joseph Hospital, became the chief operating officer of the system. The structure that was formed in ’83 was a parent, but all they did was strategic planning. They weren’t doing too many things together.

After 18 months, Joel left and went to Dallas, where he’s been running the Baylor Health System. The assumption was that the remaining administrator would become the CEO of the parent. The medical staff from Methodist said, “We’re not sure we want the administrator from St. Joseph to be in charge.” They went to the board and said, “We’d like you to go outside.” It was the typical politics of people not trusting one another even though they had worked together. The sequence was that they decided to come together, Joel Allison left, and it was early 1984. Montague Brown had been working with the two boards to figure out how to build Heartland Health and what to do with it.

Once they put the structure in place, they realized they wanted to recruit somebody. They said to Monty, “Can you recruit somebody who can lead this place?” He said, “Sure.” I don’t know that he’d ever done a recruitment before, because he wasn’t in the recruitment business. He might have been. He showed up at the ACHA meeting to try to find people looking for jobs.

It was like having our banker stop by when I was cultivating; or having my interview with Lyle Schroeder who said, “I’ll help you get in;” or having Jim Hamilton say, “You need to go to St. Barnabas,” – it was one thing after another. Or like going to Rochester, which I wasn’t particularly keen about until someone told me why and sent me back out again. At that time, very few people had merger experience. I hadn’t been the CEO, but I had seen it. A lot of people hadn’t even seen a merger. The fact that I had merger experience and system experience got me into the job in Rochester, and then there was the Jaycee experience. When you look at my exposure to the Swedish/St. Barnabas/Metropolitan Medical Center experience, and then we began working with Hennepin County General. Metropolitan Medical Center then became connected to Hennepin County, and when MMC closed, it all became part of Hennepin County General. I’ve had a series of experiences in my life without one strategic thought about any of it other than being put in these positions and

²⁸ Joel T. Allison served as president of Methodist Medical Center (St. Joseph, Mo.) from 1981 to 1984. He went on to other leadership positions, including CEO of Baylor Scott & White Health, the largest not-for-profit health system in Texas. [Goodman, M. (2014, Dec.). CEO of the year: Joel Allison. *D CEO Magazine*.

<http://www.dmagazine.com/publications/d-ceo/2014/december/ceo-of-the-year-2014-joel-allison-of-baylor-health>

²⁹ Thomas J. Hesselman served as administrator of the St. Joseph Hospital (St. Joseph, Mo.) from 1974 to 1984, and then was executive vice president of Heartland Health System for two years. He retired as president of Mercy Medical Center-Clinton (Iowa) in 2004. [Luna, K. (2004, Jan. 26). Mercy president to retire. *Quad-City Times*. http://qctimes.com/news/local/mercy-president-to-retire/article_a1f47c29-43a2-5cfe-a875-98920005d08e.html

making the most out of it.

While I do think strategically, I also understand there is balance between strategy and what you control vs. coincidence and things that you can't control. Farmers do that all the time. There are certain things you can control. There are cycles of weather year after year that you can anticipate. There are certain things that you know about the soil. But at the end of the day, there are so many uncontrollable factors – hail, wind, whatever it is – that you then have to adjust to. I grew up knowing that you're going to have bad years and good years, and no matter what, you're accountable and responsible for cleaning up after whatever happens. If you have a great year, it's not because you did anything particularly smart. It's because you had a great year. Everything happened. If you had a bad year, it's not because you're completely at fault, but in any case, you're responsible.

I think the same thing has led me through my life. I acknowledge that good things happen if you pay attention to what's going on around you and know that you always have to have good peripheral vision. I had the good sense to listen to other people when I thought I was absolutely dead right. After we had been here in St. Joseph ten or 12 years, I kept thinking that I probably shouldn't stay here my entire career. That would mean I'd be here 25 years, and not everybody should be in a job that long. Leslie said, "Anyplace you want to go is fine with me as long as you can get home on weekends." She was saying, "I think we're staying in St. Joe."

We came to St. Joe, and I put in front of the board those three objectives that they'd told me, and I said, "That's what you want to do." They said, "You're sure about that?" I said, "Yes, I am." They said, "Okay." Why did they select me? I have no idea other than that I had merger experience, wasn't so interested in running the hospital, but was very interested in community engagement.

GARBER: Before we go on and talk about how you went about fulfilling those three objectives at Heartland, I'd like to follow-up on a couple things that you mentioned. You said that you knew that if the vote was taken in Rochester and it went against what your recommendation was, that you would have to leave. Is that common in leadership circles? Was it because your credibility would have been damaged with the board?

KRUSE: I wouldn't say that every time you make a recommendation and the board doesn't agree with it that it is a triggering event. If what I was proposing – the merger of assets so that we could move hospitals around ultimately – didn't happen, then I knew that I didn't want to do that job. If it didn't happen, I would be running a very small hospital association where I really didn't have any control, and the CEOs would run their own hospitals. The potential for consolidation, the potential for the benefit of the three Rochester hospitals working together in terms of preventing duplication, all of those things, wouldn't be there. That's not a job I wanted to do.

It wasn't that we offended anybody because of the push made on a big strategic issue. I knew that the three CEOs were relieved that the decision was that they were still going to be the CEOs, because the implication was that we were only going to have one CEO. Some of the board members said to me privately, "We really want you to stay, because we think you've been doing some good things." I said, "You said 'no,' and so I need to go on to something else."

GARBER: When you were talking about interviewing for the Rochester opportunity, you said that the chairman of the board and one or two other board members knew about the desire to engage in collaboration activity. Is that an effective way for a board to operate, where some of the

board members know what's going on and the others don't? Have you seen that in other instances?

KRUSE: Yes, I've seen other instances where the full board is not engaged. One thing I've learned in my career is that there is a huge difference between knowing what to do and getting it done. When you work for a board, the only way you can get major things done is to get board approval. You can hire people and do things like that to operate, but if you want to build a new hospital or if you want to merge or close something, you've got to get board approval, right? You might know it's exactly the right thing to do, but if you can't get the board to say yes, you've got nothing. I came to the conclusion that if you're going to get anything done, it isn't how smart you are or what you know, it's how good you are at educating and bringing people along and engaging people, so that the people who have the authority will say yes.

I remember a conversation with the chairman of the Park Ridge board when we were moving on bringing Upstate Health System together. I remember saying, "Frank, that's why I came to Rochester, to Park Ridge, to put these three hospitals together." He said, "I never knew that. No one ever told me that." I asked a few others – there were only about a handful of Park Ridge board members who knew the "grand plan." The rest of them, of the maybe 20 people sitting on the board there, thought they were just on the board of a little hospital.

I was taken with the fact that I didn't even think about that, that I didn't know, that I thought the leadership of the board would tell everybody else. You learn so much from things that go wrong rather than things that go right. They thought they were doing the right thing, and we did make a lot of progress. I don't know if I had been a little more aggressive the first time, to say, "Look, we need to put the assets together on this. If we're going to accomplish anything long-term, we've got to put the assets together." It probably was my fault for not having enough experience, maturity to say, "My experience is that this is not going to go well if we don't merge the assets now."

When I came to Heartland, they said they were going to merge the boards and have a parent board and two hospital boards. A couple weeks later, after I had accepted the job, I got a call from one of the board members, who said, "By the way, we decided not to merge the hospital boards because it's too quick." I said, "Then I'm not coming." He said, "What do you mean?" I said, "I'm not coming. Why would I do that? You said you were going to merge the boards. If I come and then I start pushing to merge the boards, then I'm going to be the bad guy. If you're going to merge the boards, you do it before I come, or I'm not coming." Two weeks later, they merged the boards.

