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AMIR DAN RUBIN: SUCCESS FROM THE BEGINNING

I've never seen a CEO come in like Amir and fundamentally change the culture as he has and as fast.

— David Haray, Vice President, Patient Financial Services

We told him, "The university's on a strong trajectory and we want this hospital to be on that same trajectory and take it to the next level," and that's what he's done.

— Mariann Byerwalter, Chair of the Stanford Hospital Board when Rubin was hired

Anybody can build a plan. Most people build reasonable plans. It's making it happen. The push towards making it happen is what has differentiated Amir from other CEOs.

— Sridhar Seshadri, Vice Present, Cancer and Cardiovascular Service Lines

Managing physicians may be impossible…it's like herding cats, it's a thankless job, and best of all…it's impossible. [1]

— Philip Betbeze, Senior Leadership Editor at HealthLeaders Media

In November of 2010, the board of Stanford Hospital and Clinics announced that Amir Dan Rubin, at the time chief operating officer of the UCLA Hospital System, would become CEO at Stanford on January 3, 2011. Rubin would replace Martha Marsh, who had served as CEO for eight years and was retiring.

Rubin's career had been focused on health care and hospital administration (see **Exhibit 1** for a brief summary of Rubin's background). He was taking over what *Becker's Hospital Review* [2] listed as the fifth-largest grossing nonprofit hospital in the country and doing so at a crucial moment in its history and evolution. In 2010, Stanford was still negotiating with the city of Palo Alto over plans for building a new $2 billion facility. Like many of the hospitals in the San Francisco Bay Area, Stanford's existing structure did not meet California's current seismic

[1] http://www.healthleadersmedia.com/page-1/LED-291313/Managing-Physicians-May-Be-Impossible.
[2] http://www.fiercehealthcare.com/story/ceo-compensation-rates-10-highest-grossing-non-profits/2014-03-12.

Professor Jeffrey Pfeffer prepared this case as the basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

safety standards, a set of requirements that had triggered a boom in new hospital construction. Medical facilities tend to generate a lot of automobile traffic and Palo Alto was using the approval process as a way of extracting compensating resources. Interestingly, the hospital and the Stanford shopping center were the only parts of the Stanford campus in the city of Palo Alto. As noted by Mark Tortorich, vice president of planning design and construction and the person in charge of the hospital building project, the line demarcating the city of Palo Alto from unincorporated Santa Clara County ran between the hospital structure and adjacent classroom buildings. As part of the hospital construction project, the new CEO would be inextricably drawn both into the project's myriad details and also into the capital campaign to raise the dollars required.

Stanford Hospital was emerging from a period of financial stringency. Rubin's predecessor had been brought in specifically to staunch the bleeding of a hospital running budget deficits. Her task also entailed recovering from the aftereffects of a two-year failed merger with the hospital at the University of California-San Francisco. [3] The merger had been an attempt to enhance market negotiating power and also achieve various economies of scale. The merger's failure and subsequent unraveling left both UCSF and Stanford facing significant financial losses.[4]

By 2010, the medical center's financial results had improved and the organization was stable. As described by Todd Prigge, director of training, organization development, and talent management, "I would say that things were kind of rolling along at a steady pace. Everybody was doing good things and working on what they thought were the right things. But things were slow and methodical, sort of what might be pretty traditional for an academic medical center."

However, Stanford Hospital still faced some challenges. One issue was its orientation toward patient care. Academic medical centers have the tripartite objectives of conducting research, educating students, and providing patient care. Different institutions emphasize each priority to differing degrees. Stanford had been interested in pursuing intellectually challenging patient care and leading-edge research and publication. As one administrator who had worked in the system for almost two decades commented, "Stanford conveyed the attitude that you as a patient should be thankful that the hospital had deigned to treat you." Philip Pizzo, dean of the medical school at the time of Rubin's hiring, had come to Stanford from Harvard more than a decade before. He commented, "When I was coming to Stanford from Boston, a number of people said to me that 'Stanford medicine looks a lot better the further you are from it.' No one ever doubted Stanford's excellence in research. But the culture at Stanford had not consistently placed excellence in clinical care on a par with excellence in research in how it assessed or rewarded faculty."

Patient satisfaction scores were low, and so, too, were many other measures of hospital operational performance, including the frequency of hospital-acquired infections. With changes in the competitive landscape as health systems competed more actively for patients, evolving reimbursement practices that emphasized quality outcomes, and healthcare reform's emphasis on

[3] "The Anatomy of a Failed Hospital Merger," *Stanford Alumni*, January/February 2000, https://alumni.stanford.edu/get/page/magazine/article/?article_id=40228.

[4] Philip A. Pizzo, "Case Study: The Stanford University School of Medicine and Its Teaching Hospitals," *Academic Medicine, 83* (9), 2008, 867-872.

accountable care, Stanford hospital would need to change. It could ill afford to maintain an orientation that had traditionally eschewed an emphasis on primary care.

To make the task of cultural change more challenging, as the hospital CEO, Rubin had no line authority over a significant and very important fraction of the hospital's revenue-generating personnel and providers of care—the Stanford Medical School-based physicians who practiced in the hospital. When Stanford Medical School first moved to the campus from San Francisco in 1959 and the university built the hospital, the hospital primarily served community physicians. "In the early 1960s, faculty physicians provided care for fewer than a third of the patients admitted to Stanford Hospital." [5] By the late 2000s, medical school faculty cared for more than 80 percent of hospital patients and the proportion was continuing to grow.

Those medical school physicians reported through their department chairs to the dean of the Medical School, who, in turn, reported to the president of the university, John Hennessy. As Rubin noted, he did not formally report to Hennessy but his boss was the board that had hired him. Stanford Hospital had its own governing board, and although there was some overlap in membership with the university's board of trustees (for instance, Byerwalter had been on both boards at the same time), the composition of the boards differed. Lucille Packard Children's Hospital, also part of Stanford University and located close by, had its own CEO and its own board as well. The hospital that Rubin oversaw and the medical school that furnished the doctors who performed most of the patient care were formally quite separate entities. This governance structure was different from some other academic health centers that had a single leader.[6] Notwithstanding the separate governance and reporting relationships, obtaining the engagement and cooperation of the medical school physicians and particularly the department chairs and deans would be crucial to any improvement efforts.

