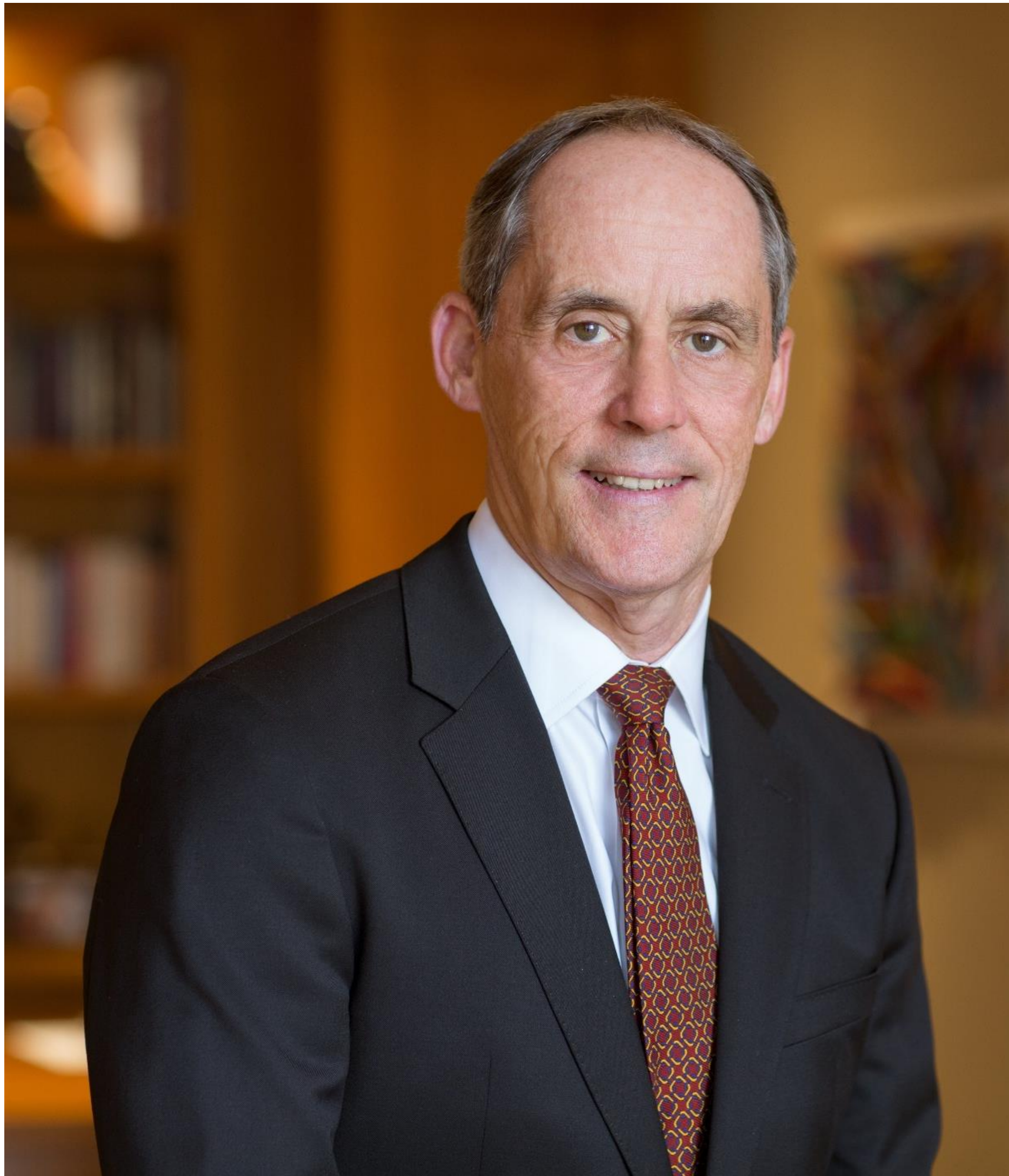

THOMAS M. PRISELAC
In First Person: An Oral History

American Hospital Association
Center for Hospital and Healthcare Administration History

2021

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

THOMAS M. PRISELAC

In First Person: An Oral History

Interviewed by Kim M. Garber
On July 13, 2021

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EDITED TRANSCRIPT
Virtual Interview from Los Angeles, California

KIM GARBER: Today is Tuesday, July 13, 2021. My name is Kim Garber and I will be interviewing Thomas Priselac, who has served almost his entire career – over 40 years – at Cedars-Sinai in Los Angeles, including over a quarter century as president and CEO. He has served as board chair for the American Hospital Association and in leadership positions with the Association of American Medical Colleges, the California Health Association and many other organizations. Tom, it's great to have the opportunity to speak with you today.

THOMAS PRISELAC: Thanks, Kim, very much. I'm looking forward to it.

GARBER: I'd like to start by asking you about your hometown, Turtle Creek, Pennsylvania. You've described it as a "classic Pittsburgh area mill town of 11,000 people." Did any of your extended family work in the steel mills?

PRISELAC: They did – the mills or some of the other related heavy industry that goes along with that, like Westinghouse Electric Corporation. Most of my family, uncles and aunts, worked in that kind of setting but my mother and father did not.

Pittsburgh was a classic example of European immigration to the United States in the 20th century. My father's family was from Croatia, my mother's family was from Ireland. Virtually every Western and Eastern European country was heavily represented. Pittsburgh was known for being made up of neighborhoods of different ethnic groups.

GARBER: Your mother had tragedy to deal with in her life, as did you, with the early death of your father. Could you talk a little bit about your mother and her values and what kept her going through tough times?

PRISELAC: She was the most remarkable person that I ever met. You commented on the tragedies in her life. Her first husband died in World War II. My father passed away in 1963 in an auto accident as he was working. My younger sister was hit by a car and died.

While these tragedies produced profound grief for my mother and our family, they also taught me valuable lessons. Among the many things that I learned from her was resilience, which in the environment we've been in over the last 18 months has been particularly useful. She was a remarkably intelligent, caring, pragmatic individual who always assumed and expected the best for all of us. The most common refrain I recall from her is, "You can be who you want to be." That's influenced my thinking and decisions.

GARBER: She was a remarkable woman. These tragedies also did affect you – it was your father and your sister. Did you find that you became more anxious or worried?

PRISELAC: I had the benefit of youth and everything that comes with that. There is no doubt it left me with a tremendous sense of the value of life. It helped me appreciate the value of every day. Did it make me more cautious or anything of that nature? I don't think so. It helped me understand at an early age that there are things that happen in life that are out of your control. Part of growing up is learning to deal with that.

