Uprooting Shady Grove

by Alita Byrd

Myriads of changes have buffeted Shady Grove Adventist Hospital in Rockville, Maryland, and its parent company, Adventist HealthCare, over the past year: high turnover in top executive positions, a dramatic drop in the hospital's quality care ranking, strained relations between the medical staff and the board of directors, and public displeasure about compensation paid to top officials.

Many of the problems that Shady Grove has faced can be traced to the board of Adventist HealthCare, which has weathered scathing denunciations in the *Washington Post*, the incredulous anger of Adventist HealthCare employees and Adventists across the country, and the disapproval and distrust of the medical staff. The board has been forced to become much more aware of things that happen at the institutions under its charge and has changed its thinking about how a board should operate.

Adventist HealthCare oversees Shady Grove Adventist Hospital, Washington Adventist Hospital in Takoma Park, Maryland, Hackettstown Community Hospital in New Jersey, seven nursing and rehabilitation homes, and other health services. It has an average annual operating revenue of $400 million. With 5,200 full- and part-time employees and 1,300 volunteers, Adventist HealthCare is the largest private employer in Montgomery County, one of the wealthiest counties in the nation. More than 1,600 doctors serve at Shady Grove and Washington Adventist hospitals, delivering more than 6,000 babies and performing 900 open heart surgeries annually. Last year, Adventist HealthCare spent more than $1 million on prevention and wellness programs for the community. Shady Grove Adventist Hospital has 263 beds, about 1,300 doctors, and sees 60,000 patients each year in its emergency room alone. It would be an understatement to say that, during its twenty-year history, Shady Grove Adventist Hospital has made an impact on its community. Now, however, after a period of intense scrutiny by the press, accrediting agencies, and the state of Maryland, Shady Grove will never carry the same reputation it once did.

"Shady Grove has gone from a highly esteemed hospital to one that's on the brink of being dissolved," says Cheryl Winchell, a family practitioner and member of Adventist HealthCare's board of directors.

Two main issues have contributed to the demise of Shady Grove's reputation: large compensation packages paid to top executives and the apparent lack of quality care, both of which were widely discussed and investigated as a result of stories printed in the *Washington Post.* Although allegations of grave medical mistakes harmed the hospital's reputation in the community and with accrediting agencies, it was especially reports of huge compensation packages that infuriated Adventists and generated intense discussion in the Church.

On December 1, 1999, the *Washington Post* reported that executives at Shady Grove "gave themselves large raises and severance payouts, according to federal tax returns." The story went on to say that Bryan Breckenridge, chief executive officer at Adventist HealthCare with twenty-five years of service, had left in September 1997 with $4.74 million in compensation and lump-sum pay, and that chief financial officer Edmund R. Peters left soon afterward with $3.1 million. The story also mentioned large compensation packages for Ron Wisbey, chairman of the board for Adventist HealthCare, and Cory Chambers, who served as chief executive officer at Shady Grove after Breckenridge retired, but who had resigned before the story came out. The compensation figures quoted in the *Washington Post* were obtained from the publicly available Federal Form 990, which includes compensation figures for key employees and board members that Adventist HealthCare, a tax-exempt corporation, must file each year with the Internal Revenue Service.

After the *Washington Post* reported the multimillion-dollar figures, pandemonium broke loose. Reactions to the exposure of the hefty compensation packages, although varied, were vehement. Hospital employees called the compensation "ridiculous" and "obscene" while some hospital officials hotly disputed the method the *Washington Post* used to arrive at specific figures.

The compensation amounts had always been duly filed with the IRS, but no one had thought to look at them before. "People told me that when these guys quit they had been compensated well," said Avram Goldstein, the *Washington Post* reporter who broke the story. "But no one could give me numbers. I just decided to check."

Even board members, whose job it was to approve executive compensation, had never seen the actual figures. The Adventist HealthCare board met the same day the story broke, according to a report from the office of chairman of the board Harold Lee, and board members expressed disappointment in top executives. According to members of the board, they had been denied all the facts regarding compensation, even though they had appropriately requested them from management.

Terry White, a board member of four years and interim president of Shady Grove after Chambers left, said he hadn't been aware of the amount of executive compensation. "It never came up, we never talked about it," he asserts. "It was just done by the compensation committee."