By late fall of 2014, as Rubin was completing the fourth year of his tenure, Stanford Health Care—the organization was renamed—was a medical center truly transformed. Revenues had increased by about 50 percent from when he had taken over and operating profits had almost tripled. These financial improvements had been achieved in the face of increasingly intense competition from regional multi-hospital medical systems such as Sutter Health, Kaiser Permanente, Dignity Health (formerly Catholic Healthcare West) and also growing competition from UC San Francisco with its new hospital and other facilities in Mission Bay (see **Exhibit 2** for selected financial data for Stanford Health Care). All of these hospitals and systems, including Stanford, were building medical offices throughout the region, and all advertised regularly on both radio and television and engaged in other marketing initiatives to build their brand and attract patient revenues.

Patient satisfaction scores had moved from the mid-40th in national percentile rankings to the mid-90th percentile, and other measures of the hospital's operating performance were also for the most part now in the 90th percentile. (**Exhibit 3** presents data on two illustrative measures of patient outcomes: survival rates for Stage IV metastatic breast and colon cancer, comparing Stanford's results to national benchmarks.)

[5] Ibid., p. 868.
[6] Ibid.

Stanford Hospital had also received numerous awards and recognition, not just for clinical excellence but also for its information technology and other performance outcomes. (**Exhibit 4** lists some of Stanford Hospital's awards and recognition.)

Accompanying these improved operational and financial results, and in large measure responsible for them, Stanford hospital's culture had changed. It was much more patient-centric. It was much more collaborative with fewer departmental silos. There was a greater sense of energy and urgency. Rubin and his team had installed many lean and total quality management practices and were working on numerous process improvements. In July, 2014, the hospital had adopted a new name, changing from Stanford Hospital and Clinics to Stanford Health Care.

As an outsider to Stanford and a non-physician leading an academic medical center, Rubin had, by all accounts, done an exceptional job of building credibility and engagement with established Stanford power-holders. He had accomplished a great deal of fundamental operational improvement and cultural change, and had enhanced the hospital's performance along numerous dimensions. As Rubin reflected on his transition into Stanford, he thought about what he needed to do next to continue the hospital system's trajectory and avoid any letdown. And he also wondered to what extent the principles that had guided his management approach at Stanford Health Care might be transferable to other, non-hospital settings.

IN THE BEGINNING

Rubin arrived at Stanford with the intention of building upon what he had done at UCLA, but with the benefit of that experience, more quickly and at a higher level. As with all organizational change efforts, he needed to figure out where to begin and what to do first. He began with a focus on patient care and the patient care experience.

Patient Experience Focus

There were practical reasons to begin with a focus on patient care. As Kety Duron, vice president of human resources explained, by the time Rubin arrived in 2010, there were all sorts of online ratings and outcomes information, and people were sharing their experiences using social media. Potential patients could go online and see Stanford's patient satisfaction scores and even some clinical outcome measures and compare Stanford's scores to those of other hospitals. Brand image counted, but so, too, did actual performance. If Stanford was going to compete successfully with entities such as the Palo Alto Medical Foundation (part of Sutter Health), it would need to move decisively into primary care and enhance both the clinical outcomes and the experience of its patients.

There were also some strategic and cultural change reasons that argued for an early focus on the patient experience. Sridhar (Sri) Seshadri, who was already working at Stanford in a senior management role, commented on how Rubin introduced the focus on patient experience and why that was such a smart place to start the cultural transformation:

> The first meeting we had was joined by the vice chair of the board, John Levin, who is now the chair, who sat next to Rubin. There were maybe five or six people in the room. And someone asked Rubin, 'So what will be our strategy?'

> The new CEO is coming in and you've got to ask the big strategy question. And his response took people aback. He said, 'We are here to improve the patient experience.' And we go, 'Really?' I don't think anyone said that out loud because he was our new boss, but later people talked about it. The clarity of his vision stuck in our minds.
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> Later on in the first monthly managers' meeting with about 300 people, he said, 'I'm Amir Dan Rubin. I'm the new CEO. When the board chair and the committee recruited me, they asked me what my strategy was. And I told them we are here to improve the patient experience.' He laughed and continued, 'You must be wondering, "So they hired a guy just to improve the patient experience?" What were they thinking?' And there was a ripple of laughter in the room.
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> With that simple strategy you can put a lot of stuff behind it. Amir has very effectively used that as the head of the arrow and he has pulled a lot of other things behind it—operations improvement, increases in patient satisfaction, building a new hospital and a cancer building in the South Bay, doing the Valley Care hospital acquisition in the East Bay. The way he framed the entry point for SHC was remarkably clear, and it had the purity of simplicity.

Moreover, as numerous people commented, who could be opposed to improving the patient experience? People could argue about the importance of growth or the relative priority on research. But no one could argue about the importance of patient care and the patient experience. It was something that everyone could rally behind and was also a strategic priority of the board that had hired Rubin.

How to improve the patient experience? By changing behavior. Seshadri explained, "We had the tradition of showing monthly scores. Rubin nixed it. He said, 'Nothing is going to change until we actually do something.' So he shifted the focus from outcome metrics to tangible improvements—both in processes and behaviors—that were relentlessly measured with process metrics."

Rubin introduced something he had used at UCLA, a mnemonic, C-I-CARE, that would, over time, become embedded in how hospital personnel interacted with each other, with patients, and with patients' families. He had laminated cards made. One side contained the hospital's new mission and vision. The other side presented C-I-CARE behavioral standards. **Exhibit 5** presents the information from that card. Rubin also made sure all hospital employees had business cards and they were instructed to hand them out to everybody they encountered in the hospital. People needed to be able to find each other, and patients needed to be able to readily contact hospital personnel.

