STEVEN H. LIPSTEIN

CEO, BJC HealthCare

EDUCATION

Bachelor of Arts, Emory University

Master of Health Administration, Duke University

Administrative Fellowship, Massachusetts General Hospital

CAREER

BJC Collaborative, LLC
Executive Vice President, 2013-present

BJC HealthCare
CEO, 2017-present
President & CEO, 1999-2016

University of Chicago Hospitals and Health System
Executive Vice President (health system) and President & COO (hospitals), 1997-1999

Executive Vice President & COO (hospitals), 1994-1997

Johns Hopkins Hospital and Health System, 1982-1994

AWARDS & RECOGNITIONS

John D. Levy Human Relations Award, American Jewish Committee, 2017

Champion for Health Award, Rx Outreach, 2017

Distinguished Service Award, Association of American Medical Colleges, 2015

2nd Century Award, Washington University, 2015

Elected to National Academy of Medicine, 2014

Citizen of the Year, St. Louis, 2014

CURRENT BOARDS & AFFILIATIONS

United Way of Greater St. Louis, Inc. Board of Directors & 2016 Campaign Co-Chair

University of California Board of Regents Health Services Committee

Missouri Council for a Better Economy Board of Directors

Emory University Board of Trustees

BioSTL Board of Trustees

Teach for America, St. Louis Regional Advisory Board

Ameren Corporation Board of Directors

Cortex Board of Directors

St. Louis Regional Health Commission

PAST BOARDS & AFFILIATIONS

Federal Reserve Bank (eighth district), Board Chair, 2009-2011

Patient-Centered Outcomes Research Institute, Vice Chairman, 2010-2014

The National Center for Healthcare Leadership is honored to present the 2017 Gail L. Warden Leadership Excellence Award to Steven H. Lipstein for his tireless work increasing access to high quality healthcare throughout Missouri and Southern Illinois. As a leader of one of the largest nonprofit healthcare organizations in the US, Mr. Lipstein has been active in transforming healthcare organizations from providers of medical services to proactive facilitators of wellness and healthcare management, while providing leadership on local and national healthcare issues. Joining BJC HealthCare in 1999, he is credited with bringing financial stability to the organization and developing and maintaining a high-performing integrated health system that consistently receives high ratings from bond agencies. With his commitment to serve all of BJC Healthcare's communities and constituents, Mr. Lipstein has brought innovation and visionary leadership to the delivery of healthcare.

Steve Lipstein Creates a Culture of Shared Values at BJC HealthCare Focused on Excellent Patient Care, Financial Responsibility, Long-Term Investments, and Remaining True to Its Mission

Steven H. Lipstein, Gail L. Warden Leadership Excellence Award Recipient

What started as a part-time job for 18-year-old-college freshman Steve Lipstein became the launch of his career. Working as a nursing unit clerk at Emory University Hospital, he became so inspired by his colleagues—especially nurses—that he committed to a career in healthcare administration so he could work alongside those people who have what he describes as "a high calling." Nearly 25 years later when Mr. Lipstein joined BJC HealthCare as president and CEO, he brought along his carefully honed leadership skills, including his genuine respect for people and the ability to make tough decisions quickly. His first priority at BJC in 1999 was to face the system's nearly $80 million operating deficit. He knew exactly where to begin.

Q. What was the first thing you did at BJC?

A. It's not hard to prioritize when you are bleeding red. We began chipping away at areas with unfavorable operating results, and one of the first things we did was to address the six-year-old BJC operating framework. It wasn't working. Nobody understood it. Were we going to be a federation of 12 independent hospitals, or were we going to operate in a more integrated fashion? It was clear that our different hospitals were not ready to accept

our efforts to impose one operating paradigm on all 12 of them. So we stepped back. We stopped trying to force consolidation and integration and began to let each hospital operate more autonomously within a set of guiding principles.

Q. How do you explain your philosophy and how is it implemented?

A. Our management philosophy is "directed autonomy with congenial controls" and we implement it by enabling each hospital to focus on four things: First, we take really good care of people—both patients and employees; second, we operate in a financially responsible way that provides the resources that enable us to provide high quality care; third, we make human and capital investments to position each hospital for long-term sustainability and success; and fourth, we stay true to our social and academic missions. We have performance metrics and scorecard measurements, we have divided our long-term positioning investments into human, physical, or financial assets, and we have made deliberate commitments to our charitable and academic missions, the former as anchor of the regional safety net in St. Louis, and the latter through affiliations with Washington University School of Medicine, the Goldfarb School of Nursing, the St. Louis College of Pharmacy, and other area colleges and universities.