GARBER: Did you have the opportunity to know all of your grandparents?

PRISELAC: Unfortunately, my father's parents were both deceased about the time I was born so I never got a chance to know them.

I knew my grandfather and grandmother on my mother's side and even my great-grandfather on my mother's side, who may have been 101 years old when he died although he was an immigrant from Ireland and there aren't a lot of records available. The family story is that he passed away after he fell while working in his garden and broke his hip.

My grandfather and grandmother on my mother's side both passed away by the time I was eight but I did get to know them pretty well, in part because we lived with them and my uncle in a large house for about two and a half years. My grandmother was a Catholic Irish woman of the time – happy, confident. She enjoyed a good party. My grandfather was the patriarch of the family. He was a coal miner and my grandmother was a cafeteria worker.

GARBER: Is there anything else you'd like to say about the values that you learned from your family or others during your childhood? Or shall we move on to your schooldays?

PRISELAC: I want to give credit to my father for teaching the value of hard work and for being willing to work hard. His day started at four in the morning and really didn't end until six or seven at night because of doing the work that needed to be done to get ready for the next day in running his business.

GARBER: You went to Turtle Creek High School, home of the Creekers where you participated in sports.

PRISELAC: Football and baseball were my high school sports. At some point, the curveball got too strong and I decided to focus on football in college. When you grow up in Pittsburgh, to not play football is almost sacrilegious. I played at a Division 3 school. I knew that I didn't have any aspirations or false hopes of playing beyond college but I wanted to play. While I could have gone to a bigger school and taken a chance on whether I'd play, that pragmatic viewpoint I mentioned about my mother came through and I said, let's play the odds here. I also wanted to get a good education. Washington & Jefferson is an outstanding academic institution with a reputation for graduating people in the sciences and pre-med which is where my interests were at that point.

GARBER: Washington and Jefferson College is located in Washington, Pennsylvania, near Pittsburgh. It looks to me like it was a little too far to commute to school. Did you live on campus?

PRISELAC: Yes, all four years on campus. It wasn't a commuter school.

GARBER: Were you on scholarship?

PRISELAC: Yes, I was fortunate enough, based on need and my high school academic performance, I was able to get a scholarship. After my father passed away, my mother worked as an office manager for a construction company in Pittsburgh. In 1969, the school cost $12,000 – that was real money. Without scholarship assistance, I would not have been able to go.

GARBER: Were you politically active during college?

PRISELAC: Yes, it was the height of the Vietnam War. I was politically active and very much so at the local college level. I was mostly participating in on-campus demonstration of one type or another that were ubiquitous at the time.

GARBER: Your undergraduate degree was in biology, and you had given thought to medical school. I read that you were more interested in the larger issues of community health than in seeing patients one by one.

PRISELAC: My interests were in science broadly. At one time, I was interested in marine biology, mostly because my older sister was in that field. On getting to W&J, I quickly developed an interest in medicine. I did all the things that one does to prepare to go to medical school, both academically and things outside of the classroom. I had a great interest in health care but the idea of taking care of one patient at a time was not where my interest ultimately lay. I may have had a better idea of what I didn't want to do than what I wanted to do.

In the first of a series of serendipitous moments, in my senior year I was leaving the biology building and there was a flyer on the bulletin board for the program at the University of Pittsburgh's School of Public Health in Health Planning. That sounded interesting so I applied to the Health Planning program and was accepted.

As I said, I knew more about what I didn't want to do. I didn't want to go to law school. I didn't want to get a degree in business, because running a business sounded boring. I read about the hospital administration program, but that sounded too much like business administration, so I wasn't interested in that. This thing called health planning was very interesting.

The United States has struggled with the cost of health care from the day Medicare began, and over the years has tried different things to try to control health care costs while making health care more accessible. In the early '70s, a health planning law was passed – P.L. 93-641 – those numbers are burned into my frontal lobes!

The concept was an excellent one in terms of the need for some sort of regional planning. Hospitals wanting to make a significant capital expenditure – build a new hospital, add a new wing, start a cardiac surgery program, even buy a CT scanner had to get approval from the local planning agency which was charged with looking broadly around the community, and approving it or not, based on community need. If the agency didn't approve it, then the hospital would not get Medicare reimbursement for that part of their capital expenditure. There was a limiting factor there. That sounded interesting to me, in terms of how health care was delivered and organized.

The way the curriculum was designed, if you were a health planning student, you had to spend three months working at a hospital, and if you were a hospital administration student, you had to spend three months working at a planning agency. This made all the sense in the world because you walked in the other person's shoes, you could understand how they were going to be dealing with the issues.

That was another of those great, serendipitous moments for me. In that three-month period, I was introduced to Montefiore Hospital, which was a local, independent academic medical center with a mission of patient care, education, research and community benefit. When I got there and saw it as well as meeting the people there, it all clicked for me. Because of what the institution did as well

as who the people were – some of the finest human beings I had ever met besides being great professional role models – I said, I'd like to be like them when I grow up. That's how I got into the field.

GARBER: Public Law 93-641, the National Health Planning and Resource Development Act of 1974, was instrumental in creating a health planning structure and establishing certificate of need (CON) regulatory programs nationwide. There are some CON programs still in existence – not very many, perhaps.

PRISELAC: Pittsburgh, Rochester (N.Y.) and Kansas City are probably three of the best examples where it worked. When I moved out here to Los Angeles, I went to my first hospital council meeting and when there was a question about emergency services, I raised my hand and asked, "Well, what does the local health planning agency have to say?" People looked at me like I was from another planet. Health care in Southern California has been very entrepreneurial for a whole host of reasons.

Among the reasons I think health planning worked in Rochester, Pittsburgh and Kansas City was because the people who led the big employers in town also often sat on the boards of the hospitals. There was aligned interest not only to make sure adequate health care was available, but also aligned interest that there was no unnecessary duplication of services, with everyone on the planet operating a cardiac surgery program, for example. The reality is, it's a big country, and that environment didn't exist then and certainly doesn't exist now in many parts of the country. Some mechanism for that kind of policy decision-making is sorely missing today.

GARBER: I'd like to talk a more about Montefiore in Pittsburgh in the sense of what makes a Jewish hospital a Jewish hospital?

PRISELAC: There's a concept in Judaism called bikur cholim, which relates to giving back, caring for others and visiting the sick. The notion of caring for each other and caring for the community is something that is highly valued in Jewish culture. There is also a strong commitment to learning, not only book learning, but also learning the lessons of life. Finally, there is a commitment to excellence.