There was yet another advantage of the early focus on the patient experience: it was an outcome where improvements could be achieved fairly rapidly and were objectively measurable by the patient satisfaction scores. Consequently, within months of Rubin's arrival, there was a significant difference in those scores, an improvement that everyone could take pride in.

To introduce C-I-CARE and to have people focus on the patient experience, Rubin used an exercise to have hospital people begin to see the organization from the patients' perspective. He related:

> So it was my first management meeting, my first week on the job. We have these once a month. We have hundreds of people get together from all of our locations. And I said, 'Don't worry, we're going to get back to the usual boring management meeting, but today, my first week, we're going to do something different.' I put everybody at tables and we gave them all a case study at their table to work on and discuss. One was: You're at work and you get a call, and your wife, or mother, or some other loved one is being rushed to Stanford Emergency Department. You're fighting traffic and you're frightened. You arrive here. What do you want to happen? And people said, "I want people to greet me, to bring me right in, to keep me informed, to understand my state of mind." And I said, 'Great. So why don't we do that?' And after some nervous laughter, I said, 'The charge is to implement what you discussed, to improve the patient experience so it would be just like you described—as something you would want to happen to you.'

Rubin proceeded to roll out C-I-CARE throughout the hospital and the clinics. Todd Prigge described the roll-out process:

> At the March, 2011 managers' meeting, Rubin and the executive team said that by tax day, April 15, they wanted every department to turn in their templates. And C-I-CARE templates for housekeeping could be, how would someone enter the room? How would one greet the patient? If someone were transporting a patient, what would they say? There were 104 departments, each with a specific template, that were created by April 15. And Rubin read and commented on each and every one.
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> In May, we began to put together a training program and created some videos. And in May we began to do a half-day training session for all of our managers. And then starting in June and running through September, each manager trained all of his or her employees. So by the end of September, literally everyone at Stanford Health Care was trained in C-I-CARE. In October, we began offering C-I-CARE recognition, and then we offered the first refresher course on C-I-CARE. And then we began to layer in active daily management, our approach to daily management and improvement. And in November we introduced MD C-I-CARE. And in December, we introduced manager rounds, where all 600 managers would meet in an auditorium. Amir would facilitate those sessions. And everyone was assigned a department, and then everyone would go into the hospital and round and have conversations with staff about what their understanding was of C-I-CARE, ask if they had been trained on C-I-CARE, and directly speak to patients and families to hear their perspectives.

Fix Small but Important Things

As Rubin noted, most organizations have irritants—small, seemingly trivial things that bother people. Many of these things do not cost a fortune to fix, but people will appreciate it if you attend to them, in large measure because such actions demonstrate that you are listening and that you care.

Dr. Ronald Dalman, the head of the vascular surgery group in the department of surgery, shared two examples. Stanford's hospital buildings were slated for demolition once the new structure was finally completed. The focus in the hospital for the past decade had been on cost-cutting and not spending more than necessary. These two factors, the cost focus and the fact that the building was not going to be used for that much longer, had led to deferred maintenance. Dalman continued:

> Where our divisional offices are, we're right underneath the helicopter landing pad. So multiple times a day, a big, heavy helicopter comes and lands on the roof on top of our offices. For at least three years, maybe longer, we had constant issues with a leaky roof. That's not going to kill a patient, but it makes for a really depressing work environment. One of my partners had this tube coming out right in the middle of his office, out of the ceiling tiles. It was a big piece of plastic collecting all the water into a tube that went into a bucket in the middle of his office that the cleaning people would empty every night when it rained. No one was willing to commit money required to put a new roof on the hospital. Within six months of Rubin being here, there are guys up on the roof and the roof got fixed. He has a holiday party at his house every year for health system and faculty leadership. At the first party I went to, I told Amir, 'Look, I know this isn't the biggest problem you're facing, but all of us are very grateful for you actually fixing the roof.'

Dalman had another example of Rubin's attention to the small things that mattered a lot:

> In our practice, 40 percent of our patients come from more than 50 miles away, many of them from the Central Valley. When they started the hospital construction, there was a parking structure that got taken out. I don't know that anybody really understood the scale of the disruption of the parking flow and access issues. We had patients waiting 45 minutes on Sand Hill Road just to pull into Stanford to try and get to the clinic. I had patients asking me, 'Can you see me at Sequoia Hospital because I can't keep coming back here, it's too much trouble.' We sent the message up the chain of command that this is a crisis, and it's going to affect the bottom line. Within a couple of weeks we had this valet parking service, ambitious and at scale. There's no line now. They moved quickly to address the problem. I don't know that everyone would pay as much attention as the current leadership does.

Rubin and his team also understood that if they asked a lot from the workforce, they needed to take care of that workforce. That included providing good human resource services. Kety Duron had worked with Rubin at UCLA. In Rubin's third year in the job, he recruited her. She

commented, "I was at UCLA for 27 years and I was never going to leave UCLA. But following Amir was definitely one of the reasons that I came to Stanford."

The HR office had been moved to Embarcadero near highway 101. When Duron arrived, she went to the office. "There was no reception area, the front door was locked, and there was no one there to open the door for me." There was a phone tree that made it impossible to reach an operator no matter how many times you punched "0." Duron soon got rid of the telephone center. She also made HR more accessible. She related an experience that shaped her thinking and approach:

> The first week I'm here, it was around the holidays, I walked outside the office. There was a gentleman standing there. He gave me a napkin with a note on it and said, 'Would you mind giving this to the HR people?' And I said, 'Sure. Why?' He said, 'My wife had a baby and the baby is sick. I have been trying to call, and nobody's answering, and I am knocking on the door and nobody's answering the door.'
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> And I thought to myself that day, 'We're changing this. We are going to open the doors. We are going to open the windows. We are going to be the HR for Stanford Health Care.' And my approach is, if a nurse is calling you, you better get that person an answer during that first phone call. That nurse is going to possibly take care of your mother or some other patient. The nurse doesn't need to worry about calling four numbers that you just gave her to resolve whatever problem she's having.