Going to Rochester, I didn't know that, but I knew it coming here to Heartland. I wasn't being mean or nasty. I was saying that my experience was that if I was tagged with the idea of merging and controlling, then I'd have to deal with that. I also knew that merging two hospitals together and merging administrative staffs was going to be a hard deal – very hard. (I'd said before that I didn't want to go through another merger!)

They said, "You know what? We're a small community. Everybody gets along really well." This was not true – these people were used to competing with one another. One of them was winning, and the other one thought that *they* were winning, and now they had to give up and be friends. If you've ever been through a merger, you've seen people come together and stand on either side of the room and fold their arms as if to say, "This isn't going to work." It's a fascinating thing. I saw it at Swedish and St. Barnabas. I saw it in our hospitals in Rochester, and I'd felt it myself.

These are all experiences that I learned the first 15 or 20 years of my career. When I came here, I said, “You’re going to merge the boards, and there’s only going to ever be one CEO of anything. We’re not going to have several CEOs running around. There’s going to be one CEO.” When I got here, I had no idea about our financial situation. We hadn’t recruited a new doctor in about a decade.

I came here in August of ’84. DRGs hit, and guess what?³⁰ You got paid for admissions, as opposed to patient days. All of a sudden, volumes started to decline, and the hospital hadn’t recruited new doctors. I looked at the equipment in the new hospital, and I realized we were having a lot of maintenance costs. I said, “Why? We’re a new hospital.” I was told, “We couldn’t afford the new equipment, so we had to move the radiology from the old Sisters Hospital.” I said, “Really?”

We had \$50 million debt, were triple-B rated, out of money. We had old equipment. Now patient volume was going down. We had 800 beds. One morning about two months after coming here, I was out running before work, and I figured out that we had 500 too many employees. I figured that out in a four-mile run. When I came into the office, I asked for a calculation of the number of employees per occupied bed to check my figures. The answer was eight or nine. In New York, we had had about three to three-and-a-half employees per occupied bed. I knew that was very lean, but by any reasonable number, we had 500 too many employees.

The fall of 1984, we put a hiring freeze on and offered an early retirement to employees. That decreased us by about 200 to 250 employees. In March of ’85, we had a layoff of about 200. We got down by about 500 in the first six months. It increased the unemployment rate in St. Joseph from a little over 10 percent to about 11 percent. The reason we had to do this was because we were losing money. I came here, we merged the hospitals, we started losing money, and the fact that we were losing money was because now we were being paid on DRGs. Seventy percent of our business was Medicare, Medicaid and no-pay. Thirty percent of our business was commercial insurance. In that first five years that I was here, everything that could go wrong did go wrong. We just didn’t have the money. We weren’t able to buy equipment, to bring new docs in. As a result of not being able to buy the equipment or bring the docs, we were not going to get new business.

When we merged St. Barnabas and Swedish to form Metropolitan Medical Center, we moved quickly to merge departments – to have one lab, one x-ray, one volunteer group, one medical staff. The pushback to forcing these consolidations was disastrous in terms of resentment and choosing one manager where there had been two. “You! You’re going to be in charge of lab. You! You’re gone. Also, we’re only going to have one auxiliary group.” They had been used to being the Swedish and St. Barnabas auxiliary groups for decades.

Instead, when I got here to St. Joe, I said, “We’re going to go through a methodical process

³⁰ Passage of the Social Security Amendments of 1983 (P.L. 98-21) resulted in the implementation of the Medicare prospective payment system (PPS) beginning in October 1983. The new reimbursement system, which was built on a patient classification system known as diagnosis related groups (DRGs), applied to inpatient hospitalizations in most U.S. hospitals, although certain types, such as psychiatric and rehabilitation hospitals, were excluded from participation initially.

[Guterman, S., and Dobson, A. (1986, Spring). Impact of the Medicare prospective payment system. *Health Care Financing Review*, 7(3), 97-114. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/CMS1191951dl.pdf>]

of figuring out what departments ought to come together and how we do common leadership.” Everyone was nervous for a long time. I didn’t know exactly what to do, but I knew not to rush into it, that things would take care of themselves. Sure enough, in one department the manager would leave, and we would say, “Let’s merge that department.”

The medical staff came to me and said, “You’re not going to force us to merge into one medical staff.” I said, “You can be two medical staffs as long as you want. Doesn’t make any difference to me. Whatever you want, but you’ve got to run it.” I stayed away from the auxiliaries and the volunteers. I took it step by step slower than anybody wanted, but you have to go slow to go fast. With a project like this, you can either do everything up front and spend time cleaning up after, or you can take some time, bring people along. It’s not that you know what to do, it’s getting it done without destroying the organization that’s the big issue. By the time I came here, after that 20 years of experience with these other mergers, I took my time, knowing the direction I wanted to head, trying to figure out how we could work ourselves out of trouble, getting to know the community, but always educating the board, always letting the board know what was going on.

People told me, “We’ve got to change the names of the hospitals.” I said, “No, I don’t think we need to do that.” Then one of the board members said, “I have been in banking all my life and as soon as we did something like this, we changed all the names.” I said, “I don’t think we need to. Let’s put it back on the agenda for next month.” In the meantime, I talked to a lot of the board members, and they said, “We probably ought to change from St. Joseph Hospital and Methodist to maybe Heartland Hospital East and Heartland Hospital West.” I said, “I don’t care,” but at the next meeting, I recommended that we change the names. One of the board members said, “Just last month, you said not to do that. What changed your mind?” I said, “I counted the votes!” He laughed and said, “That makes common sense to me.” I said, “That’s what you all want to do. Let’s do it.”

I found that it wasn’t so important for me as the CEO to know everything we ought to do and go push everybody to do it. I thought we could discover that together, take advantage of when it made sense. Obviously, if we had to move on something, we had to move. I was a lot more certain of myself because of all these other experiences, some of them failures, some of them moving too fast, some moving too slow.

That’s why to be more purposeful in educating this next generation of leaders became a thought that went through my mind, just like that thought of looking out the window and seeing those poor, destitute people in the park while I was worrying about buying equipment and making a better experience for doctors so we could get their patients. Those were life experiences that made me who I am. I devoted a lot of time to thinking about this. What’s the right thing to do? Why do we exist? It’s a unique business that we’re in, and we ought to be thinking about that.

After about five years in this community, I began to realize the difficulty we had in getting employees and attracting physicians to move to this community. By the early ‘90s, I realized that we couldn’t just think about building a better hospital. No matter how outstanding Heartland was – that wasn’t going to improve the health of the population. We had to be doing something a lot differently. I thought through the idea of changing the purpose of the Heartland Foundation from raising money for the hospital. By this time, the hospital was starting to get back on its feet, was making a little money. We gave the Heartland Foundation \$5 million and changed its mission from raising money for the hospital to leading our Healthy Communities initiative.

GARBER: Before we leave the subject of mergers, could you talk about how to merge a hospital governing board?

KRUSE: Once the decision is made to merge, the two chairs appoint a nominating committee. They'll have a discussion with the full board, and say something like, "Look, we've got 20 people at this hospital. We've got 20 people at that hospital. Do we want a board of 40? No? Okay, we need to have some kind of a board development or board nominating committee. Why don't we ask you two to co-chair it? By the way, if any of you are interested in stepping off at this point, let's get that out of the way." I don't know exactly how they did it here, but if you asked me to chair that committee, that's what I would do. Then I would go through a process of thinking about what we are looking for in terms of competencies. Let's try to get the best balance that we can and be sensitive to the politics of everything. Then you select board members and then you nominate them. Sometimes you really irritate somebody who wanted to be on the board.