A strong element in Jewish hospitals is the commitment to equity. This has been a result of their own experience and the experience of individuals in the Jewish community, including Jewish doctors who had been the victims of discrimination in the early part of the 20th century, which was the reason many Jewish hospitals were established in the first place.

GARBER: Jewish physicians were not able to get privileges at other hospitals.

PRISELAC: Right.

GARBER: Was there also an issue with medical school and training?

PRISELAC: There was an issue in that regard, but that barrier fell sooner than the barrier preventing Jewish physicians from getting privileges in hospitals. By the mid-'50s, a lot of the discrimination that had been the root of how Jewish hospitals got started, all of those kinds of things had really disappeared in many parts of the country – certainly in the Pittsburgh area. By the '60s, with the civil rights movement, those kinds of things had become outlawed.

The other thing was that Jewish patients would not be cared for in hospitals in the early 20th century, so part of it was being able to care for their own. From the beginning, fundamental elements have been also caring for the entire community as best they could and being a community resource.

With those values, it's not surprising that many of the hospitals that were begun by the Jewish community ultimately became teaching and research hospitals. Whether at Montefiore in Pittsburgh, Mt. Sinai in New York, Mt. Zion in San Francisco or Cedars-Sinai in Los Angeles, the mission of those institutions has had four parts for over a hundred years – patient care, education, research and community service. The research part was rooted in the belief that a learning environment ultimately makes for a better patient care environment.

GARBER: This is the traditional concept of the "three-legged stool" for the role of academic medical centers, except in your description there's a fourth leg, which is the community health aspect.

PRISELAC: Montefiore Hospital, like other Jewish hospitals, was started by the leadership in the Jewish community. I was fortunate to be there at the time when Montefiore – its mission and operation – was at its zenith. That was a function both of the environment that could support it as well as the leadership of the organization and the voluntary leadership from the community.

After I left, Montefiore was absorbed into UPMC as UPMC grew and developed in response to the changing health care environment. To the Jewish community's credit, they took the proceeds from that sale and created the Jewish Healthcare Foundation, an organization that has retained the focus on health care access and health care quality. They've done that as a freestanding not-for-profit organization since.

GARBER: As you said, Montefiore as a freestanding Jewish hospital doesn't exist anymore. It was acquired by UPMC – the University of Pittsburgh Medical Center. What did you mean by a changing health care environment?

PRISELAC: What I meant by the changing environment was essentially during the late '80s and the '90s. It was during that period that the so-called "competitive model" for health care emerged as the primary organizing principle around which the country would look at health care policy and health care financing. It was more about environmental change and the economic pressures associated with the need for size and scale to be viable, especially if you wanted to take on as big and broad a mission as teaching, education and research in addition to patient care. In some respects, it's the same macro-environment economic realities that are still with us today that are causing some hospitals to close and continuing to drive the development of health care systems.

GARBER: Who did you consider to be influential individuals at Montefiore?

PRISELAC: In terms of individuals who were particularly influential to me at the earliest time of my career, two stand out. Irv Goldberg[1] was the CEO at Montefiore and Dan Kane[2] was chief

[1] Irwin Goldberg (1925-2012) served in leadership for over 40 years at Montefiore Hospital (Pittsburgh). [Obituary: Irwin Goldberg, longtime chief administrator at Montefiore Hospital. (May 21, 2012). *Pittsburgh Post-Gazette*. https://www.post-gazette.com/news/obituaries/2012/05/21/Obituary-Irwin-Goldberg-Longtime-chief-administrator-at-Montefiore-Hospital/stories/201205210166]

[2] Daniel A. Kane, Ph.D. (d. 2015) served as executive director, of New Jersey's Englewood Hospital and Medical Center, of Bayonne Medical Center and in executive positions in other hospitals. [Dan Kane. (May 9, 2015). *The*

operating officer. Those were the two individuals that I worked with most closely during my internship. They were as good as it gets with regard to both professional knowledge and their personal values and ethics. I couldn't have asked for better role models.

GARBER: How did you meet your future wife, Jody Ziccardi?

PRISELAC: The moment that I met Jody was the most serendipitous event in many regards. I finished my residency period and was fortunate enough to be offered the job of ambulatory care manager for Montefiore Hospital. I was responsible for the hospital clinic and the operation and construction of some local community health centers, as well as being in charge of strategic planning for the organization. Strategic planning had just started in the field in those days. I tried to stress with Irv and Dan that my degree was in health planning, not strategic planning per se, but they said, "Well, it's close enough."

That's an example of who they were as professionals, as individuals. They gave you the freedom to do what you could do. At that point in my life and career, I couldn't ask for more than that. The way they operated was that they told you what they wanted to see get done and let you figure out how to get there. There is a tremendous learning opportunity in that.

GARBER: I've heard that thought expressed repeatedly by other leaders that we've interviewed in this series, based on their experiences with that older generation of leaders who preceded them. Do you think that's still the case today?

PRISELAC: I think it's still the case. It's the way many leaders want to operate and function as mentors and leaders themselves. Different people succeed at that to different degrees. When I started out in the field, life in general was simpler and so there was less at risk to letting people find their own way. The role of generalist was much greater. In the intervening years, health care has become much more specialized. The world has become more specialized in every way. To the extent that it's not present as much as it once was, it has more to do with the broader environmental situation in health care today compared to 1975.

The best leaders still operate with that framework. Its presence or absence is the difference between people who may be characterized as micromanagers or not. People who are successful leaders adhere to this notion of giving people clear direction of where they want to end up and giving them as much leeway as they can to figure out how to get there.

GARBER: How did you meet Jody?

PRISELAC: It was 1978 and I had been in the role that I described a moment ago for probably three or four years. I was enjoying my life and was thinking in terms of living out my career at Montefiore or somewhere in the area. My secretary, Cathy, was a UCLA grad married to a medical student at the University of Pittsburgh. She and her husband were relocating to California for his residency training at UCLA. Jody came to Pittsburgh to help them pack up and drive back across the country. It was Cathy's last day at work. Over the years, Cathy had told me about her friend, and I said to Cathy, "On your last day at work, why don't you have your friend join us for lunch?"