And so HR operations improved to provide better service to the hospital's workforce.

Visible Management

Stanford Health Care is a large, complex institution, invariably facing budget and staffing constraints. People are very busy doing their jobs. But Rubin wanted people to get to know each other and, more importantly, get to know the hospital and clinics—not as represented in numbers or charts, but the real hospital and clinics that people were experiencing. Doctors, of course, make rounds. Rubin decided that administrators would make rounds, also. Twice a month, senior leaders, not just from the patient-facing departments but everybody, makes rounds in the afternoon and evening. And Rubin goes on the rounds himself and typically facilitates the sessions. Twelve months in a year, twice a month, means that there are 24 rounds. Rubin is on most of them.

People "rounded" with different people and so got to know others from different departments. But the rounds weren't just "cruising" the hospital. They were designed to see problems and issues close up, to see what was working well and what was not, and to have leaders all the way to the highest levels available randomly to talk to patients and staff at all levels, to hear stories and get feedback.

Rubin and everyone else in senior executive positions made sure they promptly answered e-mails and phone calls from staff. They attended departmental meetings. They were everywhere. Rubin explained his thinking:

> One of the ways to lead change is to be the way you want things to be. Patient experience has been a big focus. I was here five-thirty, six o'clock in the morning, in the afternoons, and in evenings making rounds, talking with staff, talking with patients. This helped with institutionalizing our C-I-CARE rounds. Of course, being here in the morning and on night shift, 7, 8, 9 p.m., people say, 'Hey, this guy's out here and he knows us. He cares about what we have to say.' And not just me, but the people on our team.
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> And the other thing that I do is related to my service mentality—anybody can contact me on anything and I try to have a very fast turnaround time. So, be service-oriented. It doesn't mean you can always fix something, but you can always listen and try.

Yet another aspect of visible management was "going to the gemba," which is Japanese for "at the site" or "the real place," the place where work is completed. The term comes from Taiichi Ohno, a Toyota executive, and is part of the lean production system methodology.[7] Going to gemba entails going to where the work is done to ask questions, observe, and solve problems where they occur. Honda's description for this practice was actual part, actual place, actual situation.[8] The idea was that if people held a problem-solving meeting in a conference room, they necessarily dealt with a mental abstraction, an imperfect recollection of the real situation. So going to gemba entailed first-hand observation and problem solving of situations as they occurred and where they were happening.

All work groups were encouraged to have daily huddles—short, five-to-ten-minute meetings at the start of a shift in which people would check in with each other to anticipate problems, review issues, and make a plan for what they would try to accomplish on the next shift. Huddles were to be held near the "visual wall," the place where the unit's performance indicators were displayed in charts and graphs.

Participation in C-I-CARE, rounding, gemba visits, daily huddles, and one other activity, linked check-ins—in which people would meet with their direct reports and so on down the line to communicate in-person about issues and goals—meant there were a lot of face-to-face meetings and a great deal of communication. This communication helped to create alignment around the health system's goals as well as a common understanding about what the most important issues and challenges were, not just globally but in each operating unit. Moreover, all of this communication increased the sense of personal engagement and people's commitment to the activities of the hospital and clinics because employees knew what was happening and felt involved in the process.

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[7] http://en.wikipedia.org/wiki/Gemba/

[8] http://money.cnn.com/magazines/business2/business2_archive/2014/12/01/8192518/

Create the Expectation That Success (and Change) Is Possible

Rubin seldom gave a presentation that did not begin with a list of Stanford's accomplishments in medicine: eight Nobel Prizes in life science and medicine, ranked among the top two medical schools by *U.S. News and World Report*, first linear accelerator for cancer radiation treatment, the U.S.'s first heart transplant and the world's first heart-lung transplant, development of the Cyberknife for radiosurgery—and the list goes on. The implication: this is a great place with fabulous accomplishments in many ways, so great accomplishment in clinical care and patient experience is possible, too.

Rubin commented, "I wanted to communicate that I'm honored and privileged to be a part of this amazing institution. I see how special it is, and I want to help make it great. And I want to help make it great on all our missions." He went on:

> As I say today, you're always selling. 'We can do it. We've got to do it.' So alignment to the vision is important, because so many people don't report to me. And delivering some wins, some improvements. Maybe we need some new furniture. Maybe we paint some walls. Maybe it's letting somebody talk to you, but trying to be responsive. And you're not going to fix the core problems that way. But it shows that you're going to be action oriented, you're going to respond. And also it's closing the loop.
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> Saying, 'Here's what I'm hearing from you. Here's what I think we need to pursue. Will you work with me on this? Would you be part of this? And I'll see this through. I'll take away the risk.' And we did some risky things, like building new buildings, including committing to a new neuroscience center, and growing our ambulatory clinics, and finishing our eye institute, and opening up an expanded dermatology center, building a new cancer center, affiliating with another hospital system, launching a health plan, and launching a virtual care service line. And I said, 'I'm going to put myself out there and advocate with the board and push with our finance team.'

And as those things got done, as Rubin helped solve problems ranging from laboratory space to putting some people in uniforms so they looked better, people became convinced that this was all going to work, and that they would benefit from the success.

Descriptions of Rubin invariably mentioned his energy, his enthusiasm, and the fact that he had somehow been able to create more than a 24-hour day and then work even more hours than that. The energy, enthusiasm, and commitment were contagious. People believed that success was not only possible, but that outstanding achievement was going to be inevitable, given their effort and commitment.

NEXT STEPS

As he settled into the CEO role, Rubin soon moved on to additional actions to improve the performance of Stanford Health Care.

Changing People and the Structure

Not everyone Rubin inherited when he joined the hospital was either interested in the new way of operating or necessarily competent to take the health system's performance to the next level. As Rubin noted, he did not come in with preordained changes in mind, but over time, a number of senior incumbents left. In some instances, they retired. In some instances, they left voluntarily. And in some instances they were "changed out."

