



GEORGE F. LYNN
In First Person: An Oral History

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

2014

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

GEORGE F. LYNN

In First Person: An Oral History

**Interviewed by Kim M. Garber
On April 24, 2014**

Edited by Kim M. Garber

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

2014

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

Transcription by Chris D'Amico
Photo courtesy of Kim M. Garber

EDITED TRANSCRIPT
Interviewed in Haddonfield, New Jersey

KIM GARBER: Today is Thursday, April 24, 2014. My name is Kim Garber, and I will be interviewing George Lynn, president emeritus of AtlantiCare, an integrated delivery system serving Atlantic City, N.J. Mr. Lynn has been active in volunteer service in various professional associations, including serving as chairman of the New Jersey Hospital Association and chairman of the American Hospital Association. George, it's great to have this opportunity to speak with you this morning.

GEORGE F. LYNN: Good to be able to speak with you as well.

GARBER: You were born in 1945 in Buffalo, N.Y. Could you tell a bit about your parents and the values that you learned from them?

LYNN: I'm the second of five children of George and Ruth. My mother was a homemaker. My dad worked in the shipbuilding industry, so we lived near the Great Lakes for most of my early childhood, moving to New Jersey when my father became vice president of ship sales with the New York Shipbuilding Corporation in Camden NJ. Selling ships was an unusual way to make a living!

When I was a kid, I had the opportunity to work for my dad in the press room at ship launchings. These were big events covered by the press. I brought people coffee and sandwiches and had a chance to meet reporters. Because the shipyard had some government contracts, one time I got to meet Mamie Eisenhower.

We grew up as a close family. My father's side of the family came through the Depression having to work hard for everything. Our family didn't have a lot of money, but we did fine. Something occurred to me later in life that I had never noticed growing up, and that was that my parents never owned a home until we were pretty much grown up. They owned the last home we lived in together, but up until then they rented. We learned from my dad that you can't take anything for granted, that you're going to have to work for everything that you get. He worked very hard.

Tragically, my dad died when he was 52 years old. He never got the chance to see his grandchildren. After he died, my mother still had the three youngest children to raise. That was a struggle and a challenge for her and for all of us.

GARBER: Were there others who were influential during your childhood years?

LYNN: Our pastor when I was growing up was a man named Bernard Hewitt.¹ He was a gentle giant of a man, very kind. He had a lot of influence on me, to the extent that I went into the seminary. He was my mentor. I was a young kid, and he took time out of his busy life to mentor me and to guide me and to help me. He was really quite a guy.

¹ Bernard Patrick Hewitt (1923-2009) served for over 60 years as a priest. [Msgr. Bernard Hewitt, retired pastor dies. (2009, November 12). *Catholic Star Herald*. Retrieved from <http://catholicstarherald.org/msggr-bernard-hewitt-retired-pastor-dies/>]

My going into the seminary confused my family. They were spiritual to a point, but they didn't go to Mass every Sunday. I stayed for two and a half years before recognizing that my calling lay more in being married and having a family. It was a formative period in my life, and I learned quite a bit.

GARBER: Where did you go to high school?

LYNN: I spent two years at Holy Cross, a Catholic high school in Riverside, N.J., and then two years in what was then called "minor seminary" in Blackwood, N.J., which was about 30 minutes from home. Minor seminary was high school, major seminary was college. I transitioned from the last two years of seminary to St. Charles in Catonsville, which was a college that was run by the Sulpician monks.²

At minor seminary, we were involved in everything, whether we were good at something or not. You ran track, you played sports, you acted in the play. If you couldn't act, you sold tickets or cleaned the theater or made props. This was my first exposure to living in a community where everyone worked together to accomplish a shared goal. That was great preparation for me later on in facing the complexity of health care delivery. I recognized that I couldn't solve these problems on the basis of my own experience. I needed to engage a lot of other people in order to be able to accomplish what patients and communities needed.

GARBER: Is the system of minor seminary/major seminary still in existence?

LYNN: Minors are gone. Nobody goes into high school seminary.

GARBER: You mentioned that when you were in minor seminary that everybody had a shot at doing all sorts of different things. What did you find that you were good at?

LYNN: I was a good at a lot of things, but not great at anything. I played basketball. We played against some very good teams, and we lost a lot of basketball games. I was the sixth man on the team. Drama was a major part of the activities of all of the students in the school. The Passion Play during Lent was a really big production. This ran for all of Lent on Fridays, Saturdays and Sundays, with a Wednesday matinee thrown in. People would bus in from all over the northeast to see this Passion Play. It was a different kind of place. It was a different kind of community. The priests who were our teachers were the Salvatorian order. They were a marvelous group of people. It was a great experience for me.

GARBER: You matriculated at Fordham University.

LYNN: Yes. Fordham is the Jesuit University of New York City. When I left the seminary, I worked for a year to raise money for college. My folks helped as much as they could, but they didn't have the money to send me to college. I knew I was going to have to work. During the summer, I'd have to make enough money to pay the tuition, and then during the school year, I'd

² St. Charles College, Catonsville, Md., founded in 1830, was the first Catholic minor seminary in the United States. [Maryland Historical Trust. Property name: St. Charles College Historic District. In *National Register Listings in Maryland*. Retrieved from <http://www.mht.maryland.gov/nr/NRDetail.aspx?HDID=768&COUNTY=Baltimore%20County&FROM=NRCountryList.aspx?COUNTY=Baltimore%20County>]

have to have a job to pay the bills.

I wanted to go to school in a city, either Philadelphia, New York or Washington. I decided on Fordham because New York seemed to be a great place to go to school. You can do more for free in New York than you can anywhere else in the world with a pocketful of money. It was great for me to be able to be part of the bigger community, that New York community, and all the arts and everything else that's available.

I attended Rose Hill, which was the main campus. It was just about then, 1964, that Fordham was beginning to develop its Lincoln Center campus, which is now huge. I grew close to a number of Jesuit teachers there. People would give the Jesuits tickets to events, and they would share them with students. Tickets would become available for Yankees opening day, and one would find its way into my pocket. I had one suit and one decent pair of shoes and one tie, and I had a ticket to the opening of the opera. I had never been to an opera before. When I went to the opera, I had fifth row on the aisle, sitting with the upper east side society folks from New York – totally out of place. It was a great place to go to college.

GARBER: It sounds like you adjusted well.

LYNN: Yes. I lived off-campus, and I wasn't really part of the traditional college experience because I had to work. I was a bartender. I had to work every night, and that made my schedule different than most of the other undergraduates.

GARBER: A bartender! How could you serve if you were underage?

LYNN: The drinking age in New York in those good old days was eighteen. Interestingly enough, there is a movement afoot now to change the drinking age back to eighteen, with the thought that it might eliminate or minimize some of the binge drinking that's happening on campuses, which is getting to be quite a problem.

GARBER: Did you pledge a fraternity?

LYNN: No, there were no fraternities at that time at Fordham. I probably wouldn't have anyway because there wasn't enough time to do all that.

GARBER: Is that true of other Catholic universities that they tend not to have fraternities?

LYNN: It was true at that time. I don't know whether it's true today or not.

GARBER: You were going to class. You were working. Did you have any time to become involved in political activism of any nature?

LYNN: Very little time. Of course, the Vietnam war was going on, and we were all interested. It's the old story – you recognize that this is going to be an issue that you're going to have to face in your life, and it's just a question of time. We were very concerned about that. Civil rights was making headlines. The Ivies tended to be more active. My wife went to Penn, and Penn was very active. Fordham was not. Columbia was. NYU tended to be more active.

I looked at what was happening, and I understood it, but I didn't have the time to commit to

that and felt that it probably didn't make any difference. What was going to happen was going to happen. I had a life-altering brush with serving in Vietnam. During the four years that I was at Fordham, I was in the Air Force ROTC program. When I got to my senior year, so many other people had done exactly what I had done that the Air Force had more ROTC officer candidates than they could process. They said, "Thanks for your four years, but we don't have any room for you."

My next move was to enlist in Officer's Candidate School with the Marine Corps, and I was accepted. Pat and I were married in June of 1968. I had signed a contract to teach English at Fordham Prep in the Bronx, but we found out that Pat was pregnant, and we said, "Well, that's not going to work. We don't want to raise a baby in the Bronx." I gave up the contract, came back to New Jersey and got a job. Although I was supposed to report to Quantico for the Marine Corps on August 1, I got a letter saying that they, too, had too many officer candidates. You can imagine what happened next. I had a draft number in the teens, and it wasn't long before I received my draft notice.

We were looking forward with joy to the arrival of our first child. We had new jobs back home with family. Then this happened. There was a foreboding that came with that draft notice and about going to Vietnam on active duty as a private. I was prepared to report for duty to Fort Dix in October, and then was to be assigned to Fort Benning, Ga., for basic training.

My father passed away suddenly in September at the age of 52. At his funeral, a close friend of his, a lawyer who had been in politics with him locally, said to me, "This is a very sad day, but do you understand what this means for you?" I said, "No, I don't know what you're talking about." He said, "There is a part of the draft law that says that an eldest son who is the sole support of his family is exempt from service." I remember saying, "How can that be?" He said, "If you like, I'll prepare the paperwork for you." In a very real sense, my father's death was responsible for me not having to serve in Vietnam. I have thought about that often over the years. What an important time it was for Pat and I and my family. Who knows whether I would have come back or not?

GARBER: What employment did you find?

LYNN: The job market in 1968 was like the job market in 2014 for college graduates. There was not a lot out there. I had majored in English as an undergraduate and wanted to teach high school English, but there were no jobs. I took a couple of sales positions. In my first job, I earned \$3,100 a year!

I ended up working for the John F. Rich Company in Philadelphia, a fundraising consulting and public relations company that managed capital campaigns for hospitals. I liked the two principals of the company. John Rich was a Quaker and a very intelligent and modest man. He was a very small man - I don't think he was five feet tall. But he was substantial in so many other ways that he truly was a giant. Roger Wilson was the president of the company. They both liked me and offered me a position as a trainee.

They teamed me up with a senior consultant, and they sent me into the field to do feasibility studies and to help manage capital fund raising campaigns. I ended up doing some work in southern New Jersey, which was home. Then West Jersey Health System, a four-hospital system in south Jersey, announced that it was going to build a new hospital from the ground up and wanted to have

a \$5 million campaign to support that work. I was assigned to do the feasibility study and then to serve as the assistant campaign director. My boss said, “You’re just a little young to be a campaign director yet. You need some more experience.”

The CEO of West Jersey was a man named Barry Brown,³ who turned out to be a great mentor and friend. He didn’t like the campaign director that they assigned. About two or three months into the campaign, he called the Rich Company and said, “Look, we’re just not getting along, and we’d like to have George be the campaign director. Everybody likes him, and he knows us. He did the feasibility study.” I got a field promotion, stayed there and worked on that campaign for two years.

What happens in a campaign like that is that you meet everyone. You meet the medical staff. You meet the board. You meet all the business leaders in the community. As a friend of mine used to say, by the time your two years on the campaign are over, if they don’t offer you a job, it means you did a lousy job. They did offer me a job, and it was an opportunity to work close to where we lived.