Jersey Journal. https://obits.nj.com/us/obituaries/jerseyjournal/name/daniel-kane-obituary?n=daniel-kane&pid=174820096]

Being the last of the big time spenders, I took them to one of the local hamburger joints. The rest is history, as they say. There were a lot of letters and phone calls. I manufactured a vacation out here, allegedly to see Cathy again, in between. Next thing I know, I'm walking into Irv Goldberg's office to tell him that I want to move to Los Angeles, and he said, "Well, I don't want you to go anywhere, but by the look on your face, there's a woman involved." Irv was kind enough to call Stu Marylander,[3] who was the CEO at Cedars-Sinai at the time, and said, "I have a young man who is moving to Los Angeles whether I want him to or not, and you might find it worthwhile to interview him." That's how I ended up being interviewed here at the time.

How do you describe the happiest and most significant moment in your life? It's 42 years later, and two grown sons and four grandchildren. As I've said to people, "I'm the luckiest guy in the world." I borrowed that line from Lou Gehrig but that's been my situation. On the personal side, it's been what I just described, a life that I could never have imagined, and professionally, to have had the opportunities I've had here, it doesn't get any better than that.

GARBER: Let's talk about Cedars-Sinai, a famous hospital formed by the merger of Cedars of Lebanon and Mount Sinai in 1961, although the new consolidated hospital wasn't opened until over ten years later.

PRISELAC: Cedars-Sinai represents the merger of Cedars of Lebanon and Mount Sinai. Cedars of Lebanon was founded by the German Jewish immigrant population and Mount Sinai was founded by the Russian and Eastern European Jewish immigrant population. Cedars-Sinai's evolution is a reflection of the growth and development of Los Angeles in the 20th century.

In 1961, the two organizations came together. In many respects, it happened for the same reasons that mergers are happening today. In 1961, there was no Medicare. There was no Medicaid. Whatever money hospitals collected from people paying cash was all the money that came in other than donations. The leadership in the Jewish community recognized this and said to themselves, "Why should we be competing in raising philanthropic dollars when we're here for the same purpose?" That's what led them to come together.

Interestingly enough, maybe reflecting the realities of medical staff dynamics, the hospitals merged in 1961 but the medical staffs didn't merge for another ten years. One of the things about health care organizations is they have strong cultures and strong self-identities. Whether it was in 1961 or 2021, bringing together cultures in a merger is always a challenge.

The new hospital opened in 1976. It was under construction for four years before that. Interesting factoid that is a commentary about construction cost inflation – it cost $150 million to build in 1975. If we were to replace this building today, it would cost $4 billion in order to equip it to do the same thing. It's rather stunning about what's happened in the evolution of health care.

There were design elements that were unique at the time. One was all private rooms. Hospital wards at the time were common. The most advanced hospitals had two-bed rooms. The people who built Cedars-Sinai were true visionaries including the vision for all private rooms. There was a bit of a challenge with the Blue Cross organization at the time because they felt that they shouldn't have to

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[3] Stuart J. Marylander (1931-2014) served in leadership, including as president, of Cedars-Sinai Medical Center. [Nu-Med Inc. named Stuart J. Marylander as … (July 18, 1989). *Los Angeles Times*. https://www.latimes.com/archives/la-xpm-1989-07-18-fi-3887-story.html]

pay for all private rooms. That ultimately got settled but it gives you an understanding of how it represented something unique.

Another design idea was that there wouldn't be just one hospital, there would be a collection of seven hospitals stacked on top of each other – so that the patient would never leave the floor. That was an idea that was great in some planner's mind, but which ran smack into reality. In the beginning, for example, there was no Medical Records Department. The idea was the medical records would be kept on each floor. The reality is, they had a hard time having the medical records keep up with the patients as they moved from room to room during their stay.

There were elements like that which were not economically feasible. A lot of the imaging function was decentralized – that ultimately became centralized. The pharmacies were on every floor. That ultimately became centralized. There were a lot of concepts that ran up against the practical realities of economic feasibility. Over the years, some of those things have been undone.

From an engineering and architectural standpoint, there are aspects of this building that were truly visionary. Over the years, we've been able to retrofit this building as health care has evolved over the last 45 years and do it with little impact on our total capacity. That has to do with the way the building was designed.

Other things that were in the original design have also proven useful, like how material moves around the building with dedicated elevators and dedicated transport systems. In 1975, that was a system run on about ten miles of metal chain that carried carts around the building. Today, it's all robots that are moving around, using sensing technology.

My point is that many of the ideas were viable and have been preserved. Many have also proven not to be feasible. We have made substantial capital investments over the years but none of that would have been possible if it wasn't for the underlying architecture.

GARBER: You mentioned you have been able to able to retrofit the building. Is that seismic retrofitting that you're talking about?

PRISELAC: The retrofitting I was referring to specifically was more operational and clinical, as well as building out new buildings around this building over time. The campus has expanded dramatically from the beginning. Part of the work has been seismic retrofitting and there remains a significant seismic retrofitting that we're doing the planning for now.

GARBER: This is the perfect lead-in to the story of your experience on the very first day on the job as CEO at Cedars-Sinai.

PRISELAC: I had been at Cedars-Sinai for 20 years previously but my first day as CEO was in 1994 on the day of the Northridge earthquake – the most significant earthquake Los Angeles has seen in the last 30 or 50 years or so. It's a good thing that I had been at Cedars-Sinai for 20 years or so before the earthquake, because coming in brand new to the organization would have been quite an adjustment.

The way the earthquake affected the campus was an interesting documentation of how engineering standards do make a difference and how they have changed over time. The main building held up quite well. We had a couple of broken pipes. The pathology department had a huge collection

of glass slides, which fell to the floor and broke. However, the structure itself was fine.

The original Mount Sinai Hospital was still standing then but had to be torn down, as did an employee parking structure and one of our old research buildings. Those buildings were built in the '50s. Fortunately, this building was engineered beyond what was required at the time. This speaks again to the vision and wisdom and investment that the leadership of the organization had at the time to go beyond what was really required.

The staff were terrific, as they have been for every emergency. We were a major emergency treatment center for people who were injured in Los Angeles. On a lighter note, two days later we had a meeting with all of the leaders of the organization and they handed out t-shirts that said, "I survived Tom Priselac's first day on the job."

GARBER: What does a disaster drill look like? Are there different kinds?

PRISELAC: We do have different kinds of disaster drills but being in Southern California, earthquakes are a commonly drilled scenario. This paid off at the time. Emergency drills of all types get you 60% of what you need at the time of a real emergency – which is not to underestimate that. There are always unknowns and unexpected things that occur, even with the best of emergency planning and scenario planning of one type or another. That's where the skill and ability of the individuals comes into play.