You could structure it so that the first time through the nominating process you could take ten existing board members off, and then put everybody else on a one-year, two-year, three-year term or whatever, and then at the end of the term, not replace them. You can come through some process like that that allows people to ease out and get the board down to an ultimate size of 11 or 15 or whatever you want. There's a thought process, and you engage the whole board, and there is no one right way to do it. There's a wrong way to do it, though, and that is to do it by mandate and not be sensitive to people's feelings, because these are all community leaders whose support you will need over the long term.

You might be a little bit larger and less efficient than you'd like to be at the get-go. You get everybody to agree that you want a board of about X size. They'll say, "Shall we do it over time? Do you want to move quickly?" You get everybody to agree conceptually. Then you say, "We're going to have to make some decisions here, so I want to appoint a committee. We'll get three from this board and three from that board. I'm going to ask Bill here to chair it. Is that all right? Is everybody comfortable with that?" You're checking around and you take your time. You don't rush it. They're all mature people.

In my early experience, we moved too quickly. We were too abrupt at doing those kinds of things. Sometimes you can be too abrupt – because you want to get it done you keep everybody on the board indefinitely. At some point, it's just by talking it through. Reasonable people with the same data will come to about the same conclusion over time. The way you get at it is through ambassadorship and you get the respected members of the community and of the board to lead the process. They're usually respected members because they've earned that respect, and they will handle it sensitively. If you do it right, with sensitivity and thoughtfulness, it will work out.

GARBER: How do you merge a medical staff?

KRUSE: You don't force it, but you can keep the pressure on a little bit. One way you keep the pressure on would be not to tell them they have to do something. At Heartland, when they saw for themselves that they were duplicating meetings, the leadership of the medical staff said, "We want to merge the medical staff because now we have two medical records committees, we have two TPR committees." I said, "Yes, it's inefficient. Tell me what you want to do and we'll do it." They said, "You know, your problem is you can't make a decision!" I was told, "If I were you, I'd force this." I said, "That's one way to do it. But you know what? You are reasonable people. When you're ready,

you'll do it. You're going to do a great job running the two, and when you come together, you're going to do that right, too." The same thing happened with the auxiliary – ten years after we became Heartland, they became the Heartland Auxiliary. A new auxiliary president came along and said, "We need to have one auxiliary."

About the same time, we had decided we were going to keep the two hospitals, divide services between the two hospitals, and we were going to build a new office building on the Methodist site. Obstetrics was going to be here, and something else was going to be out on the east side. We had already started the pilings for the new building. I woke up one night in a cold sweat. I realized, "We don't need two hospitals. We can't afford two hospitals." The next day, I put a stop to the construction of the office building and called some board members. They said, "Are you out of your mind?" I said, "No, I think I'd be out of my mind to have us keep doing this. We need a lot fewer beds than we ever imagined. I think we have to put all the care together on one campus, and we need to start by not investing more in the downtown campus."

I couldn't have done that right away. It had been on my mind. Sometimes you spend some money. You don't know exactly what to do. We built a new cancer treatment center downtown. They had held off that decision for a couple years before they were merging, and then I held it off another year and a half or so after I got here.

As the environment was changing and Heartland was becoming a bit more stable, and we were making a little bit more money and could recruit some more doctors that helped grow the business, we found out that the business was changing dramatically. We were seeing a lot fewer inpatients. I had been educating the board about the fact that we needed fewer and fewer beds. When I finally had this epiphany that we should not be building the new office building, but that we should be thinking about consolidating the hospitals, it was in the context of how rapidly our environment was changing. I felt that we were making the wrong decision.

When you make a mistake in almost anything, you can fix it once you've found out you've made a mistake. If you decide that's not the right path, you can usually get out of it, except when you sell 30-year bonds. If you spend a lot of money on something, that is a fixed cost and you can't get your investment back. That is a huge mistake. When borrowing money and selling bonds, you're making a pledge that your revenue will pay for the bonds. I couldn't foresee a revenue projection that would pay off the bonds or whatever borrowing we would have to do.

Even though the board was surprised and a little taken aback, I had been here long enough and had enough credibility by that time that we hired architects to look at how to put everything on the East Campus. We were able to cut out half the beds – going from 800 to less than 400. It took a couple of years to merge all of the lab and x-ray and emergency room services, but we saved \$20 million or more a year in operating costs, and that \$20 million a year paid for everything we did here. Additionally, by Medicare standards we met all the criteria to become a sole community hospital, so we got another \$20 million a year from Medicare.³¹ Consolidating the hospitals, downsizing and

³¹ The Sole Community Hospital designation is available for small rural hospitals that are at some distance from other short-term acute care hospitals. Hospitals that receive this designation are eligible for more favorable Medicare reimbursement. [U.S. Department of Health and Human Services, Centers for Medicare & Medical Services. (2014, Nov.). *Sole community hospital* (Rural Health Fact Sheet Series). <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/solecommhospfctsh508-09.pdf>]

merging produced the revenue from savings that we needed to do a lot of other things.

What I believed was that we didn't want to focus just on what we needed in the hospital. We wanted the hospital to be outstanding. We kept working on mission and vision, what we were trying to accomplish. One day in a board strategic thinking process, we were looking at our vision. We said, "Obviously, we want to be the best and safest place in America to receive health care. Our moral obligation is to deliver the highest quality care we can." One of our board members said, "Write that down." I said, "Heartland Health and its service area will be the best and safest place in America to receive health care." They said, "Is that it?" I said, "Well, no. If there are not healthy and productive people running around here, then we're not doing our job." He said, "Write that down." I wrote, "Heartland Health will be the best and safest place in America to receive health care and to live a healthy and productive life." That became our vision. That guided us throughout the rest of my time at Heartland. Best and safest, healthiest and most productive.

Addressing health and productivity means you have to have a population focus. When you address the question of best and safest – that gets to operations focus. I had been looking for a quality process that we could adopt at Heartland. Our quality wasn't at a standard that I wanted to be at. The quality measures in health care and the idea of hospitals comparing quality and sharing openly their information about infection rates and fall rates – we weren't very good at that. The way hospitals would describe quality was to say, "You're the patient. We know quality. We can't describe it, but we know it." That was in the early part of my career.

Back in the mid-'80s, the Malcolm Baldrige Award³² came along because our manufacturing was falling way behind our competitors in other parts of the world. Health care was falling quite a ways behind in terms of productivity and quality measures. By the mid-'90s, Baldrige came to the American Hospital Association and to the education sector. The American Hospital Association wanted to adopt Baldrige as the quality process. I think Congress was approached back in '93 or '94 to have health care become a new sector, and it was granted that. By 1995, there were criteria for health care. What I'm working on now is that we want communities to become the seventh sector. That's our proposal – for Communities of Excellence 2026 – to bring Baldrige to communities.

I knew about Baldrige from friends in Rochester. A friend of mine was the chief quality officer for Xerox. He then moved to St. Joseph and became involved with helping Heartland do all this thinking. He had done the same thing at Xerox.