In 1973, I went to work for them and then progressed through a number of different positions. The pivotal moment was in 1977. Our new hospital had opened and was well accepted by physicians, patients and the community. The administrator, who was a good friend, died suddenly. Somebody had to run the place, while the hospital conducted a search for a new administrator. Barry Brown asked me if I was up to the job. I had studied English literature in college and had never taken a business course. This was a big 300-bed hospital, the flagship of the system. I went in as a placeholder while they conducted the search. For reasons that I can’t recall, the search was complicated, and it went on and on and on. It lasted over a year.

In the meantime, I learned some things about running hospitals. Pat was a nursing instructor, so we always had nursing students here at the house, and they were always talking about Dr. This, Dr. That, and what they saw on the floor. Instinctively, I knew to listen to the nurses. If there was a question, go find out what they thought about it. I had a very open relationship with the staff. They knew I didn’t know what I was doing. I was learning on the fly, and they were kind enough to help me along.

At the end of the search, I said to Barry, “You know, I’m getting pretty good at this.” He said, “I think you are, too, but you can’t have the job. You don’t have the credentials, and this is a very credential-oriented world. If I were to give you that job, I would own you for the rest of your career. You’d never be able to go anywhere. You might have the experience, but you wouldn’t have the degrees, and nobody would touch you. That’s not fair.”

He added, “I’ll tell you what, though. If you’d like to go back and get an MHA or an MBA, I’ll give you your choice of hospitals after you graduate, and we’ll pick up the ticket.” I said, “Can I go anywhere I want?” He said, “You can go anywhere you can get into.” I applied to the Executive MBA program at Wharton and was part of their eighth class.

It was probably the most difficult thing I’ve ever done in my life because I was working full-

³ Barry D. Brown ran the West Jersey Health System for 23 years before retiring in 1995. [Egan, C. (1995, November 3). A newly retired health administrator recalls West Jersey’s growing pains. *Philadelphia Inquirer*. Retrieved from http://articles.philly.com/1995-11-03/news/25681187_1_camden-berlin-division-voorhees]

time, and Wharton doesn't water down their MBA because the students are working full-time. Pat was going to get her Masters in nursing at the same time. We'd come home, have dinner and then we would do our homework with our kids, Maureen and Brian. When report card time came, we all matched report cards with each other.

Going back to school was a great opportunity, and it made me a believer in continuing education. When I moved to AtlantiCare in 1986, one of the first things I asked was, "How many of our staff do we have in graduate programs?" We had no one pursuing a graduate degree. I said, "That ends today. We have to help our people move up. If we do, that'll pay dividends back to the organization that you can't even begin to calculate."

GARBER: I'd like to talk more about your mentor, Barry Brown. Could you tell me about his leadership style?

LYNN: Barry's dad was an orthopedic surgeon and president of the medical staff at West Jersey, and Barry had been born in the hospital. West Jersey was in his blood. He was a graduate of Cornell's hospital management program, and knew the business well.

He had great imagination. He was a visionary. He saw multi-hospital systems before anybody else did, in this part of the country anyway. He had a very open style. If he felt you could do something, he was your biggest supporter. If you failed, he'd pick you up and brush you off, and give you a second chance.

He gave me some of the best advice I ever got as an administrator. We were going through my year-end evaluation, and he said, "You're doing a pretty good job. People seem to like you, and you're managing the budget and your people well. But, you spend an awful lot of time in meetings. That's not where you want to be. You want to be out on the floor. I'll tell you why. If, instead of staying in your office and your conference room, you take time every day to go out to the floor and walk around and say, 'How are things going? Anything I can do?' people will never forget you. And if you don't make rounds and just work out of your office, they will never forget you either."

After that, I required that all the administrators I worked with had to get out of their offices. They had to get up on the floors. They had to know the people. I'm proud to say that the gang that I worked with at AtlantiCare not only knew the people, they knew their spouses, they knew their kids. They knew who was graduating, who was having a bar mitzvah. They were close. That's how we were successful in engaging our workforce in pursuing the Malcolm Baldrige⁴ because we could engage lots of people in one effort. That's the key to transformation.

GARBER: Could you tell us a bit about West Jersey Hospital and how it developed from a single hospital in Camden, N.J., to a system?

LYNN: The hospital was founded in Camden in the late 1800s. In the mid-sixties the hospital purchased a physician-owned hospital in Berlin, N.J., which was renamed the Southern Division. The Southern Division later became the Berlin Division. In 1971, Barry Brown saw that

⁴ The Malcolm Baldrige 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 education and health care organizations (1999) and to not-for-profit and governmental organizations (2005). [Baldrige Performance Excellence Program. (2010). *History*. Retrieved from: <http://www.nist.gov/baldrige/about/history.cfm>]

the flight to the suburbs was really serious and that there was no hospital in the middle of the Voorhees-Cherry Hill area. He purchased a 35-acre cornfield, where he built the Eastern Division.

I can remember doing the feasibility study and interviews for the capital campaign. The people said, “There are no people out there, just farms. Why would you put a hospital in the middle of a cornfield?” Barry could see that by the time the hospital was built, there were going to be plenty of homes out there and plenty of people. That’s where everybody was heading. He was way ahead of his time in that way.

The fourth hospital in the system was an acquisition from Humana, which was at that time more involved in hospital management than in insurance. In a complex transaction, we were able to buy two hospitals from them and sell one back to another not-for-profit. Garden State Community Hospital became the Marlton Division. It’s still there.

Subsequently, West Jersey became Virtua. A lot of old time community hospital names have gone by the wayside and have been replaced by new names, which may or may not resonate with people. Virtua recently opened a new hospital in Voorhees and acquired a hospital in Mount Holly. They now have four acute hospitals, and the original Camden Division is now an ambulatory care facility. It’s quite a large and successful health system, one of the largest in the state.

GARBER: The initial impetus was Barry Brown’s vision that there were new suburban areas developing and that there was a need to position bricks-and-mortar resources out there.

LYNN: Right.

GARBER: You said that Camden is ambulatory only now, but it was the flagship once?

LYNN: Yes. Camden in the early ‘70s was beginning to change in ways that were not good. The crime rate was up, the poverty rate was up, but the economy was still solid. Camden was still the home office of Campbell Soup and RCA. The banks all had their headquarters in Camden. You had to be perceptive to pick up the rhythm and the flow of change, and that’s what made Barry special. He could see how the population was beginning to shift to the suburbs. He was going to be ready with a new hospital when the shift took place.

When we finished building the eastern division we found that we had the hospital that everybody wanted to go to, the largest community hospital in the region. We staked our flag around maternal and newborn services. Today, that hospital does 10,000 births a year.

When I came back out of graduate school, I became the chief operating officer for West Jersey and had operational control over all the clinical delivery sites. I was Barry’s number two guy. That was quite a challenge to be able to operate all of those different clinical areas – I was spinning a lot of plates at that time. It was challenging time for us. When I took the position, we had financial difficulties. Our coffee shop made more money than the hospital in the year that I took over. That had to change!

GARBER: Maybe they served really good coffee.

LYNN: They did.

GARBER: Other than the financial challenges – and maybe you’d like to say more about that – was it also challenging to develop a common culture among the different hospitals?

LYNN: Yes. Our solution to our financial problems was to recruit more physicians to join our medical staff from other medical centers in the region. That got our admissions numbers up in the hospitals where we didn’t have a huge charity care burden. Camden was a very large charity care challenge for us.

We were able to turn our fortunes around. That’s when I first became involved in the quality movement, which is something that I’ve spent all of my adult life working on. Part of my training when I went to Wharton was learning Japanese management styles, where quality circles and Edwards Deming⁵ and Dr. Juran⁶ and some of the early pioneers in quality improvement had made their mark. They weren’t very popular in America, but their ideas were hugely popular in Japan. I had the opportunity to go to Japan and study some of those. When I came back, I tried to instill them into the operating culture of West Jersey’s hospitals. It was pretty difficult.

What we needed to do then, and we still need to do today, is to manage the relationship between access, cost and quality. Quality at that time was more or less anecdotal. Access, we thought, was good because we had the four hospitals, and you could go to any one of them and receive care. We were a little ahead of the curve in that regard. Today that wouldn’t be enough. With cost, we always said that we were doing the best that we could. Cost was always about third-party reimbursement, so you were constantly fighting for more reimbursement. That was industry-wide. Those were really the three things that drove our business.

The area that we thought we might be able to make the greatest impact would be in clinical improvement, putting measures to outcomes and holding people accountable for processes and systems and teamwork and things like that. This was a little bit ahead of its time back in the late ‘70s, early ‘80s.

GARBER: A number of questions came to mind as you were discussing those points, and I’d like to start with recruitment of physicians. What techniques did you use? How did the other hospitals in the area react to your talking with their physicians?

LYNN: They were very upset! We had a brand-new facility with a staff that was happy to be there and very accommodating. It was ten times better than anything else that was around here. All the other hospitals were old. This was brand new. It was right out where everybody was moving. We had vibrant OB and pediatrics. We would have open houses and we would invite physicians to come take a tour. They’d meet our people and we would say, “Listen, would you be interested in having privileges here? You don’t have to move your whole practice. Just come, do some cases.” We knew if we could get them to do some cases with some patients that they’d like what they saw, and they did.

⁵ W. Edwards Deming, Ph.D. (1900-1993) was a consultant, thought leader, teacher and prolific author on topics related to statistical approaches to quality control. [The W. Edwards Deming Institute. (2014). Retrieved from <https://www.deming.org/>]

⁶ Joseph M. Juran (1904-2008) was a pioneer in the field of quality management whose work led to the development of Six Sigma and lean manufacturing methodologies. [Joseph Juran, 103, pioneer in quality control, dies. (2008, March 3). *The New York Times*. Retrieved from http://www.nytimes.com/2008/03/03/business/03juran.html?_r=0]

The simplest way to explain this is: if you have a waiting list for your hospital, I don't care how good or how bad an administrator you are, you're going to be okay on the financial side because you become efficient almost automatically. If you've got a patient that needs to get into that bed, that means the patient in that bed is going to get the attention they need in order to be discharged. We needed to have a good solid waiting list of patients that were ready to be admitted. Our fortunes turned at the expense of some of our competitors, but that's the way it was. That's the way it is.

GARBER: You mentioned having learned the Japanese techniques when you were at Wharton, and then you came back and tried to instill some of those techniques. How did you actually do that?

LYNN: The first thing we did was work with the senior leadership team. We made sure that they understood what it was, and that they could embrace it. We also made sure that they could not only learn it, but they could teach it and practice it. That was the deal. They couldn't help anybody else do a better job if they couldn't learn how to do it themselves and then teach it to others, and then practice it, becoming a role model.

Some took to it. Some didn't. Some felt it was a little faddish, and because it involved distributed authority, some senior leaders didn't like it because they liked to be the boss and say, "It's my way, and that's the way we're going to do it." There was a creative tension with it that was healthy. But we made progress and we engaged the workforce for the first time in redesigning the work and making it more efficient and more effective for patients. That's at the root of improvement.

GARBER: Would you say that you were the champion on this initiative?

LYNN: I was the champion. My primary role was to grow more champions.

GARBER: Did you have anyone else at the time who was particularly helpful to you?

LYNN: Barry was very helpful because he let me do it, and he kept the people who were naysayers off my back. Instinctively, he felt it wasn't for him. It wasn't his style, but he felt that outcomes that it promised to accomplish were worth pursuing, and even though it wasn't his idea, it didn't matter. He was great in that way, in that every new thing didn't have to come from his brain. That's why he was such an effective leader.

