Norman Gruber

EDITORS' NOTE *Norman Gruber became President and Chief Executive Officer of Salem Health in March 2003. Gruber is a diplomat of the American College of Healthcare Executives and has more than 40 years of experience in health care and hospital administration. He formerly served as President and CEO of Palomar Pomerado Health in San Diego, California.*

INSTITUTION BRIEF *Salem Health (www.salemhealth.org) is comprised of Salem Hospital, West Valley Hospital, Willamette Health Partners, and other affiliated health care organizations offering exceptional care to people in and around Oregon's mid-Willamette Valley.*

What are your views on how transformation can occur in the health space?

Most folks in this industry believe the system is broken and needs to be fixed. In many ways, we're bankrupting our country.

The problem is that we have such a fragmented system and the challenge is going to be how to align the different players and, most importantly, how to align the physician. The physician is still the major driver of resources – on average, 85 percent of the cost of the average hospitalization is generated by the physician's pen. So until you can get the physician aligned within the institution and outside the institution in some structure that is far different than we have today and a payment system that doesn't reward you for doing volume, we're not going to get anywhere.

The current system is still heavily fee-for-service and driven to a great degree by a dependence on private practice; hospitals tend to be separate entities. The challenge is how to line the folks up and get them all singing the same song.

In your market, how clear is the potential to get into a full-risk model with Medicare Advantage or other commercial plans?

The Governor of Oregon is a physician by training and has been a proponent of change for years, stating that health care is not sustainable.

His second term as Governor has produced legislation called Coordinated Care Organizations, which are, to a certain extent, a copy of ACOs (Accountable Care Organizations), which manage the health of populations versus individual fee-for service with their own local twist.

The effort centers on how we transform health care and how Oregon takes a leadership role in that process.

As we have come to realize through actual legislation, it's not that simple; there are a lot of conflicting issues, and a big issue is how one creates a shared risk model among providers.

Within our community, the challenge is moving away from a structure where one provider benefits at the expense of other providers. The model is still built on the old idea of fee-for-service and segregates providers through differing reimbursement methods rather than creating a new model where all providers are at risk together.

So we have a governor who wants to transform health care, but it doesn't play out well at a local level. The community is still embedded in the old models and in the traditional way of delivering health care.

You have been working on helping the care unfold in a high quality, lean, and efficient way throughout your operations.

On the purely clinical side with physicians, we have 8 or 10 groups – for example, there is a group of obstetricians working on using Lean (Lean Six Sigma) to address C-sections, how to standardize them and getting rid of variation.

I am convinced that it is a significant part of the solution, but it will take time to reengineer the mental models that people have been using.

It requires more than a mild level of investment behind that to get it to work; it's not easily within the wherewithal of many systems.

Part of the problem is a cultural one. We still have our committees that see independence and autonomy as an important aspect of what they do. Independence and autonomy are in many ways contradictory to the concept of standardized work.

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This is a part of the culture that has resulted from how we have developed health care in America. You have to get past that – there is value in standardization. Every human is different, but there is more that is similar than different and the value comes from applying the best protocols. Then you apply the human element, i.e. the physician, to deal with the variations that come up.

Let's move to the patient side. Some leaders within the industry are latching onto patient decision-making as the next trend. How important will that become?

There is nothing I would argue with about the premise, but I still don't see a lot of that from where I sit. I don't see patients being keyed up to make major medical decisions – I still see people defer to the decisions the physician or another health care professional makes. From concept, it absolutely makes sense; in practice, we probably have a long way to go.

Alluding to the issue of culture: the younger generation is far more oriented to ask questions and debate than the older generation.

I have had a chance to do global research on shared decision-making. When people are informed, they will more often than not take the less intensive care path. The data that I found the most compelling is when physicians themselves have a cancer diagnosis, their course of care is much different than the rest of the population.

When you discuss this as a part of the model of the medical home (and integrated approach among physicians) where you have a team to address it (the medical condition), this could work. Until you get to that model, I'm not sure how far you'll get, because the current model doesn't lend itself to that.

We're probably not going to shut down hospitals but the rate of growth of new beds will probably slow down. How are you thinking about other parts of the care continuum such as hospice, palliative care, and home health? Will you partner?

We're very much in our infancy with these areas. We're still trying to focus on creating some methodologies. For example, we're going to be liable for readmissions within 30 days. How do we do that with a conventional medical staff where our responsibility typically ended at the door when the patient went home?

We're nowhere near figuring out how to create structures with others in a way that allows for us to manage patients and be aware of them once they leave the hospital, so we have a long way to go.

I have heard some industry luminaries project that there are going to be 15 mega health systems in the U.S. in the future. What are your views on industry aggregation and pursuit of scale?

I see the health systems of America paralleling what we have seen in the airline industry. If you look at the airline industry, historically, they have dealt with overcapacity and huge fixed costs. Hospitals have overcapacity – the average occupancy in America is about 57 percent. Kaiser, for example, doesn't build a hospital until Kaiser can fill it up in most cases, based on the health plan they have and the number of subscribers.

I see more closings and consolidation of services in geographic areas – where there were three hospitals, now there may be two or one. You move your three heart programs that are all marginal to one place that does a lot of hearts and do them more efficiently at lower cost and higher quality.

We're going to parallel the airline industry. People think of scale too often as access to capital. I think scale is much more about streamlining operations, eliminating some overhead, and filling up hospitals, similar to the airlines industry shutting down airlines and getting rid of airplanes. They have taken assets offline. ●