We had tried different quality processes in the early '90s. It took me at least five years to get my mind around all the issues and figure out what to do. I went to a community event in '91 or '92, where I was looking around at the crowd. All the people were gathered on the mall over by the city hall. For the first time, I really noticed our citizens. I saw the poverty – people without all their teeth – and the smoking. I said, "We couldn't possibly do enough to take care of everybody in terms of obesity and diabetes, and on and on and on." It was one of those "aha!" moments.

We began thinking about how do we get involved in the Healthier Communities movement?

³² The Malcolm Baldrige National Quality Award was established by Congress in 1987 as a way to challenge American companies to focus on quality improvement. The Baldrige program was later expanded to educational and health care organizations (1999) and to not-for-profit and governmental organizations (2005). [Baldrige Performance Excellence Program. (2010). *History*. <http://www.nist.gov/baldrige/about/history.cfm>]

We sent a group of people representing different sectors of our community to the Health Forum's first Healthier Communities Summit. We wanted to figure out a way to engage our community in creating healthier communities. We wanted to figure out how to improve the quality. We adopted the Baldrige framework even before it came to health care. We brought in the Missouri quality organization in the early 1990s. Within a year or two, there was a framework for health care.

We changed the Heartland Foundation's mission from raising money to leading our Healthier Communities initiative. We hired a youth health coordinator whose job it is to figure out what's going on with the kids in our community. We hired a senior health coordinator to look at what's going on with seniors, and a business health coordinator to figure out how we integrate there. Donna Wilson began working with all the school nurses, and I became a good friend and partnered with the superintendent of schools. Beth Cobb did the same thing with the elderly, and Linda Bahrke³³ did the same thing with the business community. We decided to start our own HMO, because from sitting on the Blue Cross board, I realized how much data they had. I thought we needed that access to data.

We began employing physicians in order to bring them into a community where they couldn't make it on their own financially because of the payer mix. A hospital can't give a doctor money to make up for the lost revenue – you have to employ them in order to compensate them. All of these things took years of struggle. The medical staff wanted to be independent but wanted the income. They didn't want to be employed but knew they couldn't get the compensation.

No one really wanted us to get into the insurance business – including me – but we couldn't find an insurance company to partner with us that would agree to share their claims data openly with us and with the community. I convinced the board that our best option was to develop our own risk business in order to get access to the data. If the doctors and the hospital had aligned incentives, using the same database, all of us could look at the same data. If we all did well, then we would all do well together if we were all part of the same organization. We had the medical center, we had our medical group practice, and we had our HMO. We developed an integrated delivery system.

Over a three-to-five year period we lost a lot of money on the HMO before we were able to get out of some of the contracts. We lost about \$75 million. I remember going to the board leadership and saying, "I think it's time that we got out of this business. We're not doing it very well." The board chairman said, "No. We're going to do this because it's important." They were so convinced of our strategy of integrating hospital, doctors and financing – because it is the right strategy – and our work in the community to get at the cause of why kids are sick and why seniors are not doing well, that they said, "It's the right strategy. We've got to figure out how to deploy it better."

We were getting much better at quality inside the hospital. By 2000, we received the first state quality award; by 2005, another state quality award; and then by 2009, the Baldrige award. We went from being in the lowest quartile of performers in virtually any category, whether it was clinical or financial or patient satisfaction. We were a fourth-quartile performer for years. As we began to employ quality processes through Baldrige, we got into the top one percent of hospitals in virtually everything over a ten-year period.

We did a much better job – faster – improving the overall performance of the hospital than

³³ Linda Bahrke is accountable care organization/population health management administrator at Mosaic Life Care (St. Joseph, Mo.) [*HealthLeaders Media live from Mosaic Life Care: All-in population health.* <http://promos.hcpro.com/mosaic/>]

we did in terms of community, because that is generational. When 60 percent of your births are paid for by Medicaid, and 60 percent of your children are on free and reduced lunches, and education isn't particularly valued, the only way you can improve health is by improving educational attainment and jobs. We had a long way to go. Having a vision about how you need to integrate that and how you have to share the data about what's going on in your community, you engage the community. You have a lot less control of the community than you have inside the hospital. We used what we learned through our Baldrige process inside the hospital to get engaged with the community. We didn't say, "We're going to use Baldrige on you." We just used what we learned.

We involved people and encouraged other leaders to come together. At the time, Mayor Glenda Kelly,³⁴ wanted to develop a strategic plan for the community in the '90s. We thought it was a great idea. We were very supportive of that. Five years later, out of that came the idea that we were not following up on the plan, and maybe what we needed was to form an alliance of all the sector leaders to have some kind of an ongoing process. Now we have the St. Joseph Alliance, which funds an alliance director who keeps all the sectors working together on community issues.

How did we make the transition from a hospital-centric organization to this broader community focus? It was time and all of the heavy lifting of repositioning the hospital and downsizing and putting everything on one campus and the money that produced. It took my own experience that you need to have a good connection with the payment side. We had no other option to bring doctors to town other than employment. We began talking about a common information system.

By that time, I had enough experience to know the parts of a successful integrated delivery system. When I left Minneapolis, the big idea was multihospital systems. Later in my career, the big idea was vertically-integrated systems – where you have the hospital, doctors and financing. I wouldn't have known about that in Minneapolis because I wasn't involved in the financing; and, for the most part, hospitals didn't employ their doctors, unless it was a teaching hospital. In Rochester, a lot more of the doctors were employed. I was used to the employee model by the time I got here.

Over the first five years here at Heartland, I thought about how we would stay in business. The next five years was about repositioning through downsizing and putting everything in one hospital. We also began to focus on quality and on community strategy – starting with this foundation's mission being changed.

I knew we were heading in the right direction. Wanting to be the best and safest hospital, there isn't any question about that. If you don't want the best and safest hospital for your patients, then you probably ought not to be in health care. If you say, we've got to figure out a way to improve the health and productivity of the population, who is going to disagree with that? Every two or three weeks or so, we had a small group of community leaders come together at the hospital for lunch, and I would give presentations about what drives health care costs and how you improve the health of a population, the role that education plays. I would talk about what was being done in the community to get at all of these things, and it started to make sense to people. You can't do that in a hurry.

What I learned in that whole process is that it's a matter of using your common sense, of doing the right thing, understanding your environment and bringing people along. When you don't know

³⁴ Glenda M. Kelly served as mayor of St. Joseph, Mo., from 1989 to 1994. [*Previous St. Joseph Mayors*. <http://www.stjoemo.info/index.aspx?NID=373>]

how to do something specifically, like implement a quality strategy or do open-heart surgery or educate children, you have to rely on all the people around you, the good people wanting to do the best they can. If you're doing the right thing that makes sense to people, everybody wants to help.

If it looks like you're trying to get the credit for everything, if it looks like this is a hospital project, it isn't going to work so well. You have to be authentic. You have to have a true concern and passion for what you're doing in your community. As time went on, people knew that I was sincere about what I was trying to accomplish. They saw the progress – more doctors coming to town, a new facility, partnership with the school system so that every child was getting access to the health care services that they needed, dental care. It all happens over time. As a “smart guy,” I could have come in here and figured all of it out, and tried to do it all by myself in a short period of time. It would have never worked.

You have to develop knowledge of what's the right thing to do, how to get it done, build support and educate people. It's an interesting process. There's a lot of art to this. There's a lot more art than science when you get to the leadership levels that I'm at. I've worked at it most of my life. There are a lot of relationships. You have to be knowledgeable about what you're doing, but I've found out that you don't have to tell anybody how smart you are. The more power you have, the less you use it. The power of the position brings people together. The knowledge you have helps figure out what people should come together. Then, tell them where you're trying to go and see if they agree, and then say, “Okay, let's go do it.” I tried not to be in charge of everything, but to be a coach in guiding things.

