Quality Leadership: A Conversation with Dennis R. Barry

Dennis R. Barry is CEO emeritus and former president and CEO of Moses Cone Health System, a nonprofit organization based in Greensboro and comprising five hospitals and a range of outpatient facilities serving a four-county area in North Carolina. With more than 7,400 employees, Moses Cone Health System is recognized as a leader in cardiology, neuroscience, oncology, rehabilitation, obstetrics, and wide-ranging community service efforts. From 2002 to 2005, Barry was chairman of the board of trustees of the American Hospital Association, a nonprofit group with a membership of nearly five thousand hospitals, health care systems and networks, and other care providers. Barry was previously general director of the North Carolina Memorial Hospital in Chapel Hill and an associate professor and assistant dean at the University of North Carolina School of Medicine in Chapel Hill. Since 2005, Barry has served as chairman of the Greensboro Partnership, an umbrella organization covering the Greensboro Chamber of Commerce, the Greensboro Economic Development Partnership, and Action Greensboro, an organization dedicated to creating an economically vibrant community and fostering an environment that attracts business and industry and stimulates business formation and development. Barry is also a former chairman of the Greensboro Chamber of Commerce and member of the advisory board of the University of North Carolina at Greensboro’s Bryan School of Business and Economics. He holds an M.B.A. degree from the University of Chicago Graduate School of Business.

Barry recently spoke with David Altman, vice president of research and innovation at CCL, and Tracy Patterson, a research and innovation associate at CCL, about the current challenges facing leaders in the health care field. (Patterson also served as a guest editor for this issue of LiA.) Here are excerpts from that interview:

DA: Today’s health care leaders face crises involving a multitude of complex challenges, such as improving the quality of care in the face of spiraling costs, overbearing regulations, shortages of skilled health care providers, and lack of access to even basic care for millions of Americans. You have been recognized nationally for your leadership and your contributions to improving the quality of health care. What are some of the leadership lessons underlying your success that might inform leadership development in health and health care?

DB: The challenges are easy. It’s the leadership part that’s hard to respond to. First, I should say that I think you can improve the quality of care without increasing costs, even though costs and inflationary factors continue to be a problem. In fact I think that in many cases we have found that when we improve quality, costs are decreased rather than increased. So there is a significant business case for improving quality.

From a leadership point of view, the hard part of improving quality is not assembling the talent and other
resources needed to focus on a quality improvement agenda but rather creating an organizational culture in which quality and safety become everyone’s top concerns. We have found that hospital staffs can relate to that rationale very easily and can adopt it as part of their ongoing behavior.

A serious medical error usually occurs as a result of many different errors being made along the way. If you envision a straight line through layers of Swiss cheese, you have to literally line up enough of the holes for an error to really occur. And that’s really true in the hospital setting because there are so many people involved in patient care and many checks and balances along the way. In short, lots of things have to go wrong for a serious error to occur. It’s also important to bring everybody to a level of understanding about quality and errors in a nonthreatening environment, allowing staff to feel free to be honest about examining what went wrong and designing systems to prevent such errors from occurring in the future. That’s really what we’re trying to achieve at the individual organization level. Critical leadership is required to assemble the talent and other resources to address these issues. Leadership must also change the culture to one of quality and safety if such efforts are to be successful.

At the national level we’re trying to achieve somewhat of the same thing. One of the problems we have in America is that we don’t have a single system of care or a single system of paying for care. Therefore we don’t have a single database or a single electronic health record for each individual. Some other countries have these systems in place, which can greatly facilitate quality measures on a standardized basis. The United States is starting to build a uniform database, under the Centers for Medicare and Medicaid Services, which will enable us to see how a specific hospital performs relative to standardized quality measures. This is a recent start-up that will be built on over time. Nationally, if we’re serious about improving the quality of care, then the leadership has to come from the top of the organization, starting with the federal government and others.

In the Moses Cone Health System, part of the senior management incentive program each year is based on quality results, not just financial results. And we’ve created a scorecard that measures not only the financial and productivity results of the operation but also its quality results. This scorecard is used throughout the system, beginning with the board of trustees.

**TP:** Is that unusual for a health care system?
**DB:** It was unusual seven years ago but it’s becoming far more common today. The culture in hospitals is changing as a result of quality initiatives. Some health systems are starting to put quality and patient satisfaction measures on their Web sites, for example, to promote transparency.

We started the quality effort in our organization about six or seven years ago and have used it to also help develop the leadership team. You can’t undertake a quest of changing the organization’s culture and focus without also engaging in a lot of leadership development, both at the individual and team levels.

**TP:** It sounds positive, given all the negative things being reported about the health care system.
**DB:** I think it is positive. But health care costs are still going up much too quickly and we still have forty-five million Americans without health care coverage. That doesn’t mean they don’t have access to health care. They access health care through emergency rooms and clinics. Unfortunately, they don’t necessarily access health care services on a timely basis. Therefore what may have been an easy problem to deal with becomes terribly difficult.