The organizational structure in the fall of 2014 was different from that in 2010. Comparing the two charts, one could see the differences in who populated the senior executive team. There was a new chief operating officer, a new vice president of human resources, a new chief medical officer, a new chief information officer, and a new vice president of development, among others. Other people had been moved into new roles. The vice president of business development was now the chief strategy officer with an expanded purview. Seshadri had gone from being the vice president of organizational effectiveness to overseeing the cancer and cardiac lines of business.

These moves and Rubin's own level of energy convinced people that Stanford's hospital and clinics would operate with a different level of intensity, and that those who were not prepared for the hard work required would not be around for long.

A Four-Pronged Strategy

Academic organizations, maybe all organizations, try to buffer people from the external environment so they can focus on their daily work as efficiently as possible. But one unintended consequence of this buffering is that people sometimes do not understand the competitive realities and how their actions and what they have been asked to do relate to the organization's success.

Rubin, in numerous meetings, made clear not only the realities of ubiquitous cost-containment pressures in health care and the increasing competition for patients, but also how Stanford would meet those challenges. There were four elements he talked about: complex care, a network of care, accountable care, and virtual care.

Complex care was the leading-edge, research-based care delivered at Stanford hospital and clinics. That was sort of what Stanford was doing. But Rubin implicitly and gently posed the question: "If Stanford care is so great, so leading edge, so important in making people's lives better, in curing what otherwise might be incurable, why should access to this wonderful treatment be restricted to people who are willing and able to get to Palo Alto?" In fact, it should not be, according to Rubin. Under Rubin's leadership and with the support of the health system's board, Stanford began a program of systematic geographic expansion—the *network of care* idea providing regional access and referrals. While still not much present in San Francisco or the mid-Peninsula (although Stanford was still trying to get permission to open a facility in Burlingame), Stanford had purchased medical practices and more recently hospitals in the East Bay, and was building facilities and expanding its coverage in the South Bay. As part of the network of care idea, Stanford was also approaching leading employers to partner with them in both wellness programs and providing medical services for their employees.

Next, it was clear to everyone that with the rise of accountable care organizations (ACOs) and changing reimbursement regimes coming from Medicare and health insurers, traditional fee-for-service medicine was profoundly changing. Medicare and employers did not want to pay for procedures or pills, they wanted to pay for results—an entire course of treatment. And the hospital would need to be accountable (*accountable care)* for making that care work financially for a given population, such as the employees of a large employer, given the price Stanford negotiated for providing coverage. To get into that way of thinking, Rubin offered a healthcare plan to Stanford employees, the Stanford Health Care Alliance, sometimes described as Stanford doctors at Kaiser prices. This move made it incumbent on Stanford to provide not just great care but great care as efficiently and cost-effectively as possible. In the future, this type of arrangement would be table stakes for being a player in the health care market, as various risk-sharing arrangements were increasingly part of the negotiations over health insurance rates.

And finally, there was *virtual care*. Kaiser-Permanente was already running television advertisements showing people taking pictures of various body parts and transmitting them to their doctors. Humor aside, the expectation in the twenty-first century was for more connectivity and more use of advanced (or maybe not so advanced) communications technology. Mayo Clinic provided health information online, free to the public. Stanford had begun to make investments, and was making more, to provide Stanford health in the cloud. Stanford Health Care was the first health system to launch video visits using Epic, the electronic health record software system, and was developing additional capabilities and products. Naturally, the growth of this service would be tracked by patient portal usage. Along with the expanding geographic network of doctors and facilities, virtual care would permit Stanford to bring its leading-edge, advanced patient care—the fruits of its substantial investment in basic and clinical research—to more people, and do so in a cost-efficient manner that respected people's ability to access, or not, the full resources of Stanford Health Care in Palo Alto.

Metrics and Systems

A fundamental element of lean production and total quality management is to get measures and make those measures visible—as on charts posted on the walls. The principle is that what gets inspected gets affected.

As he described it, Rubin went to each unit and asked them a simple question:

> 'How are you doing?' They'd say, 'Great.' And I'd say, 'Fabulous. How do you know?' And then, 'Well, what are you looking at? And do the people on your team know what you're working on? Is it on your visual wall? Do the doctors know?' And 'Does everybody on the team agree that we're going to work on this?' And then, 'What are your improvement plans for the year, what are your baseline measures, and what are your targets? And what initiatives are you going to take?'
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> And so over time, you get clear goals, clear metrics, and then that leads to the second part of the operating system, where we have people focus on the process. The value stream mapping and improvement work.

Rubin never presumed to tell the units how to define their performance measures or what their priorities should be—only that they should have sensible performance measures—and that they try to move those measures in a positive direction. If you went into Rubin's office, there were charts mapping his progress on his individual strategic priorities. Similarly, charts were everywhere—measures of waiting time, telephone answering times, missed calls, times to complete laboratory tests—whatever measures made sense given the priorities of a given work unit in its efforts to deliver high-quality, patient-centered care.

Rubin talked about the Stanford Operating System (SOS) and its components, including metrics and making them visible, the various meetings, and the behavioral standards. They were all interrelated. People's rounding activities and their huddling and linked check-ins were measured—the health system had built software applications to make tracking these behaviors easy and almost automatic. People had tools to help remind them of how they were to manage, to help them spend their time wisely, what they needed to do, and how to more effectively problem solve.

The metrics, the meetings, and C-I-CARE, with its behavioral emphasis, made the process of cultural change both visible and systematic. Elizabeth Aron, a consultant in the Performance Excellence department, contrasted what she had seen at Stanford, where she had been for less than 18 months, with what she had experienced in other health systems in Boston where she had worked before joining Stanford:

> The consistency of Rubin's messaging is very powerful. He has used a case study, C-I-CARE, to implement the beginning of a lean management system. C-I-CARE is a behavioral standard that is an easy concept for everyone to understand. By starting with a behavioral standard, a universal concept, he was able to engage an entire healthcare organization.
>
> At Partners Health [in Boston] we [the process improvement team] helped lead a number of "point" improvements and projects, sort of one-offs, with some success. The difference I see here at Stanford is that the executive level acknowledges the importance of implementing a management system as a top priority. It's not just about doing single projects to obtain some gain, financial or otherwise. If you don't have a management system, ultimately the improvement efforts and projects do not succeed, at least over time.