GARBER: If you were to assign a letter grade to this implementation effort, what would you give it?

LYNN: I think I probably would have given it a B. The thing I regret the most is that after I left, it disappeared.

GARBER: You mentioned the financial challenges of running a hospital. This might be a good time to talk about rate review in New Jersey. Could you tell us a bit about how the system worked? Rate review is not in effect any more here.

LYNN: No, it is not.

GARBER: But rate review was in effect during most of the time you were in leadership. How did rate review work?

LYNN: Rate review started as a peer review system. The Rate Setting Commission would pick CEOs of hospitals to sit on a panel and review the rates of other hospitals. Today, if you advanced that idea as a way of coming up with a more efficient system, you'd get laughed right out of the room. Even then, people complained. Even the hospitals complained about it. It reminds me of the old joke, "How do you know when you've encountered a planeload of hospital administrators?" The answer is, "When they turn off the engines, you can still hear the whining."

That's what happened. We whined about every system, even the ones where the fox was watching the chickens, we complained about that. Then it became a more structured system where you would go before a rate setting commission composed of regulators and consumers. New Jersey was at that time one of the most regulated states in the country. You'd make your cases for higher rates. It was like a public utility kind of model.

From there it went to the DRG system.⁷ We've had a long history of having rate regulation at the base of our reimbursement. As a result, financial success became more a question of managing payer mix and case mix in hospitals than of getting higher rates. If your payer mix had high levels of commercial insurance and less of Medicaid and charity care, chances were that if you were running an efficient operation, you were going to do fine. Financial success was also an accident of geography. Inner city community hospitals struggled and their suburban neighbors did better. That's changing now. We'll see how that all plays out with the Affordable Care Act.⁸

GARBER: Initially it was a peer review system. Was that before your time in administration or were you involved in that process?

LYNN: I observed it. I was in administration, but I didn't have anything to do with that.

GARBER: How did the process work?

LYNN: It was administered by the New Jersey Department of Health and Human Services. Hospital administrators would sit on a panel and review other hospitals that weren't in their market. By the time the year was up, the rates of all the hospitals had been reviewed by a panel of their peers. They submitted a set of standard financial information to the reviewers, and I can't recall exactly what that was, but it resulted in your rates for the year.

GARBER: What happened if the panel didn't like your proposed rates?

⁷ Diagnosis-related groups (DRGs) are the building blocks of a classification system that groups together patients with similar illnesses or types of surgical procedures. Implementation of a DRG-based reimbursement system in New Jersey served as a model for nationwide adoption of DRGs as part of the prospective payment system which went into effect in the mid '80s. [Bushnell, B.D. (2013). The evolution of DRGs. *AAOS Now*. Retrieved from http://www6.aaos.org/news/PDFopen/PDFopen.cfm?page_url=http://www.aaos.org/news/aaosnow/dec13/advocacy2.asp]

⁸ The Patient Protection and Affordable Care Act (P. L. 111-148), later known as the ACA or Obamacare, was signed by President Barack Obama in 2010. [U.S. Government Printing Office. (2010). *The Patient Protection and Affordable Care Act*. Retrieved from <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>]

LYNN: They would adjust them—hence the whining.

GARBER: Was it a similar sort of exercise as New Jersey changed to the rate setting commission model, except now it was government officials on the panel?

LYNN: It was government officials, yes. It was much more rigorous.

GARBER: State staffers were doing the legwork.

LYNN: State staffers and consumers on the rate setting commission.

GARBER: Were you involved as it became the rate setting commission, and then the DRG model?

LYNN: No, that was handled by the financial staff. I was pretty much all operations at that point.

GARBER: Do you consider the rate setting model to have been effective in controlling costs?

LYNN: No. Well, I shouldn't say that. I'm sure it was. The costs would have been higher without it, but it didn't really go after a value equation that you could offer to a consumer that would make any sense at all. These rates had no basis in fact and still don't. If you think about what charges look like in a hospital compared to what hospitals are actually paid, and you look at that process, you'd say, "Who invented this? This is crazy! You get a bill for \$400,000 from the hospital, and they get paid \$4,000. What is the relationship between those two numbers?" Nobody can explain it to you, and there is no transparency.

Because of these controls, there couldn't be transparency. We never knew how much an MRI of the knee cost. Is it with contrast, without contrast? If it's done here, it costs less than if it's done there. Then everything was blended together, particularly in a four-hospital system. You couldn't have four different sets of rates.

GARBER: What was it that eventually killed the rate setting system in New Jersey?

LYNN: DRGs.

GARBER: We've now come to a point in your career when you are about ready to make a move. Why did you start looking around in the mid-to-late '80s?

LYNN: I started getting calls from recruiters through the work of a lot of people. We had been able to turn West Jersey's financial situation around. I was beginning to think that I would like to do more in the way of leading an organization that really wanted to embrace change, really wanted to do things differently, really wanted to look at quality improvement as a key part of the management of the enterprise. I was interested in an enterprise that would respect the notion of team building and teamwork in problem solving. It was time that I thought I should look around. Barry agreed. He was a great supporter of mine and still is.

I had a number of different opportunities to look at. One was at what was then called

Atlantic City Medical Center—which included two hospitals in southeastern New Jersey, one in Atlantic City, the other on the campus of the Stockton College.⁹ The hospital was in terrible trouble. It was broke. Labor unions were trying to unionize the workforce. The morale wasn't very good. The hospital had a lot of problems. When I met the board during the interview, I thought, "This group is desperate for new ideas. I can come in and try to institute some new ideas in a turnaround situation."

I took that position and ended up staying as the CEO of that organization for 21 years, and then another three years as emeritus. Part of our success was the continuity of the management and the board and the medical leadership, that we were all in this together for the long haul. That helped us build trust and relationships where you could sit down and tell each other the truth without penalty.

GARBER: Atlantic City is unusual because of casino gaming. Could you talk a little about how this came about?

LYNN: By the '70s, Atlantic City was dying. It had lost its luster as times changed. It was a place in the '50s and in the '60s that families would go for vacation. You could walk the Boardwalk and go to the Steel Pier and see a first-run movie and a show. But the city lost its family appeal. The hotel owners had not reinvested in their properties.

Casino gaming was seen as the device through which the city would be reborn. To some extent, that's happened. There has been a lot of investment in Atlantic City. However, the regulators of that industry didn't require the companies to reinvest in their properties, so the profits that were made in Atlantic City were invested in jurisdictions that produced more cash than Atlantic City did. Our casinos deteriorated. That happened at the same time that every other jurisdiction in the country said, "We need to have casinos because it lessens the tax burden." The amount of competition has increased, and as a result, Atlantic City is in decline once again.

The challenge for those of us in the not-for-profit world was that we have all the challenges of a major city in a small place. Atlantic City is a barrier island – a tiny little piece of geography. If I had breakfast with you at one end of the island, we could finish walking the entire island by lunch. That's how small it is. And yet, we had all the challenges of a big city. Atlantic City serves 25,000 permanent residents and about 25 million tourists. There is only one hospital.

It fell to us to be all things to all people, which we still endeavor to do. The pressures that it put on the organization were different than those you'd find in most other hospital settings because we had so many visitors. When people would fall ill, they had a significant other that was with them who had no place to stay, no money, no knowledge of the community, probably some social service needs of their own, and no one to provide care other than us. We had lots of challenges in building support systems for people who were not from this area. Frequently, they didn't pay us, and so that made it even more challenging.

Through that, we learned to integrate ourselves more into the community to be more of a civic leader, opinion-maker and a trendsetter. We all belong to communities, with a small "c"-communities of business people, parents, families, church communities and such. We had 5,000

⁹ The Richard Stockton College of New Jersey is located in Galloway, N.J., about 15 miles from Atlantic City.

employees in all of those communities, and when we took a hard look at it, we were leading many of those communities. They were the heads of the PTAs and the church groups. We used those relationships to strengthen the connection between our organization and the people we served, the unofficial leaders of the community, and we were able to get some things done that I think are valuable to the town, even to this day.

GARBER: Going back to when you first went to Atlantic City, you mentioned that there was continuity in the board and medical staff. Do you recall who the chief of the medical staff was at the time you started?

LYNN: Yes, the president of the medical staff was Dr. Alfred Rosenblatt,¹⁰ who was a general surgeon. He and his brother Morton had operated on just about everybody in the county. He was a great man, and he became a good friend. The chairman of the board was Edward Knight,¹¹ who just passed away last week at age 96, who became a lifelong friend and supporter and mentor. The vice chairman was Stanley Grossman,¹² who also became a close friend and mentor and confidante.

I was the new guy in the fall of 1986. We talked about how we were going to try to manage the turnaround and what we needed to get done. The Teamsters were trying to organize the nurses, which I always felt was an odd combination. If we lost that election, I knew I was going to be running this race with my shoes tied together.

At the time, we had a fairly large contingent of Filipino nurses. I remember taking a tour of the facility to meet the staff, and someone said, “You need to talk to Fe Egueras. She is an RN who is like a mother to all of these Filipino nurses who come over here. She helps them get settled, and makes sure that they have the support systems that they need to integrate into the community.”

I remember going to Fe, and she looked at me skeptically like, “Who are you? What are you all about?” I said, “Where do you stand on the union action?” She said, “I think we need to have some representation.” I said, “If you give me a chance, you can represent yourself directly to me. You don’t need a middleman.” She helped organize the nurses and defeat the union. I had the opportunity to get to know the staff and find out what was on their minds and get to work in terms of solving some issues rather than having somebody dictate a set of demands to me. We started off on the right foot. I spent a lot of time doing what Barry had counseled me to do – walk the floors, meet the people, listen to what they have to say. It’s not complicated.

¹⁰ Alfred A. Rosenblatt, M.D., and his older brother Morton A. Rosenblatt, M.D., both graduated from Jefferson Medical College in Philadelphia, interned at Atlantic City Medical Center and took their residency training at Montefiore Hospital in the Bronx before starting their surgical practices in New Jersey. [The American Board of Medical Specialties. (2003). *The Official ABMS Directory of Board Certified Medical Specialists*. St. Louis, Mo.: Elsevier Science.]

¹¹ Edward R. Knight (1917-2014), an attorney and judge, served as president of the board of governors at AtlantiCare from 1973 to 1987. [The Honorable Judge Edward R. Knight, of Margate. (2014, April 18). *Jewish Times of South Jersey*. Retrieved from http://www.jewishtimes-sj.com/news/2014-04-18/Obituaries/The_Honorable_Judge_Edward_R_Knight_of_Margate.html]

¹² Stanley M. Grossman served as the founding chairman of the AtlantiCare board and also served on the AtlantiCare foundation board. [ARMC city campus opens new Stanley M. Grossman Pediatric Center. (2008, July 25). *Jewish Times of South Jersey*. Retrieved from http://www.jewishtimes-sj.com/news/2008-07-25/Health_and_Nutrition/034.html?print=1]

We had a big financial challenge. We literally didn't have any money. The burden of charity care for the obstetrical staff had gotten so high that they resigned en masse and said, "You have to find a different way of compensating us. We can't be on call, come into the hospital to deliver a baby and not be paid anything." I thought this was reasonable, although I didn't think their solution to the problem was reasonable.

At the time, Molly Coye¹³ was the commissioner of health for New Jersey, and she was just as new and green as I was. Molly went on to become the commissioner of health in California. She became a leader in the quality movement. She's been involved in think tanks and she's been on the board of the American Hospital Association as well.