Cheryl Winchell, who has served on the board for almost ten years, says that the board never saw any specific executive compensation information.

> All we got was aggregate data for all the employees working in the support center, about 200 people. We pressed for specific data but were told that the liability for setting salaries should be kept away from the board and that the compensation committee would take care of that. The idea was that we were being protected. The perks like vacations, cars, and retirement benefits were also never presented to the board. If I'd pressed harder at the time perhaps we could have avoided this public excoriation. . . . [I]t's been painful, but hopefully this was a learning experience.

Even the compensation committee didn't discuss specific dollar amounts, but evaluated raises, bonuses, and salaries in percentage terms, according to the minutes and members of the compensation committee. "While I was on the compensation committee we didn't talk about fringe benefits," says Dale Beaulieu, former treasurer of the Columbia Union and member of the board and compensation committee since 1997. "We talked about salary and bonuses . . . but in all the times I served we never talked in dollar amounts, only in percentages. We set rates based on the counsel of employment experts . . . who were supposed to make sure the percentages were okay and examine how we compared to hospitals in the area." Bealieu continues: "They would say something like 'You are about 17 percent lower than the community and you need to come up.'. . . But with the fringe benefits—like housing, vacation, expense accounts and all that—we [the compensation committee] were way out of line. That's all been pulled back to what [other Adventist health systems] are doing."

"Unless you see a dollar amount it's hard to see what it would really mean in dollars to the system," claims Les Pitton, former executive vice president for Adventist HealthCare. "I think that's why some of the board members may have felt they didn't have full disclosure."

Although upset that compensation amounts were not fully disclosed, board members and others argue that the aggregate figures published in the *Post* are not what they seem to be. "The *Post* reports were misleading," says Charles Scriven, a member of the board. "One-time only contributions to retirement funds is what led to these astronomical numbers."

Beaulieu concurs: "Retirement benefits skewed the totals [reported by the *Post*]. They [the executives] withdrew a lot of income from retirement funds that was counted as income."

Henry A. Smith III, of Smith & Downey, the tax attorney who provides tax counsel, explains the high numbers thus: "Apparently the *Post* reporter simply added up all amounts of any kind reported on the federal tax return that were accrued by Mr. Breckenridge over any period during his twenty-five year AHC career and reported them as 'received in September 1997.'" According to Smith, Breckenridge's actual salary for 1997 was $326,251, with a bonus of $103,853 for meeting performance goals, as determined by "an independent committee of community board members, acting upon the advice of a nationally recognized compensation specialists." Smith says that the rest of the money is listed because Breckenridge "did retire in 1997 and elected lump-sum distributions of certain of the deferred compensation and other benefits accrued over his distinguished twenty-five-year career."

Some of these other amounts consist of a withdrawal of Breckenridge's personally funded savings plan in the amount of $589,302, a cash-out of twenty-five years of unused vacation and sick leave in the amount of $648,769, and withdrawal from an employer-funded retirement plan with a payout of $1,305,633.24, according to Smith and corporate compensation office records. Also included in the form—as required by the IRS—were severance payments that followed termination of employment for a three-year period valued at $869,995, plus continued benefits worth $124,365, and $517,965 in deferred compensation benefits payable in February 1999.

The contract Breckenridge worked under gave him three years of severance pay equal to his full salary plus benefits if he did not accept a job with a competing organization. He continues to receive his full salary until August 2000. The contract was called an Employment Agreement, drawn up individually for each executive, and was initiated on June 1, 1995, for Breckenridge and Peters, and on September 1, 1997 for Chambers. The Employment Agreements included an evergreen clause, which automatically renewed the three-year contract each day so that the employee always had three full years remaining in his contract. The evergreen clause made it possible for the executives to be paid a full salary for three years after leaving the organization.

"The latest revelations about Adventist health care compensation are only the most recent in a decades-long discussion about what constitutes fair pay for executives and how it should be determined."

Hospital officials and others say that the 990 forms do not accurately show income. "Goldstein conveniently fails to mention the difference between an IRS Form 990, which has complicated reporting rules that include accrued benefits, and a W-2 income statement, which lists income earned during a given year," argues Kenneth B. Stefano, vice president and general counsel for Adventist HealthCare, in a letter to the *Washington Post.*

"No one in any health care organization trusts the 990's at all," says Monte Sahlin, vice president at the Columbia Union Conference.