Training in Processes

Good intentions and good motivations are insufficient to drive excellent performance. People need the tools and the skills to do a good job. As a devotee of the quality movement, Rubin believed in systematic processes for doing work, even or particularly, the work of leadership. It was important to hire the right people and to onboard them in a way that got them off to a good start. But doing that required processes. And if people were going to execute these processes, they would need to be trained in them. So training, and particularly training in the components of the Stanford Operating System, was a priority.

As Rubin noted, for many organizations, "training is a one and done." Not at Stanford Health Care, where training was ongoing and repeated. The fall training on leading within the Stanford Operating System (SOS) was illustrative. More than 200 people attended, a group that included physicians, senior leaders from the health system, and people from human resources and performance excellence. Everyone sat at round tables. Rubin opened with an introduction and a presentation that emphasized the goals and strategies of the health system, what a special place it was, and the elements of leadership in that environment. Then the large room was divided into three, and people participated in breakout sessions covering the topics of attracting and selecting talent, onboarding for success, and coaching and feedback. After a buffet lunch, the entire group received training in strategic deployment and visual management, huddles, gemba rounds and linked check-ins, leader standard work and a standard calendar, and recognition and celebrations. In every case, the emphasis was on the specific behaviors that leaders could and should do to increase their units' performance and success.

All participants received a notebook with all of the overheads from the training and there was also a website that included the material and slides from the fall training.

For each subject, the general flow was to present why the subject or task was important, and then, using an interactive discussion format and on occasion videos as well as group work, present some practical, actionable suggestions. (For instance, some material from the onboarding for success breakout session is displayed in **Exhibit 6**.)

Reinforcement and Rewards

Mixed messages confuse people. Many places say they want things but reward other things, or nothing at all. Rubin firmly believed in the importance of using recognition and rewards to acknowledge team members' contributions and to reinforce the culture. Not surprisingly, employee assessments evaluated not just performance but behavioral adherence to the SOS—people exhibiting the behaviors that were deemed so crucial to Stanford's success.

And Rubin encouraged everyone to provide lots of reward and recognition. At the fall training, people were understandably reluctant to ask questions or participate in the opening session. People who made a comment or asked a question got a T-shirt from Rubin.

At that training, people received a separate spiral-bound, 25-page book, *Recognition and Celebrations Toolkit*. The importance of providing recognition, and some ways to do so, were detailed in that book:

> Few things build loyalty and longevity among your staff like letting them know that their efforts and hard work are noticed.
>
> During your active daily management ask your staff what is important to them…. Find out more about your team members. Start up a chart and keep track of their start dates and birthdays. Learn about their family.
>
> Be creative. Be sure to bring your own touch to the suggested forms of recognition below: 1. Say "thank you" often. 2. Recognize special events and

> admirable conduct consistently as a matter of habit. 3. Make admirable conduct the norm by reinforcing it, and celebrating its recurrence. 4. Draw attention to model conduct. 5. Know what your team prefers. Use your imagination, but gear your gifts or acts of appreciation towards what they like. 6. Keep a calendar of the Healthcare Professionals Week and remember to celebrate your team. 7. Have an employee of the month celebration. 8. Have a chart of birthdays and start dates easily available. Check it often, and pre-plan. Most times, celebrating someone's start date will take them by surprise, since they have often already forgotten. 9. Host a potluck and say thank you with food.

Stanford Health Care aligned all of its more formal and informal rewards and recognition around the behaviors of the operating system, which in turn were geared to implementing the strategies that would make the hospital successful—starting, most importantly, with making the patient experience as good as possible.

Building and Sustaining Relationships

Rubin understood that he needed to build trust and credibility, as well as some degree of personal connection, with the people at Stanford who he needed to be successful. He worked on his relationships assiduously.

With the Dean and Faculty of the Medical School

As one Stanford senior administrator noted, Rubin, as head of an organization with billions in revenue and hundreds of millions in operating profits, had access to resources. He used those resources to do things to improve the patient experience—for instance the valet parking—and to improve people's work environments—for instance fixing the roof. Rubin also used resources to help medical school chairs and faculty with their strategic priorities of recruiting and doing important research that could improve patient outcomes. He could make sure that space and equipment and staff support were provided to help people get their work done. Consequently, as this person suggested, one reason why people liked Rubin, besides his energy and personality, was that he helped solve real problems for them. Moreover, physicians and managers had received a component of incentive compensation as part of their pay package. As the hospital's revenues and profits grew, so too did the amount of these incentives.

Rubin also was fortunate in that he arrived while Philip Pizzo was dean. Pizzo had been on the search committee that selected Rubin. More importantly, Pizzo was coming to the end of his tenure as dean. Pizzo was interested in improving the service to patients in the hospital. He commented:

> I was on a search committee for the incoming hospital CEO and was pleased to see him arrive as a young, energetic person who'd already been very involved in the UCLA experience with patient service. I was very embracing of what he was going to do and had been trying to find ways to work with previous hospital leaders on improving the patient experience at Stanford. Because of where I was at that point in my time horizon (i.e., I'd already announced I was going to step down after 12 years as dean), there was no need for me to be anything other than fully collaborative with Rubin. I was involved in recruiting him. Because I was

> interested in collaboration rather than control, it made our relationship very collegial and effective. And while Rubin's energy and vision and his ability to enlist the hospital staff was very impressive, I think part of his success was because the soil had been prepared over the prior several years and people were ready for the kind of changes he was seeking to make.

Rubin spent a lot of time with the dean and with the department chairs, not just in formal meetings but informally as well. He treated the medical school and its faculty as partners in the shared goal of providing outstanding care. Rubin's visibility, accessibility and responsiveness naturally extended to people in the medical school.