I never worked on an agenda that we were out to compete with somebody else and drive somebody else out of business. I was only working on an agenda of trying to improve the lives of our patients, our employees, the community. Everybody that I come into contact with buys that you can do good and do well. All those things that you heard – it's true. You can't be naïve. You can't be Mother Teresa. You can't give it all away. You still have to have a balance sheet and a bottom line. I don't know how to describe it any better than that. It's something you learn over time.

The learning in my career was around how to build that balanced health care system that serves the needs of the population and provides high-quality care. All of those things are important. You have to have people focusing on it. You have to have reports that measure all of that. You have to be steady on that mission. It all comes together.

There was a reason that we received the Baldrige Award and the Foster McGaw Award³⁵ at the same time. This all happened two or three months after I retired. The new CEO was on board, and he was involved in making the presentations when the Baldrige people came in, when the Foster McGaw people came in. I thought about that afterwards, that it makes common sense that we would use Baldrige in the community to the best of our ability, and that the same process would work externally as it worked internally.

GARBER: What's exciting for you now? What are you looking forward to in the job that

³⁵ Heartland Health was awarded the Foster G. McGaw Prize in 2009. The prize was created in 1986 by the Baxter Allegiance Foundation and the American Hospital Association. It is awarded to recognize hospitals that have made outstanding efforts to improve the health and well-being of those in their communities. [American Hospital Association. History of the prize. <http://www.aha.org/about/awards/foster/index.shtml>]

you're doing here?

KRUSE: My title is Senior Fellow for Healthy Communities, which is a title I gave myself so I'd have something to put on my business cards. About ten years before I retired, I wasn't sure I wanted to stay here. The board hired a consultant who spent six months with Leslie and me going through a process of helping us figure out what we truly enjoy in life. Each month we would have an assignment like: every day write down what you really enjoyed doing that day. At the end of the month, he would come out to our house and we'd talk about that. Ultimately it was to help us decide not only what we enjoy doing, but also where do we want to spend the rest of our lives? What is important to us? What's the mix of personal and family and business?

We went through this process about ten years before I retired, which was in the summer of 2009. What worried me about being in the same job for 25 years was spending the last ten years defending the decisions I had made during the first 15, because I didn't want to say I was wrong. I told the board that I was so worried about this that I wanted to have a board evaluation every six months. It was a repugnant thought to not be on top of my game until the day I was done.

I thought I'd need to move to a new job with a new challenge. The board was saying, "Well, we'd like to have you think about that." They paid for the consultant. We went through two years of conversations back and forth. My dream of running the largest health care system in America, of doing all the things I wanted to do, of being in an urban area was moderated by the fact that things were moving along at Heartland and I was seeing results.

The board always encouraged me to be involved in national things. I got involved at the state level – I've been on the Higher Ed board of Missouri for a dozen years. I'm going off this summer. I was on the Premier board and chairman of Premier.³⁶ I was a member of an international discussion group where about 25 of us would meet in different countries for a week each year and talk about what's going on in England or Germany or Australia or wherever. I'm from the little town of St. Joseph, Missouri, and these other people were heads of the health department for their country. This was a group that Rick Norling³⁷ had put together at Premier. I learned a lot about how these other systems work, and I tried to incorporate what worked in those areas with what we could do here, given our constraints of reimbursement. We designed Heartland Health, with all of its financing and its doctors and focusing around wellness in the community, around what our common sense told us we ought to be doing. Even though we didn't have the financial incentives, we did that.

All of that was working and the board was very supportive of it. The board was open to helping me go through this thought process. They wanted me to stay and I kind of wanted to stay, but I also had this bigger thing that I wanted to do.

I was watching all of the numbers go south in terms of health care. This is the thing that started driving me. The Commonwealth Fund did a comparison on different countries. If you look at the United States in the study, we spent twice as much as anybody else, but we were ranked dead

³⁶ Premier, Inc., is an alliance of over 3,000 hospitals and over 100,000 other providers which focuses on improving the health of communities and offers group purchasing and database services. [Premier, Inc. *We are an alliance of healthcare providers on a mission to transform healthcare.* <https://www.premierinc.com/about-premier/about-us/>]

³⁷ Richard A. Norling was president and CEO of Premier, Inc., from 1997 to 2009. He then became a senior fellow with the Institute for Healthcare Improvement. [Institute for Healthcare Improvement. (2015). *IHI senior fellows.* <http://www.ihl.org/about/Pages/IHISeniorFellows.aspx>]

last in virtually everything. When you go to these countries, these people are healthy.

Science has done a great job because we don't have too much of what kids used to get sick from and die from. These are the health issues facing our kids now – lack of early childhood education, teen pregnancy, low birth weight, obesity, violence – where is the reimbursement in that? Those are the health risks of our kids.

You can't vaccinate parents against making the wrong decisions in raising kids. We built our own model of what drives health. This is our strategy map that has driven Heartland from the beginning of our Healthier Communities discussion. The health care system spends its time thinking about these 2.5 million deaths and about 4 million babies are born. That's where we spend our time and our money. We know intuitively that it's these behaviors that cause these diseases. A lot of hospitals get into this space, but it's marketing as much as anything. When you really start to understand these things, you realize it's the human condition of stress and anger and unemployment and hopelessness and helplessness – it's the human condition that drives the behavior that drives the disease.

When you draw a model to help understand education, what you measure up here at the top is the number of kids graduating from high school, or the number of kindergarten children who come to kindergarten ready to learn, or how many people are educated, so there's the top of the pyramid. There's a behavior that causes people to be educated or not educated. At the base of that education triangle is this same human condition.

If you look at corrections, what you measure is how many people you have in prison, how many prison cells there are. Then you look at the behaviors that cause people to go to prison. The foundation of virtually everything in life is this human condition.

We're a wealthy country with 1 percent or 0.5 percent of people owning virtually all the assets. This group is growing bigger, which causes the top of the pyramid in health, education and corrections to go their own direction. That's what I worry about more than anything. I feel a tremendous sense of urgency about all of these things. I've felt this for years. It is easier to do heart surgery and celebrate the number of heart surgeons, than to go way upstream and prevent heart surgery. That's what we do in this country, we pay for heart surgery but we don't pay for the human condition.

No one is doing much about that because there's no money in it. There's no organization in it. Being a hospital CEO is the best job to have to deal with these issues because you see all of it and you've got money coming in. If you play your cards right, you can both do good and do well. You can start working on shrinking the number of heart surgeries. You can invest money in schools and start teaching kids how to lead healthy lives. If you're also connected to the business community, you can have the same program in the business community so they can go home and talk as families about what drives their health. What a great challenge when kids start saying to mom and dad, "Don't smoke!" and, "We need to go exercise!"

We have the Fourth Grade Challenge led by a cardiac surgeon who goes to every school and gets them exercising. They put a 20-pound vest on the students and have them run around the gym, take it off, have them run around the gym again. There's no money in that. Actually, it is designed to prevent you from getting more money. That's what we have to do because our moral obligation is to improve the health of the population at the most affordable cost possible. We're not doing that, are

we?