GARBER: Did the terrorist attack on September 11, 2001, affect Los Angeles?

PRISELAC: Yes, the terrorist attack in 2001 affected the entire country. Because Los Angeles itself was not on the receiving end of that, the degree of the emotional response in New York and Washington and Pennsylvania was much greater. We did go into a high-alert mode at the time, especially in the first 48 to 72 hours, before there was a sense of what had actually occurred as well as what otherwise might have occurred.

GARBER: Continuing along the theme of disasters and hard times, was Cedars-Sinai affected much by the Great Recession?

PRISELAC: Health care in general tends to be a little bit recession-proof because when recessions occur, many times individuals who are covered by commercial insurance typically have extended benefits for a period of time after they lose their employment. Whether or not there is an impact in any health care organization oftentimes depends on the length of the recession and it depends on in what ways the local economy is affected by the recession. For a hospital, it also a function of the payer mix that the hospital has.

Cedars-Sinai is the largest Medicare provider in the Western United States, and the largest by far in California – with a significantly higher Medicare population compared to other hospitals in the state, and we are in the top 15% of private hospitals for MediCal. The recession didn't affect the coverage for those individuals. In terms of the recession itself, the employer economy in Los Angeles is made up of entertainment, government employers, school employers and finance and professional services. Of those, the recession affected the financial services side the most. As a result, there wasn't an extraordinary impact of the recession on the hospital's activity level or our financial fortunes.

GARBER: We are recording this interview during the pandemic. How are you all doing at

Cedars-Sinai in these challenging days?

PRISELAC: Cedars-Sinai and our Marina del Rey Hospital, which is not far from Los Angeles Airport, treated the first known COVID patient in Los Angeles. It was a traveler from China, a husband, wife and their child, who were symptomatic. The screeners at LAX had them sent to Marina del Rey Hospital, which is a small community hospital, part of our own system down there. Those individuals quickly assessed the family and had them transferred up here. At that time, the existence of the virus was known but not much more, frankly. That began our experience with the pandemic.

We have actually had the highest census of any hospital in Los Angeles throughout the pandemic. That's in part a function of our size compared to many other hospitals in Los Angeles which are much smaller. Our pandemic-related census got as high as 350 out of 900 beds in the December 2020 to February 2021 period, when the big surge occurred here in Los Angeles. That's on the patient care side.

On the research side, we were part of all of the national trials with remdesivir and the various other medications that emerged as part of the treatment modalities. Our faculty members were active in educational scenarios around the country as everybody learned the most effective treatment protocols. We were very active in sharing that around the community.

In terms of where we are now, we're in the process of emerging but, unfortunately, we're not completely out. Many aspects of our patient care mission have largely returned to normal in terms of volume of cases we're seeing. At the peak, we had 350 cases a day. Now our COVID census is down between ten and 20 per day.

We are having a little boomlet right now related to the number of people unvaccinated and the Delta variant. The good news is, most of the people who are being treated are not as sick as those who were treated at the peak. As a result of the pandemic, we postponed some 3,000 otherwise necessary procedures, either diagnostic or treatment procedures, during that surge period. We have been working our way through that backlog of activity.

In our ambulatory physician network during the height of the pandemic, the use of telemedicine rose dramatically, with as many as 50% of the cases being done by telemedicine. Things have now come back a little bit to more of a formal situation. Still, 15% to 20% of our ambulatory cases are being done using some method of telemedicine.

The biggest challenge today has to do with the staff, who have been through an unimaginable amount of stress. We've tried to do everything we can to provide support for them, whether guaranteeing employment so that people don't fear losing their jobs, or providing housing nearby for individuals, especially in the beginning when they didn't want to go home and risk infecting their family members, or providing expanded child care support and family care support – a number of different things we've done, all of which I think have helped a great deal.

At the same time, we recognize that we have many, many people, many caregivers – physicians, nurses and others – who are going through a very demanding period. We're initiating a number of things on an ongoing basis to make sure they know we want to give them the kind of emotional and mental support that they may need during what has been the most challenging period in all of our

professional careers.

GARBER: What are one or two of those things that you're offering?

PRISELAC: Everything from having counselors come on site and meet with their staff on their unit and in their work areas, to providing telemedicine-based counseling services for individuals.

GARBER: Thank you, and your staff and your whole organization. Thank you for everything that you have been doing. It means so much.

PRISELAC: In 42 years, I have had the opportunity to see the organization respond to a number of challenging moments. As I shared with the staff here, I have never been prouder of the organization than I have been for the last 16 or 17 months.

GARBER: Returning to the topic of mergers, could you talk some more about corporate culture issues related to the legacy organizations, perhaps in terms of volunteers.

PRISELAC: Both organizations had strong histories of volunteer programs in the hospitals. Among the things that has really flourished in the post-merger era for the organization is our volunteer program. We have almost 4,000 people who volunteer here. That's a terrific example of what can come from a merger once the cultures are combined.

When I arrived here in 1979 – the building had opened in '76 – it was not uncommon at all for the conversation in the cafeteria to be, "Are you a Cedars person or are you a Mt. Sinai person?" It probably took until close to 1982 or 1983 before that kind of conversation and identity receded into the background and people started to think and talk more about themselves as a Cedars-Sinai person, as opposed to someone who had come from Cedars of Lebanon or come from Mt. Sinai. It takes time and you have to be intentional about how you build the new culture.

GARBER: Let's talk about governance. Has the size or structure or composition of the board at Cedars-Sinai changed over the years you've been in leadership?

PRISELAC: There are aspects of our governance that have changed and evolved in a good way over that time. One of the things that hasn't changed is the size of the board. For a variety of cultural reasons, Jewish hospitals are known for having large boards of directors. This goes back to that notion of maintaining a connection to the community or the value that comes from people in the community feeling like this is their hospital. One of the ways that this manifests itself is establishing a governance structure that has a large board.

Early on, before we made some other changes, that large size did become problematic. In the early days, the governance role for hospitals was not as complicated. In the early days, having a 42-person board was awkward and unwieldy but still manageable.

Among the things that has occurred over time has been the creation of an executive committee and the empowerment of that executive committee with the kind of practical day-to-day governance or monthly governance that needs to take place in an organization. It gives us the flexibility and nimbleness that's necessary to be able to respond and react and strategize in an increasingly complicated world.