As HR Vice President Duron noted, "To everyone he made the compelling argument, 'This will make us better, and don't we want to be the best? Don't you want to be part of that?' Or using data showing how many adverse events we have versus other hospitals, he would say, 'Why should we settle for this? We're Stanford Health Care. We should be much better than that.'" By tapping into people's pride and desire to be excellent, Rubin was able to build a common sense of purpose that to at least some degree extended beyond formal reporting relationships.

With the Stanford Health Care Board

Mariann Byerwalter was the chair of the hospital board when Rubin was hired. She noted that the board saw the changing landscape of the healthcare market and recognized that Stanford hospital needed to change as well, particularly with respect to its focus on the patient experience, in order to continue to be successful. Byerwalter saw her role as board chair as helping to make Rubin successful—after all, the board had hired him and she had developed a certain rapport with him during the selection and recruiting process. Because of her commitment to make the transition for the incoming CEO as smooth and effective as possible, Byerwalter remained longer than expected in her board chair role. The continuity Byerwalter provided was important also to Rubin, who appreciated her counsel as he entered Stanford.

Rubin spent time meeting with the hospital board members one-on-one, briefing them on what he was doing and soliciting their advice and opinions. As one board member commented, Rubin was completely transparent to the board with respect to measures: [Rubin would say something like] "Here's the data. Here's where we are, and here's where we're not, and where we're not doing well, here's what we're doing about. Here's the action plan." That transparency helped build trust with the board. His board packets were very well-prepared and his board presentations were well structured. As one board member noted, "When he does a board presentation, there's going to be structure to the presentation. He's going to walk right through it, and it fits together. He's just a very disciplined thinker."

Every board packet included a letter from a patient describing how Stanford Health Care had affected that individual's life. Rubin would often read a patient letter at many of the meetings. This action reinforced Rubin's emphasis on "one patient at a time" and also provided heart to the work people were doing.

Rubin displayed to the board the same energy and work ethic he did to people inside the health system. And as operations began to improve, the board could see those improvements and know that the organization was on the right track.

Bruce Cozadd, a Stanford GSB graduate, CEO of Jazz Pharmaceutical, and a member of the hospital board at the time Rubin was hired, reflected on what had made Rubin successful, in the hospital and with the board. He noted that one thing that helped is that a hospital is an operating entity and many of the operational measures had relatively short feedback loops. So on things like staff turnover, patient satisfaction, resource utilization, and even short-term patient outcomes, clear measures and improvements could potentially be achieved and become visible very quickly. He also noted:

> Rubin picked issues where he could get full organizational commitment to things that cut completely across the organization, were simple to understand, were achievable, and were measurable. He's tireless, I mean, he's a workhorse. He's not going to ask anyone to work any harder than he's working. And there's complete consistency. You're not going to hear one thing from Rubin on Monday and a different thing from him two weeks later. He's just completely consistent in what the priorities are, who is responsible, and how it's measured. So when I think about why can this work at Stanford, if Rubin has buy-in from the board, if he has sorted his management team into those who are believers and will do it and those who aren't and he replaced, and then all of your performance metrics and all of your reward systems work on exactly the same basis, it is just going to work.

Cozadd also described one particular process improvement effort that illustrated Rubin's orientation and his partnership with the board. Medical billing and compliance is essential to document charges and procedures so that the hospital can get paid for the services it provides. Compliance cannot be done on things that happened years ago, because people will have forgotten or have left, although those charges can be questioned and audited by Medicare, for example. Physician leaders did not necessarily understand the importance of all the detailed record-keeping and could think it was boring. Cozadd, as the chair of a committee of the board on this issue, along with Rubin and the dean of the medical school, set about to build a culture of compliance that would operate in real time. That joint work helped cement the relationships among them and also reinforced the message that processes, and compliance with process standards, were important for everyone.

Cozadd provided this description of the compliance and standards-setting work:

> Here's the self-auditing we're going to do, not of patients from three years ago, but on a real-time basis. And here's the standard we're going to hold people to. And when you don't meet that standard, you are going to have a meeting with somebody from the compliance team, your chair, and your department chair. And we're going to walk through it, explain what our findings were, and you're going to be required to go through additional training. And then you're going to get re-audited. And if you are still having problems, you will be audited more frequently.
>
> And people locked arms and said, 'I don't care if the person who ends up on that list is a brand new rookie faculty member or is a Nobel Prize winning curer of cancer. It's going to be the same.' Historically it was always, 'Well we know

> how it is supposed to work, but now we're talking about Dr. Smith, and you can't do that to Dr. Smith, everyone loves Dr. Smith.' So there was just complete buy-in going in. Here's how the processes are going to work, no exceptions.
>
> Another part was getting the whole organization wrapped around the concept of providing quality care. A great outcome is not: any time Dr. Jones treats somebody that is by definition a great outcome because Dr. Jones is a great doctor. We're going to define success as quality of care, and compliance, and patient satisfaction. You don't get to choose. You have to do all of them, and they all matter, and we're going to commit to all of the goals. And saying, 'I went two for three, please reward me,' isn't going to work. You have to do all three.

THE CHALLENGES AHEAD

Although Rubin had clearly been successful and the health system had made a great deal of progress along many dimensions, he would almost certainly face new challenges in the coming years. Some of those challenges arose from the organization's very growth and success.

First, much of Rubin's early management success depended not just on the processes he had installed but, as many people noted, on his own considerable personal charm, energy, and sense of humor. Simply put, energy and positive spirit are contagious and Rubin was very visible and present in the medical center. As Stanford Health Care expanded geographically throughout the Bay Area, so that the health system entailed operating not just one geographically concentrated facility but medical offices and health centers more than an hour's drive away, the level of personal connection and hands-on leadership would necessarily change. That raised the question: could Rubin's approach scale to a larger and more geographically dispersed operation, and if so, how?