That's why the Affordable Care Act³⁸ was right on the spot until it got bastardized by the pharma industry, the insurance industry, and to some extent, the health care industry. Newt Gingrich has a saying that I love, "Real change requires real change." There are all kinds of things about this country that are wonderful, but there is nothing that says we're going to continue to exist as a country like we are. We have a lot going for us because of our democracy, our foundation, our boundaries, but when you start looking at all of society, it is not a pretty sight. It's devastating. Twenty percent or 30 percent of kids go to bed hungry every night. You cannot pretend that that doesn't exist. Because I saw it from when I started out in my career, that's what I worry about.

I said to the board, "I've been thinking about what I want to do with the rest of my career. There are so many things I want to do that I can't do while I'm president of Heartland. I'd like to work on anything dealing with Healthy Communities, changing the leadership of communities." They said, "We'd like to help you with that. What do you need?" I said, "When I retire, I'd like to have an office and a staff person and some spending money for the rest of my life to work on that." They said, "You got it," and that's why I'm here.

It's not like it was a gift. It is a good investment. You can take somebody like me – and there are many of us – provide us with an office and staff support. This is about advanced citizenship. Now that we're done with our careers, and we can live on our retirement, we don't need anybody's money, we don't need a job. We can do these kinds of things.

Some people want to read to children. We need those people to read to children. The problem is, we've got millions of people volunteering their time doing all of these things, but operating in silos. As a result, there is much work going on, but the numbers are still declining. By "the numbers," I mean educational attainment, the number of people we have in prison, and so on. Society is getting weaker and weaker. At some point, that causes anarchy.

We've seen the results recently in Ferguson, Missouri, and in Baltimore, like back in the '60s with the riots. That's a form of anarchy. It comes from a huge dissatisfied group saying, "We've got nothing. We've got no jobs." That's an example of what can happen. Pretty soon, you don't have enough police officers. That can happen.

I wanted to do something to change all of these things, how we run communities. Because I've worked so much in communities, I believe that where you solve these problems is in communities, not at the state level or the federal level. Kids get educated in communities. Jobs are created in communities. People get sick or don't get sick in communities. We've got to start at the community level, but communities are not well led. The city manager might do a good job with the city functions, or the hospital CEO might do a good job, or the school superintendent might do a good job, but those people all need to be working together to do a good job for the community.

As I was getting closer to retirement, I worked out an agreement with the board that I would spend the rest of my career here. In exchange, I would be provided some support to do this work

³⁸ The Patient Protection and Affordable Care Act (P.L. 111-148) was signed into law in 2010 by President Barack Obama. [*Public Law 111-148: Patient Protection and Affordable Care Act.* (2010). U.S. Government Publishing Office. <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html>]

when I did retire. I was planning to retire when I was 62, but when I turned 62, the board came to me and said, “Would you be willing to stay on longer?” I said, “Until when?” They said, “How about 70?” My contract then ran to age 70. When I got to be about 64, I said, “I probably shouldn’t go on much longer.” I said to Leslie, “I think I’d like to transition in the next couple years.” I called the chairman of the board and said, “I’d like to retire by the time I’m 66.”

The Affordable Care Act was coming along. I could see that something dramatic was going to come about. I thought that the new CEO would need a pretty long runway to adjust to that. We were in a pretty good spot because we had an integrated delivery system, we had an integrated IT system, with people using a common medical record. I knew we were well organized for that. My replacement started August 1, 2009. I left that office in the middle of July, 2009, and came over here to this office. My contract was officially up when I turned 67.

The title of Senior Fellow came from Rick Norling. I was finishing up as chairman of Premier, and Rick and I were going out to lunch. I told him I was going to move to the foundation, but I didn’t know what my title was going to be. He said, “Why don’t you use ‘senior fellow’? I’m going to become a senior fellow at IHI.” I said, “Okay, I’m going to be a Senior Fellow for Healthy Communities at the Heartland Foundation.” I have no duties here. I have no job, no assignment, no anything. I’m just housed here. I was at a dinner at Premier where Tom Daschle, the former senator from South Dakota, was the speaker. He was introduced as a “distinguished fellow.” I thought, “I just got my business cards that say Senior Fellow and I could have been a Distinguished Fellow!”

I was telling Sandy Potthoff,³⁹ who ran the program in Health Care Administration at Minnesota about how I could have called myself Distinguished Fellow instead of only a Senior Fellow – I’ll come back to why I mention this in a minute. Anyway, I said to Leslie, “I have no idea what I want to do entirely, but I do want to go back to the University of Minnesota and work with students. I’d like to tell them what they ought to be thinking about during their careers. I want to set up a couple of scholarships, spend some money. We’re going to have to go big. I want to spend time with the students who are selected, and I want to speak to the incoming classes. What I’m going to tell them is that they’re being trained to run hospitals, but their job is also to lead communities. That’s part of the deal.”

Not many people think like that, so I don’t have a lot of heroes in this business. Stan Nelson⁴⁰ was one of those I related to, because I liked his style. I liked his humor. I liked his humbleness, and yet he knew what he was doing. Another is Tyler Norris.⁴¹ For the most part, the people that I look to are people like Abraham Lincoln. I read a lot about leaders – Attila the Hun, George Washington, on and on and on. For the most part, I take leadership attributes of various people I know and I say, “I like that, but I don’t like that.”

³⁹ Sandra J. Potthoff, Ph.D., is an associate professor at the University of Minnesota School of Public Health. [University of Minnesota. (2015). <http://sph.umn.edu/faculty1/master-of-healthcare-administration/name/sandra-potthoff/>]

⁴⁰ Stanley R. Nelson (1926-2012) was CEO of Parkview Hospital (Fort Wayne, Ind.), Abbott Northwestern Hospital (Minneapolis) and Henry Ford Hospital (Detroit). His oral history: Weeks, L.E., (Ed.). (1987). *Stanley R. Nelson in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

⁴¹ Tyler Norris is vice president, Total Health Partnerships at Kaiser Permanente. [Tyler Norris: *Creating healthy communities*. <http://www.tylernorris.com/>]

We developed this endowment at Minnesota, and then Sandy Potthoff made me a Distinguished Fellow at the University of Minnesota. After she did that, I said, “Well, I’ll be darned. Couldn’t I be a Distinguished SENIOR Fellow?” No, I haven’t gotten to that one yet. Today, there are six Kruse scholars at Minnesota, and two years ago we started six at Augustana, which was my undergraduate program in Sioux Falls. Leslie and I go to each campus in the fall and the spring. I kept thinking about what I really wanted these students to do. I realized that I wanted it in the scholarship application that they had a sense about “community,” and that they would dedicate their lives to doing this work if they accepted this scholarship. There’s no contract signed, but if people say that they’re going to dedicate, some of them will. That’s what we did.

I said to Sandy Potthoff, “What kind of experiences do we want these students to have while they’re doing their two years in graduate school?” It happened that I was going out to the American Hospital Association meeting in San Diego in 2010 to be on a panel. I suggested that Sandy come out to that meeting and that I would call Rick Norling. I knew people like John King⁴² and Rick and others would be out there. I said, “Let’s gather a group of Minnesota alums and friends of ours. Let’s ask them what experiences students ought to have.”

John King was chairman of the Healthcare Forum when they converted their mission from being like another American College of Healthcare Executives – ACHE – to being the Health Forum, where Kathryn Johnson⁴³ was focused on a Healthy Communities initiative. Rick Norling, in his role as the lead of Premier, also had a Healthy Communities agenda, although it was around the use of clinical data. Rick and I have been friends for many years.