I got a call from the commissioner of health, and she said, "I just heard this group has walked out." I said, "They did. In fact, I have another group that I need to put into place, but I don't have any money. You've got \$11 million of reimbursement from appeals for our hospital that date back five years. If I could get my hands on that \$11 million, I'd have enough money to solve this problem." She said, "I think that you need to discipline those physicians." I said, "I'm not about discipline. That will take care of itself. I need to replace them. That's what I need to do." I told her my idea for a solution to the problem, how she could help us, and in turn help the patients get the care they need. Two weeks later, we had our money, and we became great friends.

GARBER: I wanted to back up and ask about Fe Egueras. She was not the Director of Nursing?

LYNN: She was an unofficial leader, no title. She became an official leader of the organization as time went by, but at the time, she was one of those people who was behind the scenes. You find them in every organization. They're the opinion-makers. They're the people that you go to, to get things done. They don't have a title and oftentimes don't want a title.

GARBER: Was this during the national nursing shortage?

LYNN: Yes.

GARBER: You also mentioned that you went to her to ascertain what was on the mind of the nurses. What was on their minds?

LYNN: Number one was that they didn't feel they were fairly compensated for what they did. We set up a new compensation program where we said, "You will be compensated in the top 10 percent of nurses in the region at all times. If you ever fall out of that, we'll retroactively adjust it because our measures may lag the movement of the market sometimes. That's the deal. We value you, we value your work, and you will be paid."

Then we set up an incentive compensation system as well. This was hard because we really didn't have the money to pay it at that time. We had confidence that we were going to be able to earn it if we could get the workforce engaged in change. The deal we made was this: if we can improve the level of performance for the patient, if we can stop worrying about ourselves and start

¹³ Molly Joel Coye, M.D., has had an extensive career in public policy, currently serving as chief innovation officer at UCLA Health in southern California. [Washington, A.E. (2010). *Chief Innovation Officer*. Retrieved from <http://www.uclahealth.org/body.cfm?id=1463>]

worrying about how to do a better job for the patient, then we'll have more patients, the financials will take care of themselves, and you'll share in that.

For the 21 years that I was the CEO, we had 21 gain shares. It was different amounts of money each year, but this grew in significance over time. Every member of our staff had to do certain things to qualify for the gain share. It was a bonus system, I guess, which critics said was an entitlement and that people would get used to it. I said, "So what? If you want to call it an entitlement, call it an entitlement. In order to get it, you have to do things that are important to the organization, so it's not a complete giveaway." You can't make it so complicated that 5,000 people can't figure out what they have to do to get the brass ring.

GARBER: If I was a nurse working on a med/surg unit, what sort of things would I have to do?

LYNN: In the beginning, you had to innovate some sort of an improvement in customer service that could be measured. You would make that commitment on a card. It was a very sophisticated process: you wrote it on an index card, you gave it to your supervisor! They collectively became the improvement opportunities for that individual unit. It was very simple, you either did it or you didn't do it.

The next year, it became a little more complicated in that you had to find a colleague in another department to partner with on an improvement. We began to draw a picture of the organization that was upside down. There was a pyramid. I was at the bottom; the patient was at the top. Everything flowed up to the patient. The closer you were to the patient, the easier it was to get someone to help you innovate a solution. The further away you were from the patient, the more complicated it became. Senior leadership had to think this through, "How am I going to do this? How am I going to collaborate with somebody who is in a different department?"

We had clinical people partnering with folks in finance to accomplish something. What we were trying to do was break down the boundaries and get people talking about improvement and results and measurements and performance and bonuses and engagement. They all go together. The hardest thing was to get everybody to pursue a common goal because every department was an island, and every shift had its own set of issues and so forth. That became the way we did things. My commitment to the management team was: if you'll do this, you don't have to cover your ass any more. I will cover it for you. That's my job. You will have to go out and actually make these innovations take place, though.

For the first time, people who were running departments didn't have to have all the answers. "I don't know," was a reasonable answer, if you could follow it up with, "but I know who I can work with in order to solve this issue." It took a lot of pressure off people. The environment that it created allowed people to stretch, to work for something that maybe they didn't know the answer to, but had a pretty good understanding that it would move the needle if they could get it done. That became the basis for our team-based leadership model, which has served us very well as we evolved from Atlantic City Medical Center to AtlantiCare.

GARBER: If employees were developing all these different ideas, wasn't there the potential for them to run off in directions you didn't particularly want them to go? Was there somebody controlling the whole ball of wax?

LYNN: People did run out of control. One great story is this: the director of respiratory therapy came to me one day and said, "I have a problem with this improvement project. I can't get my people involved in it because they don't feel they're being treated as professionals." I said, "Why aren't you treating them as professionals?" He said, "It's not me. They have to punch a time clock. They feel like we don't really think of them as being key parts of the care team." I said, "What are you going to do about it?" He said, "I'll tell you what I'd like to do about it. I'd like to tear the damn thing off the wall." I said, "Don't hurt yourself." He said, "You're giving me permission?" I said, "You just told me that you're going to tear the time clock off the wall. Just be careful."

He ceremoniously tore the time clock off the wall. Two weeks later, his department didn't get paid. He said, "What are we going to do?" I said, "It seems like you need to talk to payroll." His people didn't eat him alive. They said, "You goofed. You did the right thing ceremoniously, but then you didn't follow through."

The CFO came to see me about this payroll issue. He said, "This is out of control. We can't have people running around, making their own rules and changing things." I said, "I would love to agree with you, but I can't. I can't stop this. This has to find its way through a process, and then it will be okay." He said, "I don't know how it's going to work."

The way it worked was that I said to the department head, "You better go meet the payroll people. Have you ever met them?" He said, "No, I don't even know who they are." They worked in this little crow's nest of a place. There were five of them who did payroll for the whole place. Their commitment for improvement was that there would be no errors in anyone's paycheck. That was their goal. I thought it was pretty good stuff. This department head had screwed up their performance for the year because now they had all those people who hadn't gotten paid.

I said, "I'll stop by." I bought some doughnuts and coffee and went out when I knew he was going to stop by and see them. They discussed it with him. I didn't say anything. Finally, they said, "If only you had come to us, we could have fixed this for you, and then we could have been your partner." I thought, "That's the right answer."

They figured out a way that he could get what he wanted, and they could get what they wanted. There was a new system that worked. That story got around the place, because everybody was waiting to see if somebody was going to get fired.

It did get a little sloppy. You can't really control these things. Sometimes people will catch each other before they do something. We were pretty sure it wasn't going to hurt patients because we weren't working on the clinical side. We were working only on customer service improvements, like everybody needs to have a common expression when they greet a patient. Everybody needs to be taught to look people in the eye and say, "Hello." You need to end every conversation with, "Can I do anything else for you?" Those types of things can only help, they can't hurt anybody physically.

At that time, we weren't really sure where to start in terms of quality improvement in clinical quality, because we had so many challenges. It was really a question. We thought that the answer was: we've got to get our staffing to where it needs to be before we can seriously introduce clinical quality improvement.

But at least at that point, we had the organization looking away from their own needs toward the needs of patients and families. They were taking responsibility for not telling somebody else what to do, but actually doing something themselves and being accountable for it. Maybe it was baby steps, but if you get 5,000 people taking baby steps, you'd be amazed at the amount of ground you can cover.

GARBER: I'd like to talk about AtlantiCare and the concept of the integrated delivery system. What is an integrated delivery system?

LYNN: It's the whole continuum of care that you need as a patient without any of the barriers that separate segments of that care, so that you would find it to be seamless. Whether you were an inpatient, whether you were an outpatient, whether you were at home, whether you were in rehab, whether you were having surgery in an outpatient center, wherever you were within the system, it would be one system of care that was taking care of you, not fourteen different segments that were linked together by contracts or affiliations.

We wanted to have insurance be the ultimate integrator, which makes me smile now because that's what we're going through again as a country. We're not going to reform health care. We're going to reform insurance, and the reformation of insurance is going to change everything in terms of clinical delivery. There's a certain brilliance in that, not in its execution, but in the ideas that drive it.

In order to become excellent in managing the relationship between access, cost and quality, we had to be in the insurance business. We launched AtlantiCare Health Plans, and subsequently joint ventured that with Horizon Blue Cross and Blue Shield. Not only did we have the delivery system, but we had the insurance that sat on top of it. You could get most of what you needed as a patient in the AtlantiCare system. You couldn't get a heart transplant done. You couldn't have certain things that we wouldn't want to do in that community. We'd want to have you sent to Philadelphia. Otherwise, there was no reason for you to leave the community to get better care. It was right there.

It took us a while to convince the community that it was right there, because we were coming from a history where clinical quality and patient service were not the hallmarks of Atlantic City Medical Center. When we finally got to the point where our clinical outcomes were in the top three in the state, we said what we really need to go is to get validation now from outside sources that we've made this transition. We can't toot our own horn, because people aren't going to believe us.

That's when we began to look at HealthGrades and J.D. Power and pursued magnet status. I think we just got the third magnet designation for AtlantiCare. It's pretty hard to get one. Getting it three times in a row is really quite an achievement. That sent a message to the nursing community that this is the place to practice. Between '86 and '96, we had gone from having vacancies that were hard to fill to having waiting lists in nursing. We had done a lot in terms of education, in terms of scholarships and helping people get nursing degrees.

GARBER: My understanding is that the nursing shortage tends to be cyclical and that there was a nursing shortage nationally, as we talked about before, in the '80s, and then it eased up. Why was that?

LYNN: A lot of people went into nursing. Community colleges started nursing programs, because it fit with their missions. They wanted to have curricula that produced degrees that could get jobs, where there was really a market for talent. Nursing traditionally was a degree which meant you had a job for life. You could take that to the bank and get a mortgage. It was a career which was solid, with good income progression. Today, there probably are more nurses than there are jobs.

GARBER: In the '80s, when there was a national nursing shortage, the educational system responded, developed programs, and increased the number of trained nurses. Today, we're good, or even oversupplied.

LYNN: We've also got new categories of care providers that weren't there before. It's all part of the development of a care team and making sure that people are practicing to the top of their licenses. If you have caregivers doing as much as they can with the education that they have, this frees up the person who has more training to practice a little higher on their license, all the way up through to the physician.

GARBER: What will happen over the next five or ten years with that trend?

LYNN: There will be more care providers. There's going to be more team-based delivery of care, more medical home models. I'm on the board of Cooper Rowan Medical School,¹⁴ where the medical students are being trained in a completely different way than the faculty that teaches them were trained. In a typical medical school, you're in your second or third year before you even see a patient. At Cooper Rowan, students see patients the third week that they are there in their first year. They're not treating them, but they're learning how to be a part of a team. They're learning how to take a history, how to listen, how to communicate. They're learning how to understand what people are really telling them, and how to deal with issues like the lack of compliance, the social problems that patients bring into a setting that may be impacting their health or their ability to get well. They may not have enough to eat. They may not have a place to live.

These students are being trained to see themselves as part of a delivery team. It's a very different way of education, much more in step with where we're going as a culture around health care.

There will be more care providers trained that are not physicians or RNs, because we're not going to be able to solve the physician shortage. There will be more nutritionists, behavioral health folks, exercise physiologists. There will be more IT people on these teams to make sure that the information is flowing, that there is more in the way of data analytics, more trying to understand what's working in the system and what isn't.