We do keep the board that meets four times a year for that value of the ongoing connection to the community. Over the years, the size and number of our committees have also changed. There are a number of committees that we had at one time that aren't relevant today. For example, at one time, we had a building committee. In today's world, that's not so relevant. At the same time, other committees have evolved consistent with the changing times. At one time, we had an audit committee, and purely an audit committee. Now we have a corporate integrity committee to make sure that at the governance level we have the right kind of oversight, not only with regard to traditional audit work, but also with the full scope of regulatory challenges that are part of health care today. Over the years, the committee structure and size has evolved to try to meet the environment around us.

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

PRISELAC: The key to the success of any hospital or health care organization is the relationship between the board and the management of the organization. The two most critical individuals in that regard are the board chair and the CEO. The chair of the board has to be an individual who, by virtue of life, work experience and knowledge, understands what governance means in about as large and complex an operating organization as one can imagine. The board chair has to have that understanding of the type of institution it is by mission and by what it requires in order for the organization to be successful.

I think the chair of the board has to be an individual who is every bit as committed to the mission of the institution as anybody in the executive management of the institution and who, like them, models the values of the organization. The board chair has to understand the role of the board and the role of management. Done well, the board can be extremely effective at holding management accountable or delivering on the strategic plan and operating results of every aspect of the operation.

GARBER: Has your leadership style changed over the years?

PRISELAC: I'd like to believe the answer to that is yes because if you're not constantly learning and growing, you're not being as effective as you need to be. Having said that, I do think certain things have remained consistent at the same time. So what do I mean by both of those statements?

My core personal values and how I have tried to see those reflected in my behavior are the same today as the day I first walked in the building. I believe that to be the case. With regard to everything I say, you'd have to ask the people here! They're the ones who are able to answer that question! But all kidding aside, I learned from my parents – respect for everybody and treating everyone the same. I have a sense of integrity and set high standards for myself and therefore those who work with me. I also have a strong commitment to recognizing and acknowledging the incredible work that the people in the organization do. I hope those things are the same as when I walked in here and I hope they will remain that way until I leave.

What's changed? As my role has changed, a couple things. I've gotten more comfortable with change. As you move into roles in which you become more of a leader and less of a manager, you have to be more comfortable with ambiguity.

When I was younger, I had a stronger sense of what I thought was right. I had a conversation one day with Stu Marylander in which I was expressing frustration. I had some great idea, and I

couldn't seem to get people excited about it. He looked at me in the way that only he could and he said, "Look, let me do you a favor. One of the things you've got to learn is that being right's not enough."

I've played that back in my head over the years and I've come to appreciate the multiple different meanings in a valuable way. Recognizing that being right is not enough, that whatever your idea is, no matter how good it is, it won't go anywhere unless it's something that means something to the people who need to make it happen. I've gotten better at that.

Lastly, I've gotten better at holding people accountable, which was something that another mentor mentioned to me earlier in my career. If there is an art form to being a successful leader, it includes things like being able to properly hold people accountable – on the one hand, recognizing the achievement, but also being able to describe the opportunity for improvement and then providing the support to the individual to achieve the improvement that you might think is possible.

GARBER: I'd like to talk about the general topic of all of the work that a CEO typically does in volunteering for various professional organizations. You've served on a number of organizations – how did you fit all of that volunteer service into your busy schedule?

PRISELAC: I fit it into my busy schedule because I think it's fundamental to the job. I don't think that one can be the CEO of a major health care organization and not be involved in the kind of association work I've done.

One reason is purely a matter of professionalism, which was among the things I learned from Irv Goldberg and Dan Kane when I was at Montefiore. That's where it started, watching them and seeing how they spent their time. This was reinforced here at Cedars-Sinai in my work with Stu Marylander and with another mentor I haven't mentioned yet – Yoshi Honkawa – he's a legend.[4] Among other things, Yoshi taught me the value of being a mentor myself. I've tried to live up to that over the years. Yoshi has been very active in the association world, and I have him to thank for making the introductions and opening many of the doors that ultimately enabled me to participate in those organizations the way I have.

Participating in these organizations does two things – one, it gives me the opportunity to get advanced insight into changes that are occurring in the world that must be incorporated into our own strategic thinking here. That is a core job responsibility that is enhanced as a result of doing it. Also, I sometimes joke that I've had the chance to have this job as a way of satisfying my core interest in health policy questions. Interest in the broader health policy issues goes back to my original decision to get a degree in health planning.

GARBER: I'd like to ask about the AAMC – the Association of American Medical Colleges.

PRISELAC: The Association of American Medical Colleges is an advocacy organization and a professional development organization for academic medical centers and the people who work in them. Its constituency includes the deans of medical schools, the faculty of medical schools, the

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[4] Yoshi Honkawa (b. 1924) served in leadership positions at Cedars-Sinai Medical Center (Los Angeles) from 1975 until his retirement in 2001. [Leadership through relationships. (2014, March 22). *Modern Healthcare*. https://www.modernhealthcare.com/article/20140322/MAGAZINE/303229936/leadership-through-relationships]

researchers and the CEOs of the hospitals themselves or the health systems that are responsible for the academic medical centers around the country.

The organization serves in an advocacy role exactly the same way as AHA, but in this case, specific to the unique interests and issues that academic medical centers face. As a professional development entity, it has a variety of membership organizations and sub-councils for which individuals participate based upon their own professional interests.

They develop and administer the medical school admissions test program used by U.S. medical schools. From a professional guidance standpoint, they are involved in curriculum development, both for medical students as well as for graduate medical education (GME) programs. They work in concert with the other relevant regulatory agencies, whether it's the Liaison Committee on Medical Education (LCME) or the Accreditation Council for Graduate Medical Education (ACGME). LCME is the entity that accredits medical schools. The ACGME is the entity that accredits graduate programs. They work hand-in-glove with them, trying to make sure that on the one hand, the regulatory environment is holding the medical schools and teaching hospitals appropriately accountable but also preventing those entities from overreaching when it comes to the regulatory side of things.

GARBER: How is leadership at AAMC structured?

PRISELAC: AAMC has three major constituency groups, the Council of Deans, the Council of Teaching Hospitals (COTH) and the Council on Faculty and Academic Societies (CFAS). I served on the Council of Teaching Hospitals for several years, ultimately becoming Chair of COTH. Subsequently, I started on the top governing body for the AAMC and in that role served as Chair of the AAMC for the year as well.

GARBER: I'd like to ask about your experience on the board at AHA. That is an intense commitment with a lot of travel.