Goldstein says that the 990s, all of which are public information, were all he had to work with. "They [the administration] told me if I looked at the W-2s the numbers would look different. But they wouldn't show me the W-2s." (The W-2s for hospital executives still have not been released on the advice of legal counsel. Privacy laws protect W-2s, which cannot be released without the permission of individuals involved.)

"The 990s have nothing to do with base salary," claims White. "Nine-Nineties are dangerous. That's one

reason the IRS set it up this way. They had no way to regulate the nonprofits, but they could use the whip of public opinion."

"Of course, the numbers will be big after the money has sat in an account and accrued interest for decades," says Sahlin.

Disgruntled employees complain that, even if the amounts listed on the 990 form are not accurate measures of annual income, the money eventually went to the person being reported and payment still involved millions of dollars, whether in the form of retirement funds, bonuses, salaries, or accrued income.

The intersection between the faith community doing charity and big business looking for profit is a difficult one to define. Expectations within the Adventist community are generally very different from those of the national market or even local community. "Here we had a melding of private industry and church philosophy," says Winchell. "Our executives got the big salaries normally paid by private corporations, but they also got all the benefits, many of which are offered to church workers to make up for their puny salaries. Contracts of this kind are highly unusual."

"This is not really a charitable activity any longer," asserts Sahlin. "It's really a highly competitive business. The government has done this to us with managed care and all of that."

In its April 13 issue, the *Adventist Review* published a story that compares compensation for executives at the eight Adventist health care corporations in the United States based on each corporation's 990 forms. Compensation amounts are given in a table published on the *Adventist Review*'s web site <www.adventistreview.org> that lists each corporation according to its total operating revenue. Because employee compensation is based on revenue, it is logical that executives at larger corporations are paid at higher rates.

This wasn't always true, however. Adventist HealthCare, the fourth largest company of the eight, paid its top executives more than any of the other corporations for years, according to the 990 forms. In 1996 and 1997, Adventist HealthCare reported that its average operating income was $337,299,779 and that its highest paid executive, Bryan Breckenridge, was paid $586,665 and $593,230, respectively, including only reported base salary and bonus. Adventist Health System Sunbelt Healthcare Corporation reported an average operating revenue of $1,731,892,667 and revealed that its highest paid executive received $417,287 and $497,652, respectively. Although executive compensation at all the corporations is in six figures, Adventist HealthCare executives seem to receive a much higher percentage of their annual budget than do executives at the other corporations. "It seems apparent that other Adventist health care systems [other than Adventist HealthCare] have followed lower levels of executive compensation," the *Review* concludes.

Adventist HealthCare's base pay for executives is comparable to executive pay at nonprofit hospitals in close geographic proximity to Shady Grove in affluent suburban Maryland. Holy Cross Hospital in Silver Spring, Maryland, has an annual revenue of just under $200 million and pays its president and CEO $313,062. Suburban Hospital in Bethesda, Maryland, has an annual operating revenue of $137 million, and compensation for its president and CEO is $405,431, according to their filed 990 forms.

As chair of Adventist HealthCare and Kettering Adventist HealthCare, Ron Wisbey did not make a salary as large as Breckenridge and the top executives, but was still paid handsomely by Adventist standards. Wisbey, an Adventist minister, served as president of the Columbia Union Conference and, in that capacity, as chair of the health care organizations, as had previous union presidents. In 1994, he felt that health care needed more of his time, resigned as union president, and accepted a new position created to be liaison between the Columbia Union and Adventist HealthCare and Kettering HealthCare. In 1997, as a professional chair, Wisbey received a base salary of $124,315, $37,229 in benefits and bonus for meeting performance goals, and $55,594 for retirement investments by the health care corporations. When the *Post* stories on salaries appeared, Wisbey suddenly decided to retire citing personal health reasons. After Wisbey's abrupt departure in January, no new health care liaison was named, and it is not yet clear whether that position will continue to exist.

Harold Lee took the job as chairman of the board after Wisbey left. This change put the duties of board chair back in the hands of the union president. Along with the title, Lee inherited the responsibility to explain how Shady Grove had gotten into such a mess. Lee's office put out a "Report on Recent Developments at Shady Grove Adventist Hospital" and presented it to top church officials, the board, and other interested parties. It was then published in the Columbia Union *Visitor*. The report gave detailed information about compensation and quality care issues and tried to

explain the background of recent problems.