For example, if you were to take responsibility for a panel of 1,000 patients, we used to measure patient outcomes based on claims data for the patients you saw. That's great, except what happened to the 20 percent of patients who never came to you and are chronically ill? You don't know anything about them because they didn't issue a claim. We need more of a real time way of

¹⁴ The Class of 2016 will be the first to graduate from the new Cooper Medical School of Rowan University in Camden, N.J. [Heyboer, K. (2011, June 9). N.J.'s new medical school at Rowan University to begin recruiting students. *The Star-Ledger*. Retrieved from http://blog.nj.com/ledgerupdates_impact/print.html?entry=/2011/06/njs_new_medical_school_at_rowa.html]

gauging what's happening in this population. The patients you're not seeing are as important as the patients that you are, in terms of their health status and your compensation. All of this is changing as we're looking at how to effectively deliver care to a patient, and that's, once again: access, cost and quality. We're looking at how to do all three of them better than we're doing them today.

GARBER: We're talking about concepts of population health now.

LYNN: Yes.

GARBER: You were saying a moment ago that this team-based care will continue, and expand, because we will not be able to solve the physician shortage. Why wouldn't we follow the same model of solving the nursing shortage?

LYNN: To some extent we may be able to do that, but it takes such a long time for somebody to go through the training that it would be a good ten years before we could see any change there. All of these other changes are going to happen within that ten-year period.

GARBER: You mentioned the concept of medical home. What does that mean?

LYNN: A medical home is a single place where you go to receive your care. One of the ways of thinking about it is concierge medicine for the sickest patients. If you have co-morbidities – if you have diabetes and congestive heart failure and you're overweight and you suffer from anxiety and you have a bunch of different things going on in your life that need to be treated – rather than going to five different places to get the treatment, you go to one. Your care is coordinated. You may see the physician, you may see a nurse, you may see another professional who will help you. For many of these patients, the system has ignored them or compartmentalized them as a diabetic – but we're going to ignore everything else. In the medical home model, you enter at the appropriate level, and you receive all of the care that you need.

Patients love it. They just love it. It's more efficient. The model is designed to make sure that you're getting your treatment in the lowest cost, most appropriate setting. Rather than readmitting you to the hospital, you have a care provider who makes sure that you're getting care in the right place at the right time and at the right price.

GARBER: As a patient with a medical home, am I walking into a family physician's office but being seen by different people, or are we moving away from the bricks-and-mortar model?

LYNN: It's more of a clinic model, I would say. What you're trying to minimize is having the patient make trips to different care providers and trying to negotiate the boundaries that separate them. A lot of care delivery will take place in the home. Devices will become more interactive. You will be able to step on the scale in the morning and we'll know what your weight is. If your weight is off and you have congestive heart failure, we know we better pick up the phone and find out what's going on. All of that technology is here. We don't necessarily have it organized in a way that is useful yet, but we don't have to invent the technology. We have Bluetooth and wireless devices and are using real-time data to analyze what's happening with patients. It's all available.

GARBER: It sounds like it might be expensive with all those different professionals that you're bringing together and the different technology.

LYNN: It is expensive in a different way. If you could eliminate unnecessary hospital admissions, you can pay for a lot of technology.

GARBER: You mentioned that AtlantiCare has received a third magnet hospital designation. What is a magnet hospital and what do you have to go through to earn that status?

LYNN: Magnet is sponsored by the American Nurses Association. It is a set of criteria that you have to meet which describes you as a “magnet” for other nurses to come and practice in that setting. There are clinical competencies, there are educational competencies that you have to have. You fill out an application and you get graded, and when you hit a certain level, you achieve magnet status. It’s been around for probably about 15 years. You earn it for a three-year period. The scrutiny is fairly constant across time, which I think makes the designation valuable and valid.

GARBER: This is something that nurses are very conscious of.

LYNN: Very.

GARBER: For patients this magnet designation is perhaps not of as much importance?

LYNN: I would agree with you, to patients it is perhaps not as important. Patients are getting smarter about things like this, though, because they know that while their physician is extremely important, during a hospital stay they’re not going to see their physician as much as they’re going to see their nurses.

GARBER: AtlantiCare also earned another major award – the Baldrige. I think that process may have started while you were still there, although the award itself was made after you left.

LYNN: Baldrige is described by many who participate in it as a journey. It is a way of organizing your work to produce best-in-class outcomes. It is a process that requires you to answer questions about how you do things in seven categories. One of them is planning. One of them is human resources. One is management information, and so on. For example, a question might be, “How do you communicate with your staff about the priorities of the organization?”

The first time you go through this, you tend to answer the question in terms of what you do. Then you realize that what you do and how you do it are two different things. You are graded on the basis of how effectively you’re doing against what the best companies are doing. You get a score, and you get a feedback report. Before we adopted the Baldrige criteria, I knew we were not doing everything as well as we could, but I didn’t know what we should be doing to improve. The feedback report tells that. It is like “Quality for Dummies.” Here are the answers. All we had to do was go through this process, which is not easy, and then get a feedback report.

When you finally reach a point where your scores are high enough – in other words, you’re doing things much better than you did before – and you’re scoring well against the best companies, you get a site visit. Seven or eight examiners will come and spend a week crawling through your organization at all hours of the day and night. They will give you a feedback report as well. It’s a richer feedback report, which includes identifying organizations that do superbly what you don’t do well. If an organization has won the Malcolm Baldrige Award, one of the requirements is that they open their organization to you. You can come visit and learn for very little money – the cost of your plane fare. If you win, you have to do that as well. It’s a very open learning experience.

There are a number of challenges. One is engaging your entire organization in the work. One of the frustrating things about quality improvement is you do great things over here in this area, but you're not so good somewhere else. If you're managing multiple campuses, you inevitably say, "Boy, this one is humming like a top, but this one over here – whew, we've got problems." How do you get everybody engaged in the work? That's what makes quality improvement so incredibly difficult.

I think the year was 2003 or 2004 when we accomplished our goals in terms of clinical performance: to be in the top three in the state in outcomes and, for our specialty programs like cardiac surgery and others, to be best in class (top decile). Financial performance was where it needed to be (top three in the state), retention was good – we had a number of targets that we had set out and beaten.

I used to have regular meetings with middle managers, where I'd give a talk for 15 minutes about where we were, and then I'd listen for 45 minutes. I'll never forget – it was a couple of the nurses who said, "What's next in terms of our quality journey?" I said, "That's a good question. I'm going to turn it back on you, but I can tell you that I've been looking at Six Sigma and lean, both of which are intriguing, but don't really have as much to do with quality as they do with efficiency. I'm not sure how we would apply that work to clinical outcomes and have it make sense." One of them said, "What about Baldrige?" I said, "What do you know about Baldrige?" She said, "I have a cousin who works for Ritz-Carlton and they won the Baldrige award."

I said, "I'll tell you what I know about it and how difficult it is. It's going to take renewed commitment." This was an audience of 40-something, mostly women, double-degreed – with some sort of clinical degree and an MBA, too. They were our secret weapon. They were energized people. Because they are women managers, they are more collaborative than their male counterparts. They have to be collaborative in order to do everything that they need to do – raise a family, cook dinner, get to the Boy Scout meeting. They naturally know how to work together.

The senior leadership team said, "This is really worth looking at." I went to the board and said, "This is not my idea. This is our middle management organization's idea of what we should do next to become better." I said, "Because they thought of it, I think we could do it. They really are the control mechanism, because all the employees of the organization work for them."

We started the process. The first year was hilarious. We couldn't even figure out what the questions meant. It took us a year to understand the language. I was an English major, and I couldn't understand what some of the questions were asking us to do. Baldrige is a journey. It becomes a way of life. It's the way you think. It's the way you act. There is no problem that you can't solve. The more challenging the problem, the more people want to work on it. There is no hiding. There is no faking. A mistake is an opportunity for improvement. That's what's really marvelous about it, if you can get everybody into it. That was the challenge. How do you get everybody? We learned from the Ritz-Carltons of the world and the GEs just how you do that – how you engage the entire organization in this body of work.

One of the questions that frustrated me when I first got involved in Baldrige was, "How do you know that your employees understand the priorities of the organization?" How do we know? The answer was: we don't know. I made presentations. We sent out newsletters. We communicated, but I had no evidence that they read it or understood it or cared about it.

Our answer, the year that we were awarded Baldrige, was that everyone in the organization had to process their personal commitment to accomplishing our system-wide goals. They carried that around printed on the back of their name badge. If you stopped a housekeeper or a security guard and asked, as the Baldrige examiners did, “How do you make a difference in quality improvement for patients?” they could say, “Look right here, I do these five things every day.”

In the old days, when people would realize that there was a Joint Commission inspection coming up, they would say, “I think I’ll take vacation time because I really don’t want to have to deal with these folks!” With Baldrige, they couldn’t get enough. They said, “I hope they pick me to talk to, because I’ll talk their ears off.”

GARBER: That’s exciting. Other than the group of middle managers you mentioned who sparked the idea, was there a particular Baldrige champion at AtlantiCare?

LYNN: Yes, there were a number of them. I was one. We had captains for each of the seven categories, who would organize the work. We had writers and editors in each of the seven categories. Expressing ourselves clearly in the written material meant that the value of the feedback report would be even better. There had to be hundreds of champions in order for us to be effective.

It was a great experience when we received the award. Vice President Biden gave it to us with all the other award recipients. It was like a quality geek convention, with all of these people talking about processes and workflows and measures that they used. It was really interesting and fun.

GARBER: It sounds like it would be valuable to have some sort of Baldrige winner society where you could continue to share ideas.

LYNN: Yes, there is. It is held in Washington every year, and Baldrige recipients are the faculty. They make the presentations. You can bring your team and interact with them. You see a lot of former Baldrige winners going to pick up new ideas and techniques.

GARBER: Switching gears a little bit, I’d like to talk about affiliations. AtlantiCare recently announced a partnership with Children’s in Philadelphia [CHOP].¹⁵ I’m not sure whether this was ever completed, but there was an exploration of an affiliation with Geisinger.¹⁶ Were you involved in affiliations at the time that you were there?

LYNN: When I was there, we had affiliations with Jefferson¹⁷ for medical education. It was a loose affiliation. We had some affiliations with NYU around cardiac surgery,¹⁸ with duPont Hospital for Children around pediatric care.¹⁹

AtlantiCare has reached the point where it is a system that will deliver high quality, highly efficient care, but it needs a bigger market area in order to do it. Southeastern New Jersey is just not

¹⁵ The Children’s Hospital of Philadelphia. [Retrieved from <http://www.chop.edu/>]

¹⁶ Geisinger Health System (Danville, Pa.). [Retrieved from <http://www.geisinger.org/>]

¹⁷ Sidney Kimmel Medical College, formerly known as Jefferson Medical College, is part of Thomas Jefferson University in Philadelphia. [Retrieved from <http://www.jefferson.edu/university/jmc.html>]

¹⁸ NYU Langone Medical Center (New York). [Retrieved from <http://www.med.nyu.edu/cvsurgery/index.html>]

¹⁹ Alfred I. duPont Hospital for Children (Wilmington, Del.) is part of the Nemours health system. [Retrieved from <http://www.nemours.org/welcome.html>]

big enough to scale it in this new world where you're being paid not for how many things you do to a patient, but for the value. It's the move from volume to value. You need a lot more people to make it profitable.