We all did get together. Rick said, “Come over to my house for dinner.” John King, Michael Bilton⁴⁴ from the American Hospital Association, Rick Norling, two or three other people, Sandy and myself were there. We sat around and talked about this. As the evening wore on, as I tell people, and we got more into Rick’s wine cellar, we were coming up with really big ideas. Rick said, “Baldrige is 25 years old, and it’s losing its steam. A lot of quality initiatives have come along in the country, and Baldrige is not the same vibrant, growing program. What if we brought Baldrige to the community and had our students engaged in not only thinking about healthy communities, but thinking about bringing the quality process to the way we rate communities.”

My first reaction was, “I wouldn’t even know how to do that.” When you’re doing it in a health care organization, what have you got that a community doesn’t have? You’ve got a CEO. You don’t have a CEO for the community. We were intrigued by it. I remember how far Heartland was down – in the bottom quartile. All of the people were good people and they were working hard. It was the same people 15 years later when Heartland received the Baldrige Award. They went from the bottom quartile to the top 1 percent. What changed? This process and a belief system and passion and sharing the same value system. Could you possibly do that in the community? We had no idea.

We started talking about it. Six months or a year went by. I’m on the board of the Stowers

⁴² John G. King was president/CEO of Evangelical Health System (Oak Brook, Ill.) and later of Legacy Health System (Portland, Ore.).

⁴³ Kathryn E. Johnson was CEO of the Health Forum for 25 years until her retirement in 2002. [Samueli Institute. (2015). *Kathryn E. Johnson*. <https://www.samueliinstitute.org/about-us/kathryn-johnson>]

⁴⁴ Michael Bilton was founder of the Association for Community Health Improvement (ACHI), a personal membership group of the American Hospital Association. [Verite Healthcare Consulting. (2015). <http://www.veriteconsulting.com/ourteam/michaelbilton.html>]

Institute in Kansas City. The Stowers Institute was started when Jim and Virginia Stowers⁴⁵ donated a couple billion dollars of their wealth to start a cancer research center. Jim and Virginia had started American Century Mutual Fund, and both had had experience with cancer. They decided they wanted to give their wealth to finding cures for cancer. A friend of mine, Dick Brown,⁴⁶ is chairman of Stowers Institute and chairman of American Century.

A couple of years ago, at one of our board meetings, I was talking with Dick about what I was doing, and I said, “I’ve got an office at the Foundation. I’ve got some students at the University of Minnesota. We were trying to figure out what their experience should be, and Norling said, ‘Let’s see if we can bring Baldrige to communities,’ and we have no idea how to start.” Dick Brown said, “Do you know Joyce Allegrucci?” He told me that Joyce was Kathleen Sebelius’ friend and confidante. She was her chief of staff and ran Kathleen Sebelius’ campaign for Governor of Kansas. He said, “I want you to meet Joyce.”

Joyce came over to the Stowers Institute and we spoke. She said, “I think Kathleen would really like to hear about this.” Kathleen came to Kansas City, and I talked to her in the same way I’ve been describing it to you. This is what our fear is. Here are the charts and graphs, it’s all laid out. She said, “I agree with you.” I said, “The Affordable Care Act is going to be able to do some of this, but it’s got its own set of issues. We do need to figure out a way to improve the way we lead communities, to improve educational attainment, because all of that’s connected.” At that point, we were thinking about doing it just in Rochester, Minnesota. We knew we had to pilot this someplace. In Rochester, the Mayo Clinic uses Baldrige as its management model and trains all executives on Baldrige. There are probably three or four Baldrige recipients in Rochester, and maybe 20 or 25 state quality winners.

We said, “Rochester is close enough to the University of Minnesota so that we could start figuring out how to pilot and develop criteria for communities.” Kathleen said, “Could you do it in more states?” My reaction was that we could do it more states – we didn’t know how to do it in one state, but we could “not know” how to do it in other states, too.

That got us to thinking about developing a group of pilot communities in different states. Rochester had already signed up. Joyce Allegrucci got engaged with us, supporting Kathleen’s desire to spread this idea. We formed a not-for-profit organization called “Communities of Excellence 2026.” That’s the language of Baldrige now, it’s “Baldrige Performance Excellence.”

We wanted to test this in various settings, and we thought the settings should be a small rural community, a large rural community (as in multi-counties) – that’s what Tom Vilsack⁴⁷ and the Rural

⁴⁵James E. Stowers, Jr., (1924-2014), and his wife Virginia G. Stowers, have been called among the “world’s biggest givers” because of a donation of \$2 billion, or about 95 percent of their personal fortune, to found the Stowers Institute for Medical Research in Kansas City, Mo. [Harris, E.A. (2014, Mar. 19). James E. Stowers, Jr., benefactor of medical research, dies at 90. *The New York Times*.

http://www.nytimes.com/2014/03/19/business/james-e-stowers-jr-benefactor-of-medical-research-dies-at-90.html?_r=0; and, The Stowers Institute. (2015). *James E. Stowers, Jr.* <http://www.stowers.org/James-E-Stowers>]

⁴⁶Richard Brown worked closely with the late James E. Stowers in leadership at American Century Investments and at the Stowers Institute for Medical Research, where he was named co-chairman in 2004. [Stowers hands over control of American Century. (2010, Feb. 19). *Kansas City Business Journal*. <http://www.bizjournals.com/kansascity/stories/2010/02/15/daily42.html?s=print>]

⁴⁷Thomas J. Vilsack served two terms as the governor of Iowa (1999 to 2007) before being named by President Barack Obama in 2009 as the 30th U.S. Secretary of Agriculture. [U.S. Department of Agriculture. (2015). *Secretary of Agriculture: Tom Vilsack*. <http://www.usda.gov/documents/vilsack-bio-072415.pdf>]

Policy Institute believe is the future of rural America: regional thinking. We wanted to do it in a small urban community (Rochester), and in a large urban community like St. Paul or Kansas City or Minneapolis. We need about \$6 million over three years to build this framework, but we have not been able to raise the money.

We're regrouping to figure out how we can get our pilots going. In the last week or so, we've signed up San Diego County as our first urban pilot. We've hired Rick's daughter, Stephanie Norling, to be our managing director. The 18 counties of northwest Missouri, where we've been doing all of this work, will be the large rural region. We've got Rochester still on the hook to be the small urban, and we've got a couple smaller rural communities, one in Iowa and one in Minnesota, that have expressed interest. The difference now is that each of the communities has to help us raise the money to do the project. That's where we're at right now.

I said to the group about a year or so ago when we were forming this thing, "Why don't we call this 'Communities of Excellence 2026'?" The reason I suggested that is because our country is going to be 250 years old July 4th of 2026, and we are starting to sputter a little bit – all the numbers. Wealth is all going to one very small group of people. We've got to change that. If we want to improve the health of America, we've got to improve educational attainment and jobs. In order to do that, we have to improve the way communities operate.

Why don't we target the beginning of the next 250 years as the next iteration of how we're going to run our country? The success of our country is going to be predicated on the success of our communities. Our communities are predicated on the success of individuals. We focus a lot of time trying to educate our kids so that they can be successful – so that our communities can be successful. That's our argument.

The idea of creating a book of criteria that can help communities use the best performance excellence standards keeps picking up steam. By the way, Baldrige is used in over 90 countries in terms of managing their industries.

Where did this all come from? This came from a lifetime of being in the ideal position in the ideal industry to watch everything going on inside of a community and in the organization that I ran. It will take us the next decade to get this up to the point where it works and get it to start to spread around the country. My stake in the ground is July 4, 2026. I'll be 82 years old. My commitment is to work with students. In ten years, there will be 60 or 75 Kruse scholars – they're going to be living in communities all over the United States, and we're going to be keeping in touch with them. If the National Baldrige Association is doing something about it, and if the National Association of City Governments understands this, and if we're presenting community performance excellence standards at conferences throughout the United States – who knows? That's what it's about.