PRISELAC: My overall experience at AHA has been enjoyable and professionally rewarding and has helped my professional development. I think that experience has been among the most helpful of all the ones I've had. This includes serving on the Regional Policy Board, task forces, and then serving on the board and as chair of the board.

We talked a little while ago about the governance process. A lot of my thinking about good governance was strongly influenced by what I saw at the AHA and trying to bring back some of those concepts here and adapt them rightfully to the particular circumstance here, because it's a different kind of organization. From that standpoint, it was extremely valuable.

It was a great object lesson in building consensus, which is a big part of what this job is here. In the case of the AHA, building consensus requires doing so among the largest constituencies an organization can possibly have. On the content side, as I said earlier, I have strong personal interest in health policy matters. I was fortunate enough to be given opportunities on task forces and otherwise on the board to have a hand in critical health policy issues. The pinnacle of this was that I was chair the year when the ACA was in development. The Affordable Care Act was passed as legislation and signed by President Obama in March 2010 but the work to fashion it had occurred in the 12 to 18 months leading up to that. It was a once in a lifetime opportunity to be involved in that process at a level that I never imagined I would have the chance to do.

My chair elect year was during President Obama's first term. Among the things that he campaigned on was the issue of expanded access to health care. Given that this was going to become a hot political item, AHA rightfully engaged in the internal process that ultimately led to the development of AHA's policy positions used during the ACA negotiations.

A big part of that was reflected in the document called "Health for Life."[5] This was the articulation of guiding principles that AHA went through in an organization development process across the membership to get agreement on those principles and then make use of them as the ACA when through the political process. They were used as a sounding board and a reference point with membership to ultimately secure the support and agreement of the membership for where the AHA ended up.

All of us who were involved in leadership at AHA were rightfully proud, not just for where the ACA ended up. Holding the membership together at the same time was as challenging. The same differences of opinion and political differences that played out in the development of the ACA, and in some regards has haunted the ACA in the ten years since it was passed, those same politics exist within the membership in some regards. There were two separate but very important related tasks – one was to keep support among the membership for the policy position ultimately developed, and two, to continue to keep support among the membership for AHA as an organization so that it could continue to be effective. We were able to succeed at both of those.

GARBER: What a terrific experience that must have been.

PRISELAC: It was invaluable. It was terrific in every way. There have been multiple times I've said to myself, "How does a kid who grew up in Turtle Creek, Pennsylvania, end up across the table from the President of the United States telling him what I think he should do to make sure American health care is affordable and accessible and high quality?"

On the other hand, I was also on the receiving end of a not very pleasant phone call from a politician who will remain unnamed. As the provisions were being debated, he called to pressure me to have the AHA back off of its support. That's part of the process. That's part of the story of how politics in America works.

The involvement with AHA at that time is among the things I'm most proud of in my career. The biggest question in passing the ACA was how it was going to be paid for. Part of the process was getting the various health care constituency groups, (hospitals, physicians, device manufacturers, health plans. pharmaceuticals, etc.) to agree how they would forego sources of revenue that would otherwise come to them if the existing system remained in place.

In the course of developing the act, hospitals were asked to forego $150 billion in Medicare revenue that otherwise was forecasted to come over a ten-year period so that the Treasury could take that money and use it as part of the funding source to expand coverage for 40 million Americans who were then uncovered. I've joked with my colleagues over the years that my tombstone will read, "He

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[5] Health for Life documents include: American Hospital Association. *Health for Life: Focus on Wellness.* Fall 2007. https://www.aha.org/system/files/content/00-10/071204_H4L_FocusonWellness.pdf; and, American Hospital Association. *Health for Life: More Efficient, Affordable Care*. Fall 2007. https://www.aha.org/system/files/2018-02/071204_H4L_Efficient_Affordable_0.pdf

presided over the largest reduction in Medicare payments in the history of hospitals." It was in service of the right cause. It was the right thing to do.

GARBER: It's a little wordy.

PRISELAC: It will be a big tombstone.

GARBER: In closing, is there anything else you'd like to say about your family?

PRISELAC: Meeting Jody changed my life. The love and caring and support that she's provided to me over the years is beyond description. Literally and figuratively, I wouldn't be here today without her. She's my reason for existence. Along the way in my professional life, she's kept me sane at the most challenging times. She's held me accountable to myself and to what it is that I say I believe in.

She has done the things that one's partner needs to do to allow both of us to feel successful as parents as we've both pursued our own successful careers. She started out as an advanced placement math teacher, then moved on to UCLA, leading what they call Center X over there, which is the educational equivalent of an applied medical research center. For the last ten years or so she has served as associate dean, responsible for community relations and programming in the Education School. She has been a role model for me professionally as someone who has lived her personal and professional values. She is an ardent believer in the importance of public education and equity in public education. She's been an inspiration.

Whatever work/life balance I've achieved has only been made possible by what she has brought to our relationship. Work/life balance is something you need to work at. There is no perfect state where you are going to say to yourself, "I've reached work/life balance." What's more important is to be intentional and at the end of the day satisfy yourself. Have I come reasonably close to making the decisions that are consistent with what I tell myself I believe?

It was important to me to be there for my sons when they were growing up. I was the chief operating officer for part of that time, and then CEO when they were still in their formative years. I made the time to coach their baseball and soccer teams and made sure I was part of their lives. At the same time, I know there are things I missed that I wish I could have been involved in, and the whole family has had plans disrupted in one way, shape or form. I have had to leave family vacations to fly back or fly somewhere for something that was urgent. I've tried to do what I advise others to do, which is be intentional and honest with yourself and try to make decisions that are consistent with what work/life balance means for you.

GARBER: Thank you for your time this afternoon. It's been a privilege and a pleasure.

PRISELAC: Thank you, I appreciate it. I really am grateful for the opportunity.