I’ll give you an example. I had a call one day several years ago from a man who was upset because his wife had been in our emergency room recently, and it took a long time to treat a relatively modest problem. I told him I would be glad to look into it. It turned out that she had come to the emergency room at the most busy time possible. She was having an acute asthma attack. Although she was uncomfortable, her condition was not life-threatening, and it took them a long time to see her. Once they gave her some medication, she recovered quickly. I called the husband back, and in discussing the situation with him I learned that his wife had stopped taking her asthma medication because he had lost his job and his health coverage. So she had access to care on an emergency basis, but the real problem was that they didn’t have coverage and couldn’t afford ongoing medications, which would have prevented the attacks in the first place. Unfortunately, the American health care system is fraught with these kinds of exam-
ples, and much more serious examples of patients who because of economic barriers don’t take measures to avoid serious illness.

**DA:** The epidemic of diabetes must present similar types of problems.

**DB:** Today a lot of that is lifestyle induced. Another part of the problem with the American health system is that we pay for and emphasize diagnosis and treatment but we don’t have a system that encourages us to live healthy lifestyles and undertake needed preventive measures. In that respect we are far behind other modern countries that have progressive health promotion programs. America spends far less than other nations on prevention and health promotion.

**TP:** You’ve had a distinguished career in the health field, serving as a major force in improving patient safety, accreditation, and quality of health care nationwide. Despite your many successes I suspect that some of your efforts may not have been as successful as you hoped. Can you share with us one or two of these less-successful efforts, and what you learned about leadership as a result?

**DB:** Being successful in leadership roles does not mean you have not experienced many less-than-successful events along the way. I have always subscribed to the axiom “I’d rather be lucky than good.” There are all types of failures along the way. Some occur because you can’t persuade an external force to collaborate or you fail to properly develop your top managers or you misread or misdiagnose a problem and craft a solution to a problem that does not exist. The events that are most difficult are those where you do all the right things but still fail to be successful in dealing with an important problem. One always experiences failure as a leader. Having said that, there are two principles that apply. The first is that being a successful leader is not about not experiencing failure but rather that one has a successful batting average—many more successful outcomes than not. The second is that one learns from the failures of the past and makes sure that the past causation factors are not repeated in the future. Another important lesson to remember is that as leaders we need to rely heavily on others to help us make the right decisions and do the right things. Choosing and developing the right individuals and ensuring that mutual understandings of what needs to be done are intact are essen-

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**DA:** The world has recently experienced several natural disasters: the tsunami in Asia, the earthquake in Pakistan and Kashmir, and devastating hurricanes in the United States. These disasters have posed grave threats to public health and exposed weaknesses in our relief capacity. In each of these disasters we had an opportunity to witness leadership in action. From your experiences in health leadership, what key leadership lessons can we derive from these disasters?

**DB:** I don’t know much about the earthquake in Pakistan or the tsunami other than what I’ve read and heard about in the news, so I don’t know much about the response and relief capabilities in those other countries. But I can comment on the hurricanes in the United States and the problems they posed. From what I have seen, the response from the health field, particularly hospitals, has been outstanding. I can’t tell you how many planeloads and helicopter loads of patients were brought to other places in Louisiana and other states throughout the South. The Woman’s Hospital in Baton Rouge, for example, evacuated numerous postpartum and active-labor patients and newborns, both normal and premature, out of New Orleans and brought them to Baton Rouge. They brought the doctors and nurses up with them and housed them at the hospital. Emergency clinics were set up throughout the South where evacuees were being relocated, especially Houston. Hospitals from other parts of the country sent staff, mobile clinics, and mobile hospitals to serve those in need. In many cases these successful efforts went forward despite the ineptness of the overall disaster leadership.

For obvious reasons, hospitals maintain very effective disaster plans and capabilities. Some have more sophisticated plans than others because of their size and capabilities. Hospitals’ biggest problem in large natural disasters, however, is the ability to take care of patients when there is a huge spike in the volume of patients who need care.

Assembling and managing the human resources required to provide care to large volumes of patients for an extended period of time becomes a real challenge. Given the massive amount of illness and injury and the need to care for those in the affected hospitals, the response during Katrina and other disasters has been outstanding. Certainly much better than other segments of the disaster response apparatus.
TP: Was it a national organization that provided the leadership role in the health care response to the hurricanes, or was it a network of hospitals?

DB: There is a national network of health care disaster readiness that is operated through the Department of Defense. There is a capacity tracking system that each state maintains and therefore a health care emergency response system that works well for natural disasters in the United States.

TP: You’ve been getting the word out about the health care crisis. What do you see as the role of grassroots leadership—citizen participation—in bringing about improvements in the health care system?