Q. Have you lost anything by deferring the integrated approach?

A. I describe it as restarting our journey towards integration by beginning at a place that was within BJC's "comfort zone." We encourage each hospital to be the best at something, allowing their individual brands to shine. Barnes-Jewish Hospital aspires to be the best hospital providing comprehensive medical care in almost every specialty, coupled with missions in education and research. One of our small rural hospitals aspires to be the best at customer intimacy; they know the names, families, and personal stories of all their patients. One hospital aspires to be the best at taking care of kids, another at orthopedics. By allowing healthcare professionals to be the best in the world at something, and associating their individual brands with their sense of what makes them special, we are harnessing and accelerating organizational aspirations that far exceed what you get from forcing everyone to be the same.

Q. What did employees think about eschewing an umbrella brand?

A. I'll tell you a true story. I was meeting with leaders at St. Louis Children's Hospital and a manager asked me whether she worked for Children's Hospital or BJC? I said, "Who do you want to work for?" She replied, "Children's Hospital. I've been at Children's for 28 years and I just want to work with kids." So I told her she worked for Children's. At the same meeting another gentleman said he wanted to work for BJC HealthCare because he liked the flexibility to work at different hospitals while retaining his benefits, seniority, and his affiliation to the parent company. I told him that he works for BJC.

I could relate to this issue from my own experience. When I started as a clerk at Emory University Hospital in Atlanta, I didn't work for Emory, I worked for Floor 5G. It was those nurses who made me feel special, a part of the team. At BJC—with 31,000 employees—I understand that each individual wants to relate to their nursing unit or department where they are valued, where they make a contribution and where they have some control over the work environment. I want people to feel good about being part of BJC and also identify with the place where they do their daily work.

Q. The trend in most industries is for consolidation and integration. Is healthcare different?

A. Healthcare is different and you can make a big mistake pretending that healthcare is like anything else. Here's an example. I am often asked why healthcare lags other industries with regard to information technology. For instance, a commercial banking "technology platform" has about 160 different transactional services that are all quantified in dollars and cents. By contrast, a pharmacy "technology platform" must perform over 2,000 transactions that are in a variety of units of measure. The complexity of our world—and the fact that we provide human services to people who are afraid and anxious, or injured or ill—doesn't easily translate to other industries. So we believe that a "directed autonomy with congenial controls" approach still allows for BJC to have shared values and common purpose to make medicine better in all of its forms. As a leader, my job is to help stimulate that aspiration to be better, and not to stifle it with hard and fast standards that may have no beneficial impact on the quality or cost of the healthcare being delivered.

Q. What about conventional wisdom that recommends a single culture?

A. We have a shared value to take very good care of people. We also embrace inclusion of many cultures that reflects a diversity of traditions, religions, races, and ethnicities. Why would we want to take away each individual organization's culture and impose one culture that may not fit? We value human services and we value each other, including our differences. We are financially disciplined. We exist for the benefit of our diverse community, not for any investors or owners. We make human, physical, and financial investments for the long term. That's our shared purpose and our shared values.

Q. What has inspired your leadership style?

A. Back to my early days in healthcare, I had a real "aha" moment when I was a unit secretary. I learned that the patients did not want to be in the hospital, and we could not expect them to exhibit their very best behavior. But I was fascinated by our nurses who would get up every day to take care of them. Nurses are not the most highly compensated professionals in our society, but they have a very high calling. I was inspired to be part of their world. What I enjoyed the most was working in the hospital and being part of the delivery of patient care and that special opportunity to make a difference in someone else's life. I learned to value the importance of everybody's role, from nurses and therapists and technologists to food-service workers and the maintenance people. They were the people without whom we couldn't do the work of a hospital—admitting patients, helping them to feel better, providing their medicines, giving them a clean room. Part of what has shaped my leadership style is my deep respect and admiration for all of these people.

Q. You have been an active supporter of the administrative fellows program. How did that benefit your career and your understanding of healthcare?

A. I was a fellow at Massachusetts General Hospital from 1980 to 1982 and then I helped establish a fellowship program when I went to Johns Hopkins in 1982; at BJC we started one in 2002. The administrative fellowship program played a critical role in creating a pipeline of talent that populated the needs at Hopkins and also provided a candidate pool for health administration positions across the nation. Fellows are provided with a rotational experience, allowing them to be immersed in the mix of functional areas that are required to deliver healthcare. I firmly believe young people need to spend time in the service-delivery units; at BJC HealthCare our fellows work in the hospitals rather than at the system level to help them learn and understand the delivery of patient care and services. An impressive list of individuals who are running top institutions throughout the country today started their career in administrative fellowship programs.