The affiliation with CHOP replaces the affiliation with duPont, around subspecialty pediatric care. It's a make-or-buy decision in which AtlantiCare says, "There is this suite of services we need for kids. We can make them – but it's going to be time consuming and expensive – or we can partner with the number one children's hospital in the country, which is 60 miles away in Philadelphia. That's a pretty easy decision to make.

The decision with Geisinger is more complicated because AtlantiCare needs to have a bigger market to do what it does best, which is deliver an integrated solution. Geisinger is a very integrated health system with an insurance company. It's the perfect fit, in some ways. Culturally, the organizations are very similar and they care about the same thing. They're maniacs about quality and service, so culturally that will all fit together beautifully. From a marketing standpoint, the community that AtlantiCare serves doesn't know Geisinger. That's not a brand name that they would recognize or value.

Part of the trick in this merger will be to have Geisinger enhance the performance of AtlantiCare through information technology investment and some clinical investments, and yet let the name AtlantiCare continue to be the brand. As an alumnus, what I'll be watching is: does the Geisinger name replace the AtlantiCare name? Does the AtlantiCare name remain because it's known and valued in the community? We'll see. We'll see how it plays out.

GARBER: This is a merger, then.

LYNN: It's a merger.

GARBER: Has it happened?

LYNN: It's in the final stages. It probably has another 45 days to go before it's finished.

GARBER: Why is this particular merger desirable?

LYNN: There are two ways of looking at it. Can you become more efficient by being a part of a larger system? Can you have a more efficient supply chain management? Can you manage your IT structure, your financing structure, your balance sheet management, your debt – can you do all that in a less costly way? If the answer is, yes, then there are some savings there.

The second piece is: you have a set of needs in terms of data analytics, information flow, care management, those types of things. Do you buy that or make that – or could you download it from a system that already has it? Which would be the most efficient way to go about that? A merger has to meet two tests. It has to meet an efficiency test, but then it has to meet an effectiveness test. At the end of the day, you say, "Are we more effective in caring for patients than we were before?" If all you're getting out of the relationship is efficiency, it's probably not enough to hold up. I think a lot of collaborations fail on the effectiveness side because they get the efficiencies out right away, but then there is nothing else that happens.

GARBER: What makes AtlantiCare an attractive partner from Geisinger's point of view?

LYNN: I think Geisinger looks at New Jersey as an opportunity to offer an accountable care solution to employers, and they have the insurance license in the state. AtlantiCare already has an integrated delivery system, so that's a good combination. They can hit the ground running with that combination. They'll need to expand it either north or west in order to get more population.

GARBER: Could you talk about the governance structure of AtlantiCare?

LYNN: When I first went there, there was a board of the hospital. The hospital is over 110 years old. It had a fairly rigid board structure. As we evolved as a system, we changed our governance structure to permit some of these new ventures, which were more entrepreneurial, to grow. We developed a division called AtlantiCare Health Services, which was all of the clinical services that were not hospital-based – outpatient, lab, surgery centers, those types of things – 60 different distribution points.

If you managed and governed that from the hospital, you'd kill them because they are competitive. The surgery center that we were trying to launch was competing with our outpatient surgery program in the hospital. So, we thought we would get managers who were more entrepreneurial, and deploy them to a new organization with a new board that had experience in startup ventures.

When we started our health insurance board, we structured it as one third consumers, one-third physicians, and one-third hospital managers. There was always a dialogue happening between those board members in terms of what was best for the community. That board was very different.

We had a foundation, which raised money and engaged in public relations. We had a system board that managed the balance sheet and the strategy for the entire enterprise. We picked board members and put them in the places where we thought they could play the greatest role.

It was a mess to manage. I went to multiple meetings and gave the same report several times a month, but I couldn't think of a better way to organize it. The better way to organize it for me would have been to eliminate all those boards and let us do what we wanted to do, but that wasn't going to happen! It meant multiple meetings and multiple reporting and probably a lot of wasted time. At the end of the day, though, we had 80 community leaders who understood what we were trying to do and could communicate that to the broader community. That was valuable.

That board structure has been replaced. As the strategy has been changing at AtlantiCare, the structure has changed. It's a simpler, more streamlined board structure today than when I was the CEO.

GARBER: What does it look like today?

LYNN: Today there is a system board, a hospital board, and a foundation board.

GARBER: How many board members are there at those levels?

LYNN: Probably 30.

GARBER: Thirty altogether for the three boards?

LYNN: I would say the foundation board is probably larger than that. But the system board is under a dozen and the hospital board is around 20.

GARBER: What are the characteristics of a good board chair?

LYNN: In a hospital system?

GARBER: That's an intriguing question. Does it matter?

LYNN: Oh, sure.

GARBER: A good board chair in a corporation is different from a good board chair in other settings?

LYNN: Very.

GARBER: How so?

LYNN: The board chairman of a profit-making venture is trying to make sure that the planning and execution of the work of the company is enhancing the value to the owners, or the shareholders – that these things are being done for the benefit of those who own the company.

You don't look at that responsibility the same way if you're in the not-for-profit world. You look at the community. How do you define community? Would you define it geographically, or would you define it the way we defined it at AtlantiCare, which was: all of us are parts of communities. You are part of a community of mothers with kids in the sixth grade, or a community of Rotary Club members, or a community of nurses – we're all members of multiple communities (with a small "c"), and in aggregate, these represent the Community (with a big "C"). You can draw the geography of it if you want to.

The challenge of the board is to be broad enough that it can touch those smaller "c" communities and understand what's important to them and communicate with them. To be effective, the board chair has to have time, has to have above-average intelligence – because this stuff is really complicated – and has to understand the Community and value it. Those are things that make a good chairman.

You're going to leave your ego at the door; you're going to leave your business agenda. You can't do business with an organization if you're going to be on the board. You just can't do it. You come in and say, "My value is to build a bridge between the work that we're doing in the institution and the community that's supposed to be benefitting by it." Board members validate that, and the board chairman leads that process. That's a good board chair to me.

GARBER: You had the opportunity to serve as chairman of the board of the New Jersey Hospital Association. Do you have comments about your experience doing this?

LYNN: In a state the size of New Jersey, if you're in your position as CEO of a hospital for any length of time, it's going to come around to you to serve in that capacity. It's an honor, but it's also a requirement. Because I wasn't traveling all over the county changing jobs every three years, sooner or later, I was going to get a tap on the shoulder to chair the Association.

GARBER: Did you have any particular burning issue at the time you were chairman at the state association?

LYNN: Always reimbursement – always, always – regulation and reimbursement. The business model for health care has been the same for over 50 years. People get sick. People go to the doctor. Doctor puts the person in the hospital. Hospital makes them better. That’s the equation.

As long as that’s the way you’re executing the work that you do, your business model is to maximize the amount of money you get paid for that work and to minimize the disruption – the regulation. I don’t think New Jersey was any different from other state associations in having these two things as the most important advocacy: 1.) Pay us more money. 2.) Decrease the amount of regulation.

That is changing big time now that we’re in ACA-land, because now the business of health care is changing. We’re going to have insurance offered to consumers in a way that they’re going to be making their choice with their money. They’re going to further that by making choices about where they’re going to go to get care.

At the same time, the work that we do is changing. We have to reinvent it. It’s not all going to be about a sick person in a hospital bed. Maybe in the future, the person doesn’t get sick because we do a better job of managing health. You get sick, maybe you don’t go to a doctor. Maybe you go to a medical home. When you get sick, maybe you don’t go to the hospital. You probably don’t. You go to some other setting.

All those things are changing. That’s what makes this a crazy time for providers. The business is changing, the work is changing, and we’re doing it on the fly while we’re still taking care of patients under the old system. That’s as crazy as it gets.

GARBER: What was the path that led to becoming chairman of the Board of Trustees at the American Hospital Association?

LYNN: When I was chairman of the state association, one of the things that I was exposed to was some of the staff at AHA. I listened to the Washington Update and other staff presentations. I decided after that that I would try to serve on the Section for Metropolitan Hospitals.

I had been in my position with AtlantiCare at that point for quite a long time. One of the questions I was asking myself was, “Where am I going to learn more about best practices? Who is doing things that are exciting and innovative?” I found that I could make a lot of relationships through AHA and learn a lot from staff members and bring good ideas back to AtlantiCare. I talked to Gary Carter,²⁰ who was the head of the New Jersey Hospital Association and some other friends. They agreed, “Take a shot at going on the board of AHA.”

Board of Trustee members are supposed to serve three years. I ended up serving an

²⁰ Gary S. Carter served as president and CEO of the New Jersey Hospital Association from 1993 until 2008. [Next NJHA president named. (2007, November 17). *AHA News Now*. Retrieved from http://www.ahanews.com/ahanews/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_071115_NJHA&domain=AHANEWS]

additional three years associated with the chairman position. Then I stayed for one more year because of changes within the Association.

I got to travel to all parts of the country and listen to small and rural hospitals talk about their issues, large academic medical centers, and just about everything in between. I was exposed to some great ideas. I found it stimulating and rewarding for our organization and for me personally. When you talk to executives about the AHA, they say, “Whew, I don’t know that I have the time.” I say, “You ought to make the time.” In terms of the exchange, what you give versus what you get back, it’s pretty lopsided in terms of what you get back. I’ve had the opportunity to meet leaders in every part of health care and make some fast friendships that are still very much alive today.

GARBER: When you were chairman of the AHA Board of Trustees the first time in 2005, was there any particular burning issue?

LYNN: Yes. At that time, we had anticipated that health care reform was going to find its way onto the national agenda. It was beginning to happen. We felt that one of our problems in the past was that we had been reactive – that we were put into a situation where we said, “We don’t like this, we don’t like that.” You can’t constantly be against something. We felt that we ought to be proactive. We ought to develop a set of principles in which we said, “This is what health care reform should be all about.” It was called “Health for Life.”²¹

We worked diligently on this. The way that AHA works is that you do a position paper, roll it out to the membership, and to all of these different RPBs and special sections.²² Then you roll it back, sort it, edit it, and try to figure out what it is that you’ve got. You may have to do it a second time in order to really distill it. We were doing that work, which the Board had decided was going to be led by the Board. Staff was going to do the work, but the time and energy to analyze what the key issues were and understand them and be able to articulate them was board leadership responsibility.

The Board was working overtime on this work. I think the Board was right to say, “We need to not just lead this work, but we need to lead it in a way that we can understand it and be there to support that, not just hand it off to staff and say, ‘Run up to Capitol Hill and see whether you can sell this to somebody.’”

GARBER: Is there anything else you’d like to say about what happened in 2005?

LYNN: I had been on the Board at that point for four years. In 2005, I sensed that the Board came together in way that they hadn’t come together before. Maybe it was the urgency of the issue of health care reform, and for the Association to take a position on offense rather than defense required people to come together. We had an extraordinary board in terms of their commitment, their intelligence. There were great friendships that were formed. It was fun. The spouses participated and enjoyed each other’s company.