DB: Unfortunately, the improvements that must be made must be accomplished at the national level. So much of the health care system today is underwritten and controlled by government. So the government has a huge role, not only as a financier, as in the case of Medicare and Medicaid, but also as a provider for various segments of the population. The states play an important role as well by funding part of the care for Medicaid patients. So much of the system is driven by government that it’s hard to envision that we could change the system significantly without a significant change in Medicare and Medicaid. That does not mean that we have to nationalize our system, as Canada has. There are other successful models that we can tailor to America that use a public-private approach. The health care crisis in America continues to get worse and worse. Major political will and determination will be required to change our system. What we can do is challenge our legislators to seek solutions. Ask your legislative candidates to take key positions on health care reform and vote for those who have the courage to tackle this tough problem.

Today’s system is highly fragmented, very complicated, and very expensive to operate. We have literally thousands of health plans in the private sector. The amount of paper shuffling that has to be done to get paid under all these programs is an absolute disaster. It’s very expensive for the providers and payers to administer. You need a lot of administrative talent and computer systems to manage this complicated process. Years ago the system was much less complicated. Blue Cross, for example, was a nonprofit organization and was able to administer claims and manage its business for about five or six cents on the premium dollar. Today that cost is about twenty cents. It’s far more expensive because of the managed care contracting, marketing, and profit levels. Today many health insurance companies in this country are making record profits and have been doing so for a number of years. Medicare, however, is an example of a government program that’s relatively efficient because it’s a standardized system. It costs the government only about three cents on the dollar to administer that system. So you begin to get some sense of what scale and standardization can do in terms of cost effectiveness.

The real challenge, however, is to bring health care coverage to the forty-five million Americans who are not covered today. Clearly, not covering a large portion of our citizens—one out of five under age sixty-five—is not in our best interest as a productive society. We need a system that supports and encourages us to adopt healthier lifestyles and improves the overall health of the nation. Currently we lag well behind the other leading nations in health statistics—outcomes—even though we spend by far the greatest amount of our GNP on health care. We must elect legislators who are willing to address and reform our health care system.

DA: Globalization is a concept that has generated much discussion and debate. Thomas Friedman’s recent best-seller, The World Is Flat: A Brief History of the Twenty-First Century [Farrar, Straus & Giroux, 2005], is a good example of the current thinking about the growing global connectedness and interdependence of people, economies, and systems. What do you see as the key opportunities for and threats to global public health?

DB: Other than natural disasters the most serious threat is infection, such as bird flu or the SARS outbreak a couple of years ago. I’ll give you an example of what a sophisticated health information system can do during an epidemic. The SARS epidemic, as you’ll recall, affected China most severely. But Hong Kong was also affected. But in Hong Kong there is a government health system, and all the hospitals, clinics, and emergency rooms are on the same clinical information system; citizens of Hong Kong have an electronic health record. And during this epidemic, officials programmed that information system to identify certain symptoms that patients might have that reflected the symptoms of the SARS virus. By doing that they were able to quickly identify active patients in their system who might have SARS, isolate them, and treat
them, thereby managing this potential epidemic. That’s why Hong Kong didn’t have a serious epidemic. China doesn’t have that kind of capability, nor does the United States, I might add.

I think that another major threat is the AIDS epidemic, particularly in Africa, and it’s spreading fairly rapidly into the Middle East and India. The statistics are just terrible. Back in the early eighties, we believed it would take ten or so years to create a vaccine for AIDS. Well, here it is twenty-five years later, and we still haven’t found a vaccine. We’re able to treat people much more successfully than we were then, so the death rate is going down dramatically in the United States. And we did see a decrease in the incidence of HIV. I wish that were true in places like Africa, but it is rampant there, without an end in sight. A lot of children, through the birthing process, are ending up with HIV as well. They can live fairly long lives if they stay on medication, but many of these countries are terribly poor. Even with aid from the United States and others, the situation continues to worsen.

As a nation, we need to maintain a high level of global competitiveness, which translates into a well-educated, healthy, and productive workforce. Reforming our health care system is one key factor in maintaining our productive workforce. Addressing America’s health care problems successfully will require strong political leadership that, frankly, we have not had. This is a terribly difficult set of issues to deal with. It’s a very expensive system. It represents about 16 or 17 percent of our gross national product. We are projected to spend $1.9 trillion this year on health care. The system is so big that it’s hard to understand how to turn it around. It is a huge job.

Over the years there has been a lot of reticence on the part of politicians to tackle this difficult problem, and the situation has slowly gotten worse and worse. It can’t just go on forever. The current system is not sustainable. It’s getting too expensive for the middle classes. More and more people are without health coverage. Somewhere out there in our future, there is a health care tipping point. I don’t know where it is, but I’ll know it when I see it.