Q. What role does collaboration play at BJC?

A. Among our BJC hospitals, we share strategic thinking and plans, we make pooled investments in learning and performance-improvement platforms, and we share administrative, revenue cycle, and clinical information systems.

The BJC Collaborative, which was created in 2012 and includes eight of the largest not-for-profit healthcare systems in the largest population centers in southern Illinois and Missouri, has provided a vehicle for collaborating outside our family. We buy supplies, equipment, and purchased services together; we have developed a cancer care collaborative, and we have made shared investments in infrastructure to manage population health.

Here's how collaboration can work: In 2000, BJC operated an antiquated hospital in North County that delivered 800 deliveries annually, while nearby SSM Health's DePaul Hospital delivered 700 babies a year. Working with SSM leaders, BJC made a financial contribution to expand the labor and delivery capacity at DePaul so it could accommodate the newborn deliveries for both hospitals. Subsequently, BJC replaced its outdated hospital with a state-of-the art ambulatory care center to meet a critical healthcare need for our community. Both hospitals benefitted and the value to the community was paramount.

Q. Are you collaborators with your competitors?

A. don't think of my counterparts at SSM or Mercy as competitors. They are my colleagues and we are all pursuing the same thing—providing high-quality healthcare to our communities. We all sit on the St. Louis Regional Health Commission, so we all understand the needs of the community. To be sure, we have a competitive spirit as we work to improve quality, access, and service, and to steward our resources wisely. But we also look for ways to solve problems together by collaborating on services that otherwise might not be available in our community. The essential ingredient in collaboration is personal relationships, and being open to explore new or different or better approaches to working together.

Q. How do you implement the mentoring and education that are part of BJC's value set?

A. We do it by investing heavily in our employees' education. I am very proud of the fact that over 2,000 BJC employees are always enrolled in next-step educational course work. We aren't just developing a select group of pre-identified leaders; we develop everybody. We make an outsized investment in learning, and our employee engagement surveys consistently give us very high marks for the investment we make in the learning, education, and development of our employees.

Q. BJC is leading an effort to improve literacy as a path to better health in your communities. How is that working?

A. We know that if children are not reading on grade-level by third grade, they are less likely to complete high school. And those who do not complete high school, on average, live more than 10 years less than those who complete college. Hospitals need to redefine what it means to be a healthy newborn, thinking beyond the traditional outcomes measures of maternal and infant health, extending to early childhood immunizations, eye and dental care, nutrition, and reading literacy by third grade. We need to improve the outlook for people born into extreme poverty. We are developing a home-based, eight-year program focusing on healthcare, education, and social structure that would stay with children from birth through third grade. But we are learning that because these families live under difficult circumstances and are often single-parent households, eight years is a long commitment. We know that social determinants of health are more influential of health status and outcomes than are clinical interventions. Eleven percent of Americans live in poverty, including one in five children. Until America steps up to deal with its poverty problem, it will be hard to make progress.

Q. What gets in the way of population health?

A. In the United States, we value our individual freedoms, including the freedom to choose or not to choose good health practices. Although we might like to—and we certainly have the know-how—we can't legislate lower blood pressure, sugar, or cholesterol levels. We know the health risks of smoking and of obesity, yet still too many Americans (me among them) eat fast foods, high in salt, sugar, fat, and calories. But it sure tastes good!

Q. How do you keep your sanity amid the uncertainty of the nation's healthcare policy?

A. It's important to listen to the crowd without overreacting to the noise. The nation's healthcare policies have real consequences for the math associated with operating a healthcare delivery organization. About 160 million Americans rely on Medicare, Medicaid, the Military Health System, the Veteran's Administration, or the government as their employer for healthcare. Taxpayers finance over 50 percent of the American healthcare system, which is also the largest private sector of the American economy. In spite of all the noise in Washington, the "what" of what we are doing hasn't changed, just the "how" and the "how much."

The "what" of what we do in hospitals is still to provide high-quality care to people who are sick or injured, and to use our expertise to help people stay healthy for as long as possible.

The "how" will be forever changing and improving. The "how much" we have to spend on human and physical resources to carry out our missions will always be constrained by the political will of taxpayers and the financial wherewithal of premium payers. If we don't overreact to the noise (and keep an ever-watchful eye on the math), then even in the face of great uncertainty, a healthcare leader can maintain a "steady as she goes" approach to leadership.