²¹ [American Hospital Association. (2008). *Health for Life: Better Health, Better Health Care*. Retrieved from AHA website: <http://www.aha.org/advocacy-issues/healthforlife/index.shtml>]

²² The American Hospital Association uses Regional Policy Boards (RPBs) and Constituency Sections as a way of keeping in touch with members and developing policy positions. [American Hospital Association. *Focus on Shared Interests of Members*. Retrieved from AHA website: <http://www.aha.org/about/membership/constituency/index.shtml>]

It was a lot of work, but it was also a great period. We learned a lot from each other. We had wonderful leadership from the staff. For many of us this was the kind of meaty policy issue that we had been waiting to work on for our whole careers. The Board really wanted to roll up their sleeves and say, “Let’s go on the offense. Let’s figure out the answers to these complicated questions so that we’ll understand what it’s going to take. Who knows whether we can sell it politically, but let’s not say we didn’t put in the effort to try it.” It brought us together in a terrific way. It spilled over into 2006, because we were still working on pretty much the same issues.

GARBER: The year 2006 was a year of transition for the American Hospital Association.

LYNN: Dick Davidson had been the president of the American Hospital Association for a long time.²³ He was an iconic figure. Every year, at the end of the year, the Executive Committee would meet with Dick and we’d say, “Dick, we’d like to talk to you about succession planning and retirement.”

Dick would give us the same answer, “Look, as long as I feel good – I feel healthy and strong – and as long as Janet, my wife, is engaged in this and I feel that I’m making a difference, I’d like to continue to lead this Association.” How do you say no to that?

We would walk out of that meeting and say, “One of these years, Dick is going to decide to retire, and whoever the poor son of a gun is who’s the chairman is going to have to work on that transition for the whole year.” Everybody who took the chair would say, “Oh, it’s going to be my year!” I knew for sure when I became chairman in 2005 that it was going to be my year. At the end of the year, though, Dick was still the CEO. I remember shooting a message to Rich Umbdenstock saying, “I made it through my year. Good luck with yours!”²⁴

We gathered as an Executive Committee prior to our board retreat in January 2006. And Dick shared with us some health issues that he had encountered, which had led him to think that this was probably the time to retire, and that he should be spending more time thinking about his personal life and getting his health back under control. We said, “Oh, boy, here we go!”

We huddled as an Executive Committee. At that time, AHA had two investiture ceremonies. One was at the board retreat, which had an informal ceremony that said to the incoming chairman, “You’re now the chairman.” The second was the ceremonial installation that took place at the AHA Annual Meeting in Washington, which was held in late April or early May. Rich Umbdenstock was prepared to have his first investiture the night following Dick’s announcement to the Executive Committee about his proposed retirement.

Rich Umbdenstock and Kevin Lofton²⁵ and I talked about what we were going to do. We were going to have to inform the Board of Dick’s decision and design a process for succession at a

²³ Richard J. Davidson was president and CEO of the American Hospital Association from 1991 to 2007. [*Richard J. Davidson in First Person: An Oral History*. (2010). Chicago: American Hospital Association and the Health Research & Educational Trust. Retrieved from <http://www.aha.org/research/rc/chhah/Davidson>]

²⁴ Richard J. Umbdenstock, currently the president and CEO of the American Hospital Association, was at that time the incoming chairman of the Board of Trustees of the AHA.

²⁵ Kevin E. Lofton, who has been the CEO of Catholic Health Initiatives since 2003, served as chairman of the AHA Board of Trustees in 2007. [Retrieved from Catholic Health Initiatives website: <http://www.catholichealth.net/kevin-e-lofton-fache>]

time when there were a number of important priorities facing the Association. Our work on *Health for Life* was reaching a tipping point. We all sensed that the search process was going to be exhaustive. It was going to take a lot of time. Rich and Kevin asked me, as immediate past chairman, if I would be willing to serve as the chairman of the search committee.

I said that I would, but that I needed somebody to help me understand what we were searching for. Without any guidelines, the president of the AHA is one of those jobs where you say, “Well, I think my brother-in-law would be great,” or, “I know this person...” Even worse would have been if the political lobbies in Washington, the K Street Gang as they used to call them, would have tried to get a retiring member of Congress to take that position.

Our fear was that it would impact the organization ideologically. We tried to govern and manage the AHA in a way that no one would know whether we were an “R” or “D.” It didn’t matter. We were all “H.” That’s what we were, and if we were to take a retiring member of Congress as a CEO, all of a sudden, that political ideology would find its way into our policy.

We worried about how to fend these people off. In the middle of that discussion, Kevin said that he knew a company that helped Catholic Health Initiatives develop a set of competencies that they used when they recruited him. We hired them. They interviewed the board and all the key staff members of the Association, and state hospital execs – which I thought was great, because who would know better what you want in the leader than the people who were going to follow? There was a logic to it that I loved.

At about that time, Rich Umbdenstock and his wife, Barbara, and Pat and I went out to dinner. I remember Barbara sitting in the back seat, and we were all still trying to deal with this announcement that Dick had made. Barbara said, “George, do you have any interest in being president of the American Hospital Association?” I said, “No, Barbara, I don’t. That’s not anything I would be interested in. I’m too old for it. It needs a younger man, with more energy, and infinitely more patience than I have. Why do you ask?” Rich said, “I think I’m interested in being a candidate.” I said, “Whoa! That’s going to be interesting.”

I said, “Okay, we have to think this through, because obviously there is a conflict of interest coming at some point. I’m not sure where it is, but it’s going to affect your chairmanship.” We asked Deborah Cornwall,²⁶ who was the consultant we hired, to help us think this through. We needed process help in figuring out: How do we conduct a search in a way that is fair to Rich, fair to the Board, fair to the Association members?

She concluded her interviews with the staff. I can remember her call. She said to me, “I have some good news for you.” I said, “Great, I can take all the good news you have.” She said, “We have completed the staff interviews. We’ve written a profile of the characteristics that we’re looking for in a CEO. Rich Umbdenstock is a great fit.” I said, “That’s terrific. That is really good.”

I said, “We need to figure out a way that we share this.” Dick Davidson had been one of the key interviews. Dick said, “I think Rich would be outstanding.” What you may not know about Rich is that he began his career with the AHA. He knew the organization. He was mentored by

²⁶ Deborah J. Cornwall is the managing director of The Corlund Group, LLC. [Retrieved from The Corlund Group website: <https://www.corlundgroup.com/html/cornwall.htm>]

Alex McMahan.²⁷ He had it in his bloodstream. He named his first son Alex, that's what an impact it had on him. In addition to his resume and his accomplishments – Rich had worked as a consultant in health care and knew many of the hospital CEOs in the country – he is an amazing personality. I guess we all have egos, but it would be hard to find Rich's. He's a "WEGO" guy. He is a team person. He thinks instinctively in terms of what is right for the membership. He is a leader that you would follow to a place you would not go yourself – that is my favorite definition of leadership. He inspires people.

I thought, "This is terrific. What are we going to do with this good news now? We have to have a process. We have to have something that says we've done a thorough job." We convened the board again for an extra meeting in April, brought them to Chicago, and stuck them for a day in a windowless room at the Hilton. We looked through this report, the set of criteria, the recommendations, all of the staff comment. Then Dick and Rich excused themselves, and I said, "Rich Umbdenstock is a candidate for this position. If you look at it, it's a remarkable fit. It's the Executive Committee's recommendation that we spend the rest of the time today either deciding that this is the right thing to do or it's not the right thing to do."

The board rose to the occasion. They asked all the right questions, all the tough questions. Could it look like an inside job? Would we be likely to find a better candidate if we conducted a national search? We reasoned that, if it is an inside job but it's the right job, then we've done a good thing for the membership. There is a year's worth of work that we can go back to without being distracted with this search.

The board decided that it was what they wanted to do. Rich was appointed as president-elect. Quickly – within a matter of two weeks – we had to completely redesign the AHA Annual Meeting. The way that it would have worked normally was that Rich would have been invested as the Chair. He would have given his message, and would have received appropriate congratulations. He would have been the focal point of the meeting as the new chairman of the Board.

But if Dick was to retire, and Rich was going to move from Chairman to CEO, then somebody had to be the chairman. We talked to Kevin Lofton, but he couldn't make that kind of switch fast enough. He was prepared to be the chairman the following year, but he was up to his ears with his health system responsibility. It fell back to me. "Would I be willing to serve another term?" There was no "No" answer in that. There couldn't be. It was one of those things that, it had to work out that way or it wouldn't work out at all.

We changed the AHA Annual Meeting so that, instead of having an investiture ceremony, we had a succession ceremony – where Rich succeeded Dick – and had an opportunity to introduce himself to the membership. That's where the panel discussion first made its appearance – where a group of us sat on stools on the stage and fielded questions rather than giving speeches. That's become a standard part of the investiture ceremony now.

GARBER: How well did AtlantiCare function during that additional year of an extremely heavy travel commitment on your part?

²⁷ John Alexander McMahan (1921-2008) was president of the American Hospital Association from 1972 to 1986. [*John Alexander McMahan in First Person: An Oral History*. (1987). Chicago: American Hospital Association and the Hospital Research and Educational Trust.]

LYNN: They were great. They really subsidized me. We were able to do it because we had a team-based leadership model, where authority was distributed among a large group of people who worked together. It was difficult. What happens when you're doing both of these jobs is you end up working the weekends. You don't take a day off because you have things to catch up on. It added another year's worth of that. It was difficult for some of the people who I was mentoring because they were dependent on time, and I had made them a promise that I would be there and couldn't fulfill that. They've all seemed to have gotten over that.

GARBER: Could you talk about your experiences with mentoring others?

LYNN: I think it comes with the territory. It comes with the job. Part of building an organization is spending enough time with people that you can help them work through the really difficult questions in life. People talk a lot about the separation of work from personal life. I believe that there are no separations. You have one life and you determine how you're going to live it. If you tell me, "These are the things I believe in and these are the things I care about," the acid test would be when I look at your calendar and your checkbook. I'd know right away whether that's true or not.

It's important to help people get through that so that they can honestly answer the questions: "What do I want for myself? What do I want for my colleagues? What do I want for my family? How do I want my life to be? What do I want my work to deliver back to me? How do I get those things?" A lot of people go through life without ever getting the chance to do that. They see a set of options that someone else delivers to them and says, "You can have A or B. You can have this job or that job." They say, "I'll take A," without having had the opportunity to go through the process of knowing what you want the end to be. You know not to take A or B because it doesn't fit. It's not where you want to be.

I think those things are valuable. People spent time with me who were busy and could have easily said, "I don't have time for this." If you are fortunate enough to have been mentored, you realize that you have to find the time to do that as well. It spills over and over and over, and you find that you have become an organization where people rely on each other and trust each other and love each other and care for each other. That makes the organization and its people stronger and more effective.

GARBER: We're going to wrap up this interview with a discussion of what you're doing since you retired from AtlantiCare.

LYNN: There are a number of not-for-profit organizations that I'm involved in and a number of for-profit. The not-for-profits include the medical school that I talked about before, the Cooper Medical School of Rowan University, which is a wonderful group of people breaking the mold on medical education. It gives me a great sense that our future is in good hands. The students in this school are very idealistic young men and women, and they're very impressive. They're bright and they're committed and they're caring for the poor, and that's how they're getting their medical education.

I'm also on the board of a not-for-profit health system in this region. I've switched sides of the desk. Instead of being the CEO, I'm now on the board side. I am on the board of Our Lady of

Lourdes Health System,²⁸ which is the hospital where both of our children were born and where Pat was a student nurse and also a member of the faculty. We have fond memories of that organization. They're trying to get through the volume-to-value transition and doing a good job. I'm happy to be on their board and help them.