GARBER: That's wonderful to hear how all the strands of your career have come together to give you something that you're so obviously passionate about in your retirement.

KRUSE: Sandy Potthoff calls it my encore career.

GARBER: How has your wife contributed to your career success?

KRUSE: I use Leslie as an example, particularly in my higher education work, of a person who did poorly in school. There was a whole series of things that led to her not performing well in

school. Leslie taught me that there was a time in her life – she was 32 years old when our third child went to kindergarten – when it came to her that she should pursue her education. It taught me that we can never give up on educating people. It isn't always a four-year university. It's important to have community colleges do what they do. We want to make them strong. I've sat on the coordinating board for higher education; I'm a strong advocate. I've chaired Success by Six in our community for a dozen years. I've learned a lot about early childhood and early brain development, and we've invested a lot of our own money in early childhood. We've also invested in this Foundation that we have available to support the Healthy Communities agenda.

I've watched Leslie in her own development. Hers is a remarkable story, and I use that story. She's fine with it, because it's not an embarrassing story at all. Keep in mind, she was 18 and I was 20 when we got married. The day we got married, her parents moved to California. She got pregnant about two months after we were married and she was far away from her relatives. Imagine what she has to go through while I was off full-time going to graduate school.

Then I started my career and I spent a lot of time at that because I needed to know how to do my job. When I got involved in Jaycees, I was doing 40 hours a week on Jaycees and 40 hours on my job. Leslie got engaged with me in the Jaycees as I advanced in leadership positions. As she traveled and did things with me, she gained confidence in herself. We were both unsure of ourselves – but I had no choice. Fear of failure is a big driver for me. As I was learning, she was learning.

She was very supportive as a spouse, in terms of the work that I was doing. I am not the guy to talk to about work-life balance. I spent way too much time working and doing community leadership activities. The only offsetting thing was that on Sundays, it was always family time. If we were going to travel, it was a family event, except for the Jaycee activities.

Leslie understood that we had to balance forming my career and raising our young family. It wasn't always easy, but she got it. I'm a lot more serious and intense about everything. She's a little less so, and so she brings out the enjoyment factor in the two of us. She is a very good person, very skilled. She's an artist, a quilter, a decorator – she does all that well. She does a lot of great things for her friends.

All of a sudden, we found that we had been married 50 years and my career of 45 years in the health care business was over and now we're on to this next period of life. Maybe Leslie expected that I was going to be home more. I'm just doing a different thing in a different location. She's continuing on with her life. We do go to Sarasota for three and a half months a year, spend a little more time there together.

I think there was value, as hard as it was, for two young, immature, naïve people to get married, get educated and raise their kids together, and have both be able to hang in there through all of that. Leslie enjoys going and talking to the students, and the students love talking to her about what it's like to be married to some guy like that. A lot of the married students now are both professionals. They like hearing the stories about our early years.

Leslie has put up with it all these years. While I wasn't quite as comfortable about doing the social thing, she was good at making people feel at ease. That was an important part of what I had to do. She loved being a speech therapist and liked working with older people. After she got her Master's Degree in Speech Pathology, and we moved to St. Joe, the only facility in town where they were doing

this with older people was at Heartland. I made the decision that we could not employ her because of the family connection. They were begging her to come to work for them. I said, “Leslie, it’s the right thing to do, except it’s not, because people will talk about you working for me.”

She ended up being a parent educator. She’s substituted in the schools – doing speech therapy with the kids – she wanted to work with seniors, but it never quite worked out. She gave up that career. I’ve asked her if she ever wants to go back, but we’re both at a point where we like what we’re doing.

It’s been fascinating. I can’t imagine if this would have happened if our banker hadn’t stopped by the farm, or if Emma Johnson hadn’t said, “Why don’t you go to Augustana College?” or if I hadn’t run into Lyle Schroeder. Anybody who believes that they do this on their own is nuts. I see people who are given many opportunities to succeed and don’t take them. You’ve got to be alert to opportunities, and then you’ve got to prepare yourself. It’s like Arnold Palmer – when he chipped out of the sand trap into the cup and someone said, “Lucky shot.” He said, “The more I practice, the luckier I get.” The same thing is true about what we do. The more attentive you are, the better your peripheral vision, the more friends you’ve got, the more people you help, the more people help you.

It’s not much different from farming in terms of understanding the cycle of life and when you’ve got to plant, when you’ve got to harvest, how you’ve got to prepare to do it over again, what you have control of and when to help your neighbors. It’s pretty basic. That’s the way I think about everything, to be honest with you. It’s about as simple as that.

GARBER: That’s an excellent place to end. Is there anything else you wish to add?

KRUSE: Not that I can think of.

GARBER: Thank you very much for your time this afternoon.

KRUSE: My pleasure.

CHRONOLOGY

1944	Born February 9 in Lake City, Iowa
1964	Married August 22 to Leslie Marsden
1965	Augustana College, Sioux Falls, South Dakota Bachelor of Science, Business Administration and Psychology
1967	University of Minnesota, Minneapolis Master of Hospital Administration
1966-1977	St. Barnabas Hospital / Metropolitan Medical Center, Minneapolis (St. Barnabas Hospital merged with Swedish Hospital to become Metropolitan Medical Center) 1966-1967 Administrative resident 1967-1968 Administrative assistant

	1968-1970	Assistant administrator
	1970-1972	Associate administrator
	1972-1974	Director, Community/Consumer Affairs
	1974-1977	Vice President, Community Operations
1977-1979	Park Ridge Hospital and Nursing Home Rochester, New York President & CEO	
1979-1984	Upstate Health System, Inc. Rochester, New York President & CEO	
1984-2009	Heartland Health, St. Joseph, Missouri President & CEO	
2009-present	Healthy Communities, Heartland Foundation Senior Fellow	

MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives
Life fellow

American Hospital Association
Member

BlueCross of Rochester, N.Y.
Member, board

Chamber of Commerce
Chair, board
Member, board

Communities of Excellence 2026
Chair, board of directors

Community Foundation of Northwest Missouri
Chair, board of directors

Excellence in Missouri Foundation
Chair, board of directors

Heartland Foundation
Life trustee

Minneapolis Jaycees
President

Minnesota Hospital Association
Member

Minnesota State Jaycees
Member

Missouri Hospital Association
Member

Missouri State Coordinating Board for Higher Education
Chair, board of directors

Missouri State Family and Community Trust
Chair, board of directors

Missouri State Jaycees
Member

National Jaycees
Member
Vice President

Stowers Resource Management, Inc.
Member, board of directors

United Way
Member

AWARDS AND HONORS

1999 Visionary Leadership Award, Missouri Hospital Association

2001 Distinguished Service Award, Missouri Hospital Association

2002 Fellowship, Creating Healthier Communities, American Hospital Association/Health Forum

2003 Justin Ford Kimball Innovators Award, American Hospital Association

2009 Foster G. McGaw Prize for Excellence in Community Service, American Hospital Association (received by Heartland Health)

2009 Malcolm Baldrige National Quality Award (received by Heartland Health)

2010 Doctor of Pedagogy, hon. caus. from Northwest Missouri State University, Maryville, Mo.

2010 Distinguished Fellow, University of Minnesota, School of Public Health

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