EDUCATIONAL & PROFESSIONAL CHRONOLOGY

1973 Washington and Jefferson College (Washington, Pennsylvania)
Bachelor of Arts, Biology

1975 University of Pittsburgh, Graduate School of Public Health
Master of Public Health, Health Services Administration and Planning

1975-1979 Montefiore Hospital (Pittsburgh, Pennsylvania)
- 1975-1977 Ambulatory care manager
- 1977-1979 Assistant administrator

1979-present Cedars-Sinai (Los Angeles)
- 1979-1980 Assistant administrator
- 1980-1982 Associate administrator
- 1982-1983 Senior associate administrator
- 1983-1985 Vice president administration
- 1985-1988 Senior vice president operations
- 1988-1993 Executive vice president
- 1994-present President and Chief Executive Officer
- 2017-present President and Chief Executive Officer, Cedars-Sinai Health System

2003-present UCLA Fielding School of Public Health
Adjunct Professor, Department of Policy and Management

2007-present University of Pittsburgh Graduate School of Public Health
Adjunct Professor, Health Policy and Management

SELECTED MEMBERSHIPS AND AFFILIATIONS

American Hospital Association
- Chair, AHAPAC
- Chair, Committee on Nominations
- Chairman, board
- Member, board
- Member, Task Force on Variation in Healthcare Spending

Association of American Medical Colleges
- Chair, board
- Chair, Council of Teaching Hospitals
- Member, AAMC Executive Council
- Member, Advisory Panel on Healthcare
- Member, COTH Administrative Board
- Member, Future of GME Financing Advisory Group

Berkeley Forum – Improving CA's Healthcare Delivery System
- Member

Blue Cross of California
    Member, board

Blue Cross/Blue Shield Association
    Co-Chair, Care Delivery Leadership Collaborative

Cal eConnect
    Member, board
    Member, Business Advisory Group

California Healthcare Association
    Chair
    Member, board
    Member, executive committee

California Healthcare Foundation
    Member, board

California Regional Healthcare Information Organization
    Member, board
    Member, steering group

California Task Force on Affordable Care
    Member

Center for Corporate Innovation
    Member

Center for Medical Interoperability
    Member, board

Charles R. Drew University of Medicine and Science
    Member, board

Healthcare Association of Southern California
    Chair
    Member, board
    Member, executive committee

Healthcare Executives Study Society
    Member

The Healthcare Forum
    Member, Advisory Committee for the Power of Quality: Leadership Strategy for Business Success
    Member, Convention Program Advisory Committee
    Member, Long-Range Planning Committee

The Joint Commission
    Member, Center for Transforming Healthcare Leadership Advisory Council

LA Healthcare Options Task Force of the California Endowment
    Member

Los Angeles Area Health Services Research Training Program Advisory Committee
    Member

Los Angeles Chamber of Commerce
    Chair, Healthcare Committee
    Member, board
    Member, executive committee
    Member, Health Issues Executive Committee

The Los Angeles Coalition for the Economy & Jobs
    Member

Los Angeles County Economic Development Corporation
    Member, board

The National Academies of Sciences, Engineering and Medicine
    Member, Roundtable on Quality Care for People with Serious Illness

National Committee for Quality Health Care
    Member, board

National Quality Forum Ad Hoc Committee on Cost/Price Transparency
    Member, board

Presidential Commission on Systemic Interoperability and the Use of Information Technology in Health Care
    Member

The Queen's Health System and The Queen's Medical Center
    Member, board

RAND Health Advisory Board
    Member

Society for Health Service Administrators
    Member

The Society of Thoracic Surgeons (STS) and the American College of Cardiology (ACC)
    Member, TVT Registry Stakeholder Advisory Group

Southern California Biomedical Council

Member

Southern California Leadership Council
Member, board

UCLA Fielding School of Public Health, Department of Health Policy and Management,
Los Angeles Area Health Services Research AHRQ Funded Training Grant
Member, Advisory Committee

University of Pittsburgh Graduate School of Public Health
Member, Board of Visitors

University of Southern California
Member, Schaeffer Center Advisory Board

VHA. Voluntary Hospitals of America
Member, board of directors

VHA West Coast
Chair
Member, board

Washington and Jefferson College
Member, board

AWARDS AND HONORS

1987 Emerging Leader, Healthcare Forum / Korn Ferry

1995 Distinguished Alumni Service Award / Washington & Jefferson College

2001 Health Care Leader of Today / UCLA Health Policy & Management Alumni Association

2001 Industry Person of the Year Health Care / Los Angeles Business Journal

2001 President's Council Award / The Los Angeles Free Clinic

2002 Walker Fellowship Award / California Healthcare Association

2005 Mathies Award Recipient, Vision and Excellence in Healthcare Leadership / Partners in Care Foundation

2005 Warschaw Law Endowed Chair in Health Care Leadership / Cedars-Sinai Medical Center

2006 National Healthcare Leadership Award / B'nai B'rith

2007 Board of Trustees Medal of Honor / Charles R. Drew University

2007 Legacy Laureate Award / University of Pittsburgh

2007 National Healthcare Leadership Award / National Center for Healthcare Leadership

2007 Southern California Leader of the Year Award / Southern California Leadership Network

2008 Distinguished Service Member / Association of American Medical Colleges

2011 Award of Merit / California Healthcare Association

2011 Healthcare Icon Award / Los Angeles Business Journal

2012 Distinguished Community Champion Corporate Leadership Award / Special Needs Network

2013 Distinguished Business Leader / Los Angeles Area Chamber of Commerce

2014 Distinguished Service Award / American Hospital Association

2014 Ludlum-Gamble Award for Leadership, Vision and Commitment / National Health Foundation in association with the Hospital Association of Southern California

2018 ICONS Award: LA's Most Influential Leaders / Los Angeles Business Journal

2020 Outstanding Humanitarian Service Award / American Society for Yad Vashem

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INDEX

American Hospital Association, 14, 15
Association of American Medical Colleges, 13, 14
Cedars of Lebanon Hospital (Los Angeles), 7
Cedars-Sinai (Los Angeles), 7, 8, 9, 10, 11, 12
Certificate of need, 4
Disaster planning, 9
Economic competition, 5
Economic recession, 9
Employers, 4
Goldberg, Irwin, 5, 13
Governing board, 11, 12
Health for Life (report), 15
Health personnel, 10, 11
Health planning
  areawide planning, 3
Honkawa, Yoshi, 13
Hospital design and construction, 7, 8
Hospitals
  Jewish, 4, 5, 7
  opening new, 7
Kane, Daniel A., 5, 13
Leadership, 6, 12, 13
Marina del Rey Hospital (California), 10
Marylander, Stuart J., 7, 12, 13
Montefiore Hospital (Pittsburgh), 3, 4, 5, 13
Mount Sinai Hospital (Los Angeles), 7, 9
National Health Planning and Resources Development Act, 3, 4
Northridge earthquake, 8, 9
Obama, Barack, 15
Organizational culture, 11
Pandemics, 10, 11
Patient Protection and Affordable Care Act, 15, 16
Patients' rooms, 7
Priselac, Jody Ziccardi, 6, 7, 16
Telemedicine, 10
University medical centers, 5
University of Pittsburgh
  Medical Center, 5
  School of Public Health, 3