Lee did not inherit, however, a salary paid by Adventist HealthCare and Kettering. In March it was voted that Columbia Union officers who serve on health care boards are not to be compensated in any way by the health care organizations. Instead, Lee is paid as only a union officer by the union. His travel expenses are even reimbursed by the union.

History of Compensation

The latest revelations about Adventist health care compensation are only the most recent in a decades-long discussion about what constitutes fair pay for executives and how it should be determined. Should the standards that govern health care executive compensation be based on church compensation policy or on current market rates?

In 1989, the General Conference Executive Committee decided that, in order to recruit and retain top candidates, pay for top executives in Adventist health care institutions should be based on the current market instead of the denominational pay scale. The committee drew up a Remuneration Plan as a guide to determine health care executives' compensation.

According to the report from Lee's office, however, different people have interpreted the plan in different ways. "Some have believed that it set the maximum salary for hospital executives at the 50th percentile or mid-point of the pay of the competing health care institutions in the area," the report reads. "Others read it to mean that executives of Adventist health care organizations are to be paid no more than the lowest salary paid by other healthcare organizations in the same area."

The *Review* quotes Neal Wilson, former General Conference president and attendee at the meeting, as saying, "Most don't interpret it [the 1989 action] correctly. It specifically rejected the 50th percentile."

Lee's report indicates that a guideline was adopted by the compensation committee of Adventist HealthCare "in 1995 or prior to that time to set executive compensation at the 75th percentile of comparable, competing organizations."

At present, Adventist HealthCare has a contract with Deloitte & Touche, an international consulting and accounting firm respected for its expert counsel on executive compensation. Each year, Deloitte & Touche consultants present a report that shows what comparable health care organizations pay their administrators and recommends compensation for Adventist HealthCare administrators based on market averages. Executive salaries are set by the compensation committee, which acts on the recommendation of the consultants.

Smith & Downey, a law firm that specializes in executive compensation issues, is paid to provide tax counsel. Henry A. Smith III says he has great confidence in the report that Deloitte & Touche has prepared. "They are very highly skilled compensation specialists," he says. "Compensation scientists draw on very specific databases using sophisticated techniques and compare compensation to enormous amounts of data. . . . Then they blend the data to make it useful to Adventist HealthCare. Their extraordinary professionalism inspires confidence."

In fact, federal regulations require an outside expert to examine executive compensation. According to Smith, however, Adventist Healthcare used outside experts long before such rules required it to do so.

Did the compensation committee at Adventist HealthCare base all executive compensation decisions on the recommendations of outside advisors? Lee is not willing to release the reports developed by the experts, so it is impossible to say.

Many people agree that the base salary should be competitive with market rates, but the other benefits offered exceeded average market rates. "We were way out of line with the fringe benefits," says Beaulieu. "Where it really got wacko was with the vacation and paid days off and all that," said a union employee who studied the figures while helping to prepare Lee's report.

Lee's report states that Adventist HealthCare's compensation committee, which operated in accordance with old bylaws made inoperable by recent IRS regulations, was made up of Adventist HealthCare's board chair, its chief executive officer, and its chief financial officer, along with a few members from the community. Ron Wisbey, Bryan Breckenridge, and Cory Chambers all served as members of the compensation committee, which, in turn, determined their salaries, bonuses, benefits, and retirement packages.

According to Winchell, previously Breckenridge could write a nice contract for himself, as well as for Edmund Peters, Ron Wisbey, and Kiltie Leach, former chief operating officer for Adventist HealthCare. Denise Valenzuela, a spokesperson for Lee, claims that the recollection of most board members is that when discussion about a particular person's salary arose, that person left the room. This practice is not reflected

in the minutes, however. (Wisbey disputes Lee's report, asserting that the chief financial officer was only present as counsel and recording secretary, not as a voting member. In addition, he says that pay for executives never reached the fiftieth percentile of area hospitals, but was always below.)

New guidelines for executive compensation are now spelled out in a policy manual that will apply to all executives. The new policies limit accumulated vacation hours, set compensation at approximately the fiftieth percentile of market rate, and end the practice

Photo: Courtesy of Adventist HealthCare

Shady Grove Adventist Hospital

of banking hours, which afforded departing employees compensation for accrued vacation hours at highest salary, regardless of the level at which those hours had been accumulated. Executives will no longer work under employment agreements that they, as members of the compensation committee, might have helped tailor for themselves.

Breckenridge's handsome severance package culminated a twenty-five year tenure at Adventist HealthCare characterized by growth and prosperity. "We adored him as a CEO, " says Winchell. "We admired him as a visionary."

"Adventist HealthCare wouldn't be at the level it is if it hadn't been for Bryan Breckenridge," says Wisbey. "It's here because of his vision and the leadership he gave to the company and the board. I found it a great privilege to stand at his side and help guide the company through its formative years."

"He built it [Shady Grove Hospital] up from scratch out there," says Beaulieu. Breckenridge, who now lives in Scottsdale, Arizona, asserts that he worked very hard for twenty-five years, putting in sixty- to seventy-hour weeks. He refuses to discuss the current situation at Shady Grove or the controversy over his compensation, citing confidentiality agreements. Instead, he leaves it up to the spokespeople at Shady Grove and the Columbia Union Conference to defend compensation decisions, including his salary. Although his tarnished legacy may be sweetened by his generous retirement package, Breckenridge must be hurt by the hostility former colleagues felt after details about his compensation were revealed. "It angered me that he built up a good institution and then raided it," says an acquaintance at a neighboring Adventist institution.

If Breckenridge were to visit Shady Grove Adventist Hospital today, he would find a rectangle of darker-colored wood on a prominent wall in the main lobby behind the receptionist's desk. That is the previous location of Breckenridge's framed picture, which once acknowledged him almost as the "father" of the institution. According to several physicians, the picture quietly disappeared during heated discussions about Breckenridge's compensation.

Quality Care Issues

Although divulgence of executive compensation in the *Washington Post* rankled Adventist HealthCare employees and Adventists across the country, the local community may have been even more disturbed by reports published in a series of *Post* stories that began on October 17, 1999, and revealed deteriorating care at Shady Grove, as well as "rampant errors" that threatened patient safety.

The week before the *Post* published its first story, reporter Goldstein, a frequent writer about health care issues, received a copy of complaints and concerns about staffing, information systems, and management at Shady Grove that the fifteen-member medical executive committee had prepared for the board. Someone sent Goldstein a copy before it even reached the board.

According to doctors and nurses quoted in the report, staff cuts had led to medication errors, medical order violations, and missed opportunities to remedy problems. Goldstein started to talk with people and soon received "an unprecedented number of e-mails, letters, and calls from people who were angry with Shady Grove." Doctors and nurses alike complained about too much work and about a staff-to-patient ratio much too low. After the

first story appeared, according to one physician, Goldstein only needed to sit back and wait for the phone to ring to write follow-up stories.

The first *Post* article lambasted the hospital for several costly medical mistakes, including the death of an intensive care patient left unattended in a hallway and the replacement of the wrong hip in another. One day later, three hospital inspectors from the state of Maryland began a six-day unannounced survey. Four days afterward, a pair of evaluators from the Joint Commission on Accreditation of Healthcare Organizations, an independent organization that rates hospitals nationwide, joined the state inspectors. The findings of their survey resulted in the Joint Commission's decision to lower the status of the hospital from its top position of "accreditation with commendation" to "preliminary nonaccreditation," the lowest category, which could lead to loss of accreditation. Without accreditation from the Joint Commission, the hospital could lose essential funding from Medicare and Medicaid.

"Fifteen months after accreditation with commendation we get this?" asks Wisbey. "We've always done really well when the Joint Commission came in every three years," says Richard Boyd, manager of radiology at Washington Adventist Hospital and an employee of Adventist HealthCare for twenty-five years. "Last time we worked really hard and Shady Grove got a 99 [out of 100]. We've never had any problems like this."

In December, representatives from Shady Grove appealed the decision before a review panel at Joint Commission headquarters in Chicago. On February 3, the Joint Commission announced that it would continue Shady Grove's accreditation on a conditional basis, subject to another unannounced survey within ninety days.

The next, unannounced survey started on February 22, when fifteen examiners visited Shady Grove for a four-day inspection. They did not restore Shady Grove to full accreditation, partly because the hospital had still not hired key executives to solve important patient care problems. Continued scrutiny will continue while the hospital struggles to resurrect its image in the Joint Commission's eyes. Because of this continued scrutiny, many hospital employees and board members are wary of speaking with the media about any topic, other than the most positive or benign. They fear that any additional media attention could get them into more trouble.

> "Before we were told what to think and we left [the meeting]. Now everything is questioned and looked at with a much more critical eye. No one is spoon-feeding the board anything anymore."

Criticism of the Joint Commission

The Joint Commission which evaluates nearly 20,000 health care organizations nationwide has recently been under fire itself. The *Post* has reported that, prior to Shady Grove's problems, the accreditors were under pressure to crack down.

"The Joint Commission has long drawn criticism from patient advocates and government officials who believe its relationship with the hospitals it inspects is too cozy," a December 12 story stated. "Congress has been very hard on the joint commission and the way they survey hospitals," White was quoted in the same story.

According to Wisbey, "Shady Grove is in the backyard of Congress and consequently the Joint Commission focused on this hospital where they could prove their ability to deal with an institution from a harsher standpoint."

"It's true that the hospital may not have been as good as the rating they were given in 1998," says Alan Kravitz, a surgeon on the medical executive committee. "But it's not as bad as the [latest] score they gave it. The Joint Commission has been criticized for their whole inspection process. The hospital was unfairly slammed; they came down hard on us because they were embarrassed."

Hospitals have at least six weeks notice to prepare for the standard inspection, which occurs every three years. The Commission says it selects 5 percent of all organizations it inspects for random, unannounced surveys. In addition, it will conduct unannounced surveys in response to reported complaints.

"The inspection process is lame," claims Kravitz. He asserts that hospitals can prepare for the inspections, saying that once Shady Grove even planted trees to improve the grounds before an inspection, then ripped them out afterward. After the media reported serious lapses in patient care at Shady Grove, "JCAHO (the Joint Commission) had to look tough, and the state had to look in charge and show people they know what they're doing," says Kravitz.

The Joint Commission, however, has denied singling out Shady Grove to demonstrate toughness to the state and federal governments.

Quality Care Lacking While Executives Make Millions

Goldstein, the *Post* reporter, wrote his stories about the compensation of executives at Adventist HealthCare only after reporting seven pieces over a month and a half about the apparent lack of quality patient care at Shady Grove. "I never planned to write all these stories," Goldstein says. "But news just kept on happening."

The stories implied that terrible mistakes in the hospital were attributable to financial pressures that led to staff shortages, which then resulting in overworked nurses. So, of course, when the *Post* published a story about how the executives, who had no personal contact with patients, were making millions, the community became angry.

Nurses were disgruntled to learn that the executives made such big money. One nurse said that the hospital did not even provide pens, and that she and her coworkers had to use their own to mark patient charts. It made many people bitter to be told about cost cutting measures and feel that everyone should tighten their belts together, yet to learn that the CEO left with almost $5 million. One former nurse at Washington Adventist Hospital, who now works at Adventist Home Health Services, worried that her tithe money was paying the salaries of top administrators. According to her, many people she knows ("pillars in the community") stopped paying tithe because of this concern. (In fact, none of the compensation came from tithe money; the salaries were paid by the institution, which is not funded by the Church.)

Hospital officials have always denied that Shady Grove had staff shortages. The *Post* quotes spokesman Robert Jepson: " In comparison with other hospitals in Maryland, Shady Grove is at an appropriate staffing level." When asked what the precise figures were for layoffs in 1997 and 1998, around the time that Breckenridge left, Jepson said, "We had no major layoffs during that time. It wouldn't have been more than a couple."

Lee's report went to great lengths to show that Shady Grove doesn't have staff shortages and that any layoffs were insignificant. "There are 1,725 employees at SGAH (Shady Grove)," the report says." Of those 1,135 are clinical employees with patient contact. The actual net reduction in work force from January through October, 1999, was 44 and only five of these were nursing positions."

Where did the *Post* get the idea that staff shortages existed? The idea originally came from the memo drafted by the medical executive committee, which had serious concerns about staffing and management issues and voted to demand board action.

But there could be another explanation. After the uproar that accompanied Wisbey's retirement on January 18, Adventist Health System Sunbelt, which is based in Orlando, Florida, and runs thirty-four hospitals in nine states and Puerto Rico, came in to provide temporary executive management and consulting services. During the system's assessment of patient care at Shady Grove, representatives made many recommendations to improve quality.

"They provided us with outside eyes," says Winchell. "We have plenty of staff—the staff cuts made were a drop in the bucket. But nurses were saying they had no time and doctors were saying there weren't enough nurses. . . . How can this be?" Winchell continues: "Adventist Health System said that the staff were working so inefficiently they had to work much harder than they should have to get the work done. They weren't lazy, we just hadn't set up systems that made sense," explains Winchell. "The chief operating officer needs to set up efficient ways of getting work done. Adventist Health System said we were duplicating effort and not communicating well. . . . As a result of this scrutiny we've found out about some extremely inefficient and illogical procedures."

Some doctors quoted in the *Post* support this view. Wayne Ledbetter, an orthopedic surgeon, told Goldstein, "I have been frustrated perpetually with the lack of teamwork in the operating room as nurses are constantly reassigned and new nurses are being trained."

Lack of communication between all levels of hospital employees caused tremendous problems at Shady

Shady Grove, from nurses failing to communicate with other nurses to administrators failing to listen to doctors. Many employees said that there were not adequate procedures in place to accomplish tasks efficiently.

"There was a system for communicating, but there was some breakdown along the way," claims Beaulieu, a member of the board. "This is how communication between the medical staff and the board was supposed to work: Doctors reported problems to the executive medical committee. If it wasn't resolved they could report it to the chief operating officer. If he didn't do anything they could contact the chief executive officer. If nothing was done at that point, they felt they weren't being heard."

Bealieu goes on: "What I think was happening was that when the concern got to the chief executive officer [Cory Chambers], he would go back to the chief operating officer and tell him to take care of it. Then nothing would happen. You can't ignore the medical staff—they must be taken seriously. . . . We all should have to report to somebody. Even the president of the United States reports to Congress. We are all accountable to somebody. Now clearer steps are outlined so that everyone understands that those are the procedures."

The board began to pay a lot more attention after the lack of effective communication became apparent. "The board has gotten very involved in quality issues," says Winchell. "We used to think our job was overview—the big issues—but now we're very involved. We weren't hearing that things weren't working before. It's too bad things got to such an extreme before we heard the medical staff. Now the medical staff don't have a lot of trust in the integrity of the board, which is very sad. It's painful to see that the medical staff doesn't trust you."

Winchell believes the problem lies in poor management, not staff shortages. The performance improvement committee is working diligently to bring problems to the board level, according to Winchell. They are now working under the premise that "if you do it right the first time, you will end up with a better and cheaper product."

The idea behind bringing in Adventist Health System was that their "resources and management expertise . . . would be a valuable asset," according to an internal memo sent to all employees by Ron Wisbey, who stepped down as chief executive officer to make way for Robert Henderschedt of Adventist Health System to serve as interim president and CEO.

For a time it was unclear whether Adventist Health System would only provide temporary management or whether the two health systems would merge, which would have given the larger Adventist Health System control of Adventist HealthCare. The original agreement was that Adventist Health System would stay for thirty days, after which time the situation would be assessed.

"Initially the chairman of the board [Harold Lee] expressed a lot of interest in a merger," says Charles Scriven, a member of Adventist HealthCare's board. "He asked the board to approve Adventist Health System providing leadership. The board saw that the chair wanted a more permanent relationship, but the board . . . was never sold on a merger and rose up in fairly strong opposition. The board felt virtually unanimously that it would be best to remain independent."

"In the end," according to Scriven, "the feeling of the board prevailed. Adventist HealthCare is probably worth a couple of billion dollars. Why would we just give the company away? Members of the local community felt a little queasy about the idea that the hospital would come under the control of a corporation in Orlando. The public seemed antagonistic to the idea."

"The interim team was helpful," says Winchell, "but we as a board were never interested in a merger. Harold Lee wanted to merge, but he wasn't straight with us that that was his game plan." When the discussions of merging with Adventist HealthCare were underway, the search for a CEO was pushed aside. A new CEO was only needed for an independent Adventist HealthCare. "The board plan [to find a new CEO quickly] got strung out for so long while the hospital staff was desperately crying out for leadership," says Winchell.

On March 16, the Adventist HealthCare board voted to remain independent and to accelerate the search for a permanent CEO. The search had theoretically been going on since Chambers was forced to resign at the beginning of November 1999. Several other key management positions were also vacant awaiting input from the new CEO before they could be filled.

Such a turnover in management may have helped the hospital get rid of unqualified executives who did not do their jobs effectively, but lack of permanent replacements has made it difficult to effect improvements. The chief executive position passed into four different pairs of hands over the course of only six months. Wisbey, chairman of the board, served as interim CEO until retiring suddenly on January 18, citing health and personal reasons. Henderschedt, senior vice president for Adventist Health System, then became interim CEO until a permanent replacement could be found. Terry

White, a member of the board and a health care professional, was installed as interim president of Shady Grove during this time.

Other changes in top administration added to the instability. In November, Kiltie Leach was removed from his position as chief operating officer for all of Adventist HealthCare to become chief operating officer for Washington Adventist Hospital. Harry Weis, chief financial officer for Adventist HealthCare for two years, left in early January to accept a position as the chief financial officer for a system of five hospitals in California and was not replaced.

Fortunately, less than a month after the board voted to remain independent a permanent president and chief executive officer was named after a national search. Bill Robertson, chief executive officer of Shawnee Mission Medical Center in Kansas City, Kansas, began his duties at Adventist HealthCare on May 17. Physicians, board members, and employees express positive hopes for the future of Shady Grove under Robertson's leadership.

"His first priorities are to fill the vacant or interim management positions that exist," says Jepson. "That is the best prescription for resolving these issues."

Beaulieu, a member of the search committee, is confident that "Bill Robertson will bring great new leadership and put in place a new CFO, COO, and CNO at Shady Grove. When he gets his feet on the ground we'll see a lot of great things happening."

"His credentials are impeccable," adds Marshall Ackerman, a board member and physician. "I'm very, very encouraged that we have found someone who can really accomplish the tasks that are needed to bring us in line with all the authorities."

Robertson says that he feels "honored and thrilled to be here [at Adventist HealthCare]. It is a wonderful organization with wonderful people and a wonderful mission of service." Robertson is aware of numerous problems at Shady Grove, but says that "When you're working for people or on behalf of people in partnership with God, the problem is never bigger than God."

Under Robertson's leadership, more changes are being made. In building a new executive team, Pitton, executive vice president of Adventist HealthCare and one of the few executives left, was let go. Ed Hodge will assume his responsibilities and serve as executive vice president of general administration. Deborah Yancer has been hired as president and chief operating officer of Shady Grove, replacing Terry White who was serving on an interim basis. Robertson has also presided over the acquisition of a bankrupt psychiatric hospital located adjacent to Shady Grove for $7.2 million.

As the board installs new leaders at Adventist HealthCare and implements changes at Shady Grove Adventist Hospital, it is also reinventing its function and process.

"We used to meet every few months," says Winchell. How often does the board meet now? "Lately it feels like about every thirty-five minutes!"

"What's changed is that the numbers and policy used to be withheld from the full board," observes Scriven. "Only the small group [the compensation committee] saw those. Now the full board sees everything. There is an openness I've never seen on the board before."

The board has approved a completely new compensation and benefits policy for executives conforming to standard rules. The bylaws that govern the board are also being discussed and evaluated for future amendment as needed. The compensation committee now has more members and all board members are invited to its meetings. Minutes of board meetings are kept more carefully and board members question everything.

"Before we were told what to think and we left [the meeting]," says Winchell. "Now everything is questioned and looked at with a much more critical eye. No one is spoon-feeding the board anything anymore. Once you see that you've been caught asleep at the wheel, you make sure you don't . . . drive off that cliff a second time." According to Winchell, "Harold Lee allowed all board members to be part of policy setting. It's all a very open process. We hope others can learn from our mistakes."

Administrators, employees, and Adventist HealthCare board members are optimistic about the future of Shady Grove. "The twenty years of service Shady Grove has given to this community has built up tremendous goodwill," says Ben Wygal, vice president for prevention and wellness at Adventist HealthCare. "While that goodwill may be somewhat damaged with all this business, it is recoverable because we have such a quality future. I'm super optimistic about rebuilding the confidence that may have waned a little here and there. You have to look at the continuum rather than just a snapshot in time."

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