I work with the Bishop of Camden on health care policy mission-related transitions that we're going through as a diocese. There are a lot of interesting people and interesting things and some things that I know a little bit about and some things that I'm learning for the first time – so that part of it is very satisfying.

I'm on a couple of other boards. I'm a limited partner in a private equity firm, which is seeking out small health care-related companies that are going to be the game changers of the future. I help them evaluate companies to acquire and get to meet a lot of bright young entrepreneurs who are out to change health care for the better.

I work on the board of a hospital company, LHP Hospital Partners, with a good friend Denny Shelton,²⁹ who used to be on the AHA Board with me. While it is a for-profit organization, the business model is to partner with not-for-profit hospitals in joint ventures that allow the not-for-profits to either expand their capacity or to provide capital. LHP becomes a partner in the venture and manages the facility. That's interesting and different.

I'm on the board of Valence Health,³⁰ which is an accountable care organization manager, designer, and deliverer. They do it all. I worked with the principals of that company back when AtlantiCare developed its provider sponsored health plan. They're very much into that provider sponsored care space, and that's very interesting.

I serve as an advisor to Lillibridge,³¹ a large real estate investment trust which also works with hospitals to do financial strategic partnering, like sale leasebacks on institutions. Accessing capital is a major challenge for hospitals and health systems. Lillibridge has quite an innovative way of going about that. They're also very effective in terms of managing and redesigning distribution systems. A lot of health systems have acquired physician practices, but they don't need all those buildings any more. They need to aggregate them in a new distribution system. Lillibridge does a really good job of that.

It keeps me out of trouble, but I don't end up working more than I want to. I work about half-time. The rest of the time Pat and I have for our grandkids and for neighbors and friends – a little golf, a little travel. It's a nice balance. One of the great things about not being the CEO any more is you get your calendar back. You get to decide what it is you want to spend time on. People think when you're the boss, you're designing everybody else's day. It's really the opposite - everybody else is designing your day. It's nice to have control of your calendar.

²⁸ Lourdes Health System (Camden, N.J.) has two general acute care hospitals. [Retrieved from the Lourdes Health System website: <https://www.lourdesnet.org/about-lourdes-health-system/>]

²⁹ James D. Shelton is currently chairman of the board of LHP Hospital Group, Inc. [Retrieved from the LHP website: <http://www.lhphospitalgroup.com/james-d-shelton/>]

³⁰ Valence Health, formerly known as NextStage Provider Solutions, was founded in 1996. [Retrieved from Valence Health website: <http://valencehealth.com/company/history/>]

³¹ Lillibridge Healthcare Services, a subsidiary of Ventas, owns and manages medical office buildings. [Retrieved from Lillibridge website: <http://www.lillibridge.com/>]

GARBER: You mentioned your wife, Pat. What contributions has she made over the course of your career?

LYNN: She's been an inspiration. We decided early in my career that we weren't going to travel all over the country trying to make a living, that she really wanted to live here in this community in Southern New Jersey and raise our children here. This is where her family is located, and this is where we were raised. We both hoped that our kids would return and that we could have the kind of extended family that we grew up with. That limited the geography that I could explore in terms of my career. This has turned out to be a wonderful thing for me, though, because it opened up opportunities for service within AHA and as a way for me to continue to learn and to develop relationships that I doubt that I would have ever had if I had been changing jobs every five years like many of us do.

Pat's influence has been constant throughout my career. She helped me learn the nuances of administration. She was a nurse before I met her – practiced and taught nursing. She's always been great from a patient perspective and what should we really be paying attention to?

We've had a great marriage. We'll celebrate our 46th anniversary this year, and look forward to many more. She is a great mother and a wonderful wife – and she will tell you that she's an even better grandmother!

GARBER: What do you feel your legacy will be?

LYNN: Oh, I don't think about legacy so much. I think every story has a beginning, a middle, and an end. I think my beginning was coming in the wrong door of health care administration. Most people were taking MHAs and going through internships, and here I sneaked in the kitchen window and had a lot of good fortune that I had folks who would spend time and teach me and allow me to learn and go to places where I could never have afforded to go. I hope that part of my legacy is that I've returned that favor to others who are themselves going to be leaders in the field and will leave legacies.

AtlantiCare is a better place today than it was when I came in 1986, not necessarily because of me, but because of the opportunity to work with a group of people who are dedicated to making it as good as it can be. If you can spend your career with people like that who become your friends – more than just business associates, they become part of your life – that's great. That's the kind of legacy that I would like to give to folks.

There are lots of ways to make money and there are lots of ways to be successful in business and in life. It seems to me that the easiest path has always been through other people and the opportunity to devote yourself to something that is worthwhile and to do it with a community of other people, where you learn and you teach and you practice together. That's as good as it gets.

GARBER: Are there any other individuals you'd like to mention?

LYNN: I have learned a lot from former chairs of AHA and board members. I mentioned

Denny Shelton. Gary Mecklenburg,³² who was a chair before me, was very helpful, not just in AHA, but also in solving business problems.

Tom Prisela³³ has been a good friend and an inspiration. Rich Umbdenstock is a great friend and I think he's done a marvelous job as the CEO of AHA. I admire all of the people on the advocacy side from Rick Pollack to Tom Nickels – I always enjoy meeting with Tom because I learn something that I didn't know and I end up laughing.³⁴

I've had a longer opportunity to be with these people than most people who serve three years on the AHA Board of Trustees and then they're out. Of course, AHA never really lets you get out! They always have a hand on your collar. Those are just some of the folks that I think have made an impact. I enjoyed working with Carmela Coyle immensely when she was with the AHA staff, and we really had an opportunity to get to know her and her family.³⁵ Neil Jesuele does a great job on the business side. He could teach business at any business school in the country. He is extraordinarily well-organized and focused and effective at what he does.³⁶

GARBER: In preparing for this interview, I asked Neil Jesuele if he had anything that he would like to hear you talk about. He mentioned that he'd be curious about your views on the rise of consumerism and how you reacted to that.

LYNN: I think it's the salvation of American health care. I know that a lot of my colleagues who run institutions probably would like to take me on about that. Consumer choice has been left out of the equation so long in health care that we've built this elaborate mechanism to replace it. We talked a little bit before about regulation and about rate setting and about how people get paid and about the difference between costs and charges.

That contraption got created because consumers didn't have their own money in the game, as they do for anything else. We all know how quickly consumers can learn who builds the best car or tape recorder or camera. They get the information, they process it, they make decisions. That's been missing in health care.

That will come now with the Affordable Care Act and the opening of exchanges and the new accessibility to health insurance. People will learn. Providers will be forced to be more transparent with pricing and quality, and consumers will learn how to interpret value and to make

³² Gary A. Mecklenberg served as president and CEO of Northwestern Memorial HealthCare in Chicago for 21 years. He was chairman of the American Hospital Association Board of Trustees in 2001. [Retrieved from Waud Capital Partners website: <http://www.waudcapital.com/executive-partners.html>]

³³ Thomas M. Prisela is president and CEO of Cedars-Sinai Medical Center in Los Angeles. He served as chairman of the AHA Board of Trustees in 2009. [Retrieved from Cedars-Sinai website: <http://www.cedars-sinai.edu/About-Us/index.aspx>]

³⁴ Richard J. Pollack is the executive vice president, advocacy and public policy at the American Hospital Association. Tom Nickels is senior vice president, federal relations at AHA. [Retrieved from American Hospital Association website: <http://www.aha.org/about/org/executive.shtml>]

³⁵ Carmela Coyle served as senior vice president for policy at AHA until 2008 when she was named president and CEO of the Maryland Hospital Association. [Carmela Coyle is named CEO of Maryland Hospital Assn. (2008, March 31). *AHA News Now*. Retrieved from http://www.ahanews.com/ahanews/jsp/display.jsp?dcrpath=AHANEWS/AHANewsArticle/data/AHA_News_08033_1_AHA_Carmela_Coyle&domain=AHANEWS]

³⁶ Neil J. Jesuele is executive vice president, leadership and business development at AHA. [Retrieved from American Hospital Association website: <http://www.aha.org/about/org/executive.shtml>]

buying decisions. That's great for our country, although probably not as great for hospitals right now because not all of them are going to make that transition. In the long run, we're going to have more people with access to health care, and a higher quality set of services at a lower cost. That's the triple aim – that's what we're trying to accomplish. It's going to jar the system. It's going to be difficult for the current providers to make it through, but I'm confident that we're very innovative as a field. We have a lot of intelligent leaders. This is going to be difficult, but not impossible, and we'll end up better as a result of it.

GARBER: Thank you for your time this morning.

LYNN: Thank you, Kim.

CHRONOLOGY

1945 Born May 11 in Buffalo, N.Y.

1968 Married June 22 to Patricia Kennedy of Haddonfield, N.J.
Children: Maureen, Brian

1968 Fordham University
Bachelor of Arts

1968-1973 John F. Rich Company

1973-1986 Virtua Health, f.k.a. West Jersey Health System (Camden, N.J.)
1973-1976 Director, Community Relations & Development
1977-1982 Vice President
1982-1986 Executive Vice President/COO

1984 Wharton School, University of Pennsylvania (Philadelphia)
Master of Business Administration

1986-present AtlantiCare (Atlantic City, N.J.)
1986-1993 President/CEO of AtlantiCare Regional Medical Center
1993-2007 President/CEO of AtlantiCare
2007-present President Emeritus

MEMBERSHIPS AND AFFILIATIONS

American Hospital Association
Chair, Board of Trustees
Member, Board of Trustees

Atlantic County Alliance for the Prevention of Drug and Alcohol Abuse
Co-chairman

Greater Atlantic City Chamber of Commerce
Chairman, Chairs Council

Health Research and Education Trust (New Jersey)
Chairman

Healthcare Research and Development Institute
Chairman

LHP Hospital Partners, a.k.a. Legacy Hospital Partners, Inc. (Plano, Texas)
Member, Board

Lillibridge (Chicago)
Member, Advisory Board

Lourdes Health System (Camden, New Jersey)
Member, Board of Trustees

National Alliance for Health Information Technology
Co-Chair

New Jersey Hospital Association
Chairman
Member

Princeton Insurance Company
Member, Board

Rowan University, Cooper Medical School (Camden, New Jersey)
Member, Board of Trustees

Shopright LPGA Classic
Member, Board

United Way of Atlantic County
Campaign Chairman
Chairman

Valence Health (Chicago)
Member, Board of Directors

Volunteer Center of Atlantic County (New Jersey)
Chairman

AWARDS AND HONORS

- 1995 Volunteer of the Year Award, United Way
- 1997 Tree of Life Award, Jewish National Fund
- 1997 Doctor of Humane Letters, hon. caus. from The Richard Stockton College of New Jersey (Galloway, N.J.)
- 1998 Distinguished Citizen Award, Boy Scouts of America
- 2004 South Jersey Leadership Award, Diocese of Camden
- 2005 "100 Most Powerful People in Healthcare," *Modern Healthcare*
- 2006 Distinguished Service Award, National Association for the Advancement of Colored People
- 2006 Businessman of the Year, Chamber of Commerce
- 2007 Distinguished Service Award, New Jersey Hospital Association
- 2009 Distinguished Service Award, American Hospital Association

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- Lynn, G.F. (2010, September 20). Move forward on strategic planning for Atlantic City. *NJBIZ*.
- Lynn, G.F. (2006, April). The quality army. *HC&HN. Hospitals & Health Networks*, 80(4), 100.

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