Second, Rubin had come into an academically brilliant organization that, in some respects, had lacked operational management discipline and focus. He and his team had instituted standardized processes and a management operating system that, as good quality systems do, tried to ensure that each and every patient, in each and every interaction, would get the best possible care, measured by both clinical results and by the compassion with which care got delivered. But once those operating systems and metrics and behaviors were widespread, and once performance moved into the 90th percentile or higher on most dimensions, the question would arise, "What's next?" Often, making initial improvements, particularly in an organization with a proud history and tradition that sought excellence, is easier than maintaining a high level of performance once that is achieved. And there would be the task of keeping people engaged, motivated, and interested.

And there was a related challenge: as Stanford Health Care became more successful, with higher revenues, higher operating profits, more growth, and more awards and recognition, what could be done to overcome complacency? After all, many once successful organizations had fallen on hard times as success had dulled their competitive edge. Intel cofounder and former CEO

Andrew Grove had written a book with the title, *Only the Paranoid Survive*,[9] in recognition of the fact that in high technology, success was fleeting and companies had to continually reinvent themselves to maintain their success as markets and customers evolved and new competitive challenges emerged. Although hospital operations did not necessarily change at the same rate as high technology enterprises, the general issue remained—how to keep an increasingly successful organization and its people from becoming complacent or numbed by that success and vigilant to keep ahead of the competition and evolving patient expectations.

A woman in a senior leadership role in health systems at the University of Michigan, Rubin's alma mater, attended the fall training in December, 2014. Rubin served on her board of advisors. As she noted, what Rubin had done at Stanford was attracting national attention and comment. Rubin was among the most renowned of academic medical center hospital CEOs. Maintaining that reputation and the level of performance that formed its foundation would be a tough act to follow, even for the person who had done so much to create it.

[9] Andrew S. Grove, *Only the Paranoid Survive: How to Exploit the Crisis Points That Challenge Every Company,* New York: Doubleday Business, 1996.

Exhibit 1
Amir Dan Rubin's Background

Education:

B.A., Economics and Business, University of California, Berkeley, 1987-1991

MBA, Business Administration, University of Michigan, Stephen M. Ross School of Business, 1993-1996

MHSA, Health Care Administration, University of Michigan, 1993-1996.

Work Experience:

1996-1998. Management Consultant, APM/CSC Healthcare Consulting

1998-2002. Assistant Vice President Operations, Memorial Hermann Healthcare System, Texas

2002-2005. Chief Operating Officer, Stony Brook Medical Center, New York

2005-2010. Chief Operating Officer, UCLA Health, California

2010-Present. President and CEO, Stanford Health Care.

Source: https://www.linkedin.com/in/amirdanrubin.

Exhibit 2
Selected Financial Data for Stanford Health Care
(years ending August 31)

	2009	2010	2011	2012	2013	2014
Operating Revenue (in billions)	$1.828	$1.967	$2.109	$2.430	$2.714	$2.998
Income from Operations (in millions)	$94.680	$100.070	$172.58	$236.73	$252.78	$278.25
Total assets (in billions)	$2.184	$2.332	$2.749	$3.831	$4.268	$4.748

Source: These data come from audited annual financial reports that can be found at https://stanfordhealthcare.org/about-us/bondholder-general-financial-information/audited-financial-statements.html.

Exhibit 3
Survival Rates at Different Time Intervals for Stage 4 Metastatic Cancer, Stanford Patient Registry Data v. Data from the National Cancer Institute

Colon Cancer

	1 year	3 year	5 year
SEER (NCI) data	52%	20.3%	10.6%
Stanford data	72%	39.4%	19.2%

Breast Cancer

	1 year	3 year	5 year
SEER (NCI) data	70.7%	41.1%	25.0%
Stanford data	79.2%	49.7%	31.0%

Source: From a presentation by Amir Dan Rubin.

Exhibit 4
Stanford Health Care List Selected Awards and Recognition

Recognized for the fourth straight year by the Leapfrog Group as a top hospital in the national for performance in patient safety, quality, and efficiency.

The first hospital in the U.S. to be certified as a Comprehensive Stroke Center by the Joint Commission.

One of the first four hospitals in the United States to achieve Stage 7 designation, the highest possible distinction in electronic medical records implementation.

Designated a "Most Wired" hospital by *Hospitals and Health Networks* magazine.

Awarded "Senior Friendly" status by the Nurses Improving Care for Health System Elders program.

Winner of the Consumer Choice Award for the Most Preferred Hospital for the San Jose market.

Named the top hospital in the San Jose region by *U.S. News and World Report*.

Designated as a Magnet Hospital by the American Nurses Credentialing Center, a distinction awarded to less than 7 percent of all U.S. hospitals.

Source: Stanford Hospital and Clinics' Annual Report, 2012.

Exhibit 5
Stanford Health Care's Mission, Vision and C-I-Care Behavioral Guide

Mission
To care, to educate, to discover

Vision
Healing humanity through science and compassion, one patient at a time

C-I-CARE
Connect with people by calling them their proper names or the name they prefer
Introduce yourself and your role
Communicate what you are going to do, how long it will take, and how it will impact the patient
Ask permission before entering a room, examining a patient, or undertaking an activity
Respond to patient's questions or requests promptly, anticipate patient needs
Exit courteously with an explanation of what will come next

Exhibit 6
10 Steps to Successful Onboarding

1. Contact new employee to congratulate and welcome him/her to SHC.
2. Prepare the workplace, equipment, and supplies.
3. Select a buddy or a preceptor.
4. On the first day in your unit, introduce the new employee to the team during huddle and team meetings.
5. Schedule a meeting to review the job description and establish clear expectations.
6. Review C-I-CARE department plan.
7. Introduce Stanford Operating System Concepts.
8. Review Department Specific Orientation using the Department Specific Orientation Companion Checklist.
9. Develop a 30, 60, & 90 day touch point/provide feedback.
10. Celebrate the employee's first month, 90 days, and 1-year anniversary.