CASE 6

Ellen Zane – Leading Change at Tufts–NEMC

It was a difficult decision to take this job. But there was something about the history of Tufts–NEMC and its importance to so many stakeholders that really grabbed me as the epitome of what one could do in one's career. I'd also learned not to be adverse to risk. You have to take risk, not stupid risk, but you have to take risk. **– Ellen Zane, CEO, Tufts–NEMC**

Ellen Zane brought a cup of coffee into her home office. It was 4:30 a.m. and she was, as usual, starting the day early. She fired off a few emails to her senior staff and looked over the *Women's Business* magazine on her desk. Her photograph was on the cover, highlighting the article on the turnaround she was attempting to execute at Tufts–New England Medical Center (Tufts–NEMC). It was the summer of 2006 and it had been an incredibly rough two and a half years since she accepted the CEO position at the ailing Boston hospital. Since then the hospital had survived the worst of

This case was made possible by a grant from The Patrina Foundation. The authors, Cynthia Ingols and Lisa Brem of Simmons College, developed this case solely as the basis for class discussion. Cases are not intended to serve as endorsements, sources of primary data, or illustrations of effective or ineffective management.

Exhibit 6/1: Tufts–NEMC Income and Expense for Fiscal Years 1989–2005 (in thousands)

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Revenue:																	
Net patient services revenue	218,820	230,616	272,108	297,351	314,445	301,385	309,938	281,791	287,076	299,930	318,145	341,894	371,273	397,212	473,012	452,786	495,005
Direct expenditures on grants, contracts and other activities	21,063	21,423	23,083	25,608	28,467	33,302	60,805	52,059									
Recovery of indirect costs on grants and contracts	5,770	7,129	5,778	7,900	8,883	9,762			55,205								
Software including support and consulting			12,009	14,660	18,934	23,469	28,777	6,175									
Other revenue	22,340	23,949	16,788	14,443	14,801	13,961	13,690	17,917	22,797	24,045	22,561	26,228	36,055	33,790	51,686	42,853	48,232
Endowment earnings contributed toward community benefit										9,229	10,647	16,512	7,949	1,596			
Net assets released from restrictions used for operations										3,435	2,272	3,037	3,020	4,753	4,526	17,259	2,924
Net assets released from restrictions used for research										44,001	41,314	47,582	37,702	38,250	53,196	52,891	55,901
Total operating revenue	**267,993**	**283,117**	**329,766**	**359,962**	**385,530**	**381,879**	**413,210**	**357,942**	**365,078**	**380,640**	**394,939**	**435,253**	**455,999**	**475,601**	**582,420**	**565,789**	**602,062**
Net Investment income	5,151	698															
Unrestricted gifts, grants and awards/net assets released from restrictions	535	817					1,104	936									
Adjustments to prior year estimates with third party payors						12,600	11,342	11,800									
Total Revenue	**273,679**	**284,632**	**329,766**	**359,962**	**385,530**	**394,479**	**425,656**	**370,678**	**365,078**	**380,640**	**394,939**	**435,253**	**455,999**	**475,601**	**582,420**	**565,789**	**602,062**
Expenses:																	
Salaries and wages	104,574	113,557	128,739	143,124	158,511	160,183	167,380	146,900	184,746	191,629	180,206	203,449	222,489	227,706	297,827	295,645	308,057
Employee benefits	15,591	18,920	21,163	23,407	26,004	26,787	31,130	24,581	24,031	21,531	21,058	24,098	25,491	28,543	55,918	57,004	56,416
Purchased services of physician groups	23,033	24,579	29,648	31,236	35,354	32,051	39,620	37,176		34,021	35,875	36,416	40,201	43,075	49,461	40,303	47,627
Supplies and expenses	63,924	68,740	77,499	87,684	96,660	102,688	132,843	119,242	115,950	95,124	109,120	119,730	135,132	140,891	158,501	141,793	140,371
Interest	8,266	8,561	8,048	8,165	9,194	8,996	12,115	14,230	14,164	13,983	13,775	13,576	13,350	13,193	12,561	12,044	11,607
Depreciation and amortization	15,687	15,382	18,914	19,188	22,548	26,065	32,033	32,996	32,646	14,525	15,168	16,034	18,076	18,959	21,410	23,976	23,307
Direct expenditures on grants, contracts and other activities	21,063	21,423	23,083	25,608	28,467	33,302											
Uncompensated care/ provision for bad debts	16,433	7,911	12,171	18,878	14,087	12,796	16,187	17,175	18,853	18,344	19,492	21,309	17,099	15,747	15,934	21,184	12,541
Other expenses							(6,250)		(138,500)						14,638		
Total operating expenses	**268,571**	**279,073**	**319,265**	**357,290**	**390,825**	**402,868**	**425,058**	**392,300**	**390,390**	**389,157**	**394,694**	**434,612**	**471,838**	**488,114**	**626,250**	**591,949**	**599,926**
Income (loss) from operations	5,108	5,559	10,501	2,672	(5,295)	(8,389)	598	(21,622)	(163,812)	(8,517)	245	641	(15,839)	(12,513)	(43,830)	(26,160)	2,136
Nonoperating gains and losses:																	
Net unrestricted investment income		8,611	9,748	6,090	5,242	2,995	805	5,461	4,561	7,974	4,421	9,226	4,040	2,277	2,102	2,041	2,838
Net realized gain on sale of investments	1,490	1,405	1,814	3,876	3,770	6,570	2,357	2,253	9,711	9,100	6,083	5,506	2,691	(2,150)	3,429	4,842	11,074
Gain on sale of TSI and other property								72,958		(245)						19,698	2,075
Other nonoperating losses									50	(1,063)	(28)				(196)	188	234
Total nonoperating gains, net	1,490	10,016	11,562	9,966	9,012	9,565	3,162	80,672	14,272	16,829	10,476	14,732	6,731	127	5,335	26,769	16,221
Excess (deficit) of revenues over expenses	6,598	15,575	22,063	12,638	3,717	1,176	3,760	59,050	(149,540)	8,312	10,721	15,373	(9,108)	(12,386)	(38,495)	609	18,357
Total other capital items						(11,814)	4,765	13,455	(3,070)						18,041	5,888	2,636
Excess (deficit) of revenues over expenses	6,598	15,575	22,063	12,638	3,717	(10,638)	8,525	72,505	(152,610)	8,312	10,721	15,373	(9,108)	(12,386)	(20,454)	6,497	20,993

Source: Company Records.

its financial troubles – they were meeting efficiency goals and for the first time in years, more doctors joined the hospital than left it. Tufts–NEMC posted an $18 million gain in 2005, after losing nearly $60 million since 2001 (see Exhibit 6/1 for financial statements). People were smiling and thanking Zane in the corridors.

But that was a piece of the problem. This was the tricky part, she thought, in one of her rare moments of quiet as the pre-dawn light slowly infused the room. Zane realized that she was still deeply worried about the future:

> This place was just so fragile and I still consider it fragile. It's one month forward and one month back. This market is unforgiving and tough – I swim with the sharks and nobody glad-hands us. I tell the staff all the time – not a minute do we take our foot off the gas.

Zane struggled with how to maintain the solidarity that the financial crisis had created among Tufts–NEMC's 5,000 employees.[1] She knew from her 30 years of experience in hospital management that sustaining change in Boston's cut-throat medical industry was the hardest part of any turnaround. She had been successful before with Quincy Hospital, but Quincy had been a much smaller player. Tufts–NEMC was a 450 bed Academic Medical Center (AMC) that was the primary teaching site for Tufts University School of Medicine, and conducted over $50 million in research each year. It had 17,000 admissions in 2005 and generated $600 million in revenue. Unfortunately, while Boston's other AMCs merged, built networks, and grew stronger, Tufts–NEMC had for years floundered directionless in Boston's rough seas. As Zane headed to her office overlooking Boston's Chinatown she wondered: How could she create and sustain true and lasting change for Tufts–NEMC?

The Health Care Industry in Boston

Health care, together with education and computer technology, is what Massachusetts is known for throughout the world.2 Home to several high-profile Academic Medical Centers, the Boston area was a world-renowned destination for health care services. Massachusetts General Hospital (MGH), Brigham and Women's Hospital (BWH), and Beth Israel/Deaconess Medical Center were affiliated with Harvard Medical School, Boston University Medical Center with Boston University, and Tufts–New England Medical Center with Tufts. These large AMCs led the way in capturing $2.3 billion in National Institutes of Health (NIH) research grant money, second only to California. Massachusetts hospitals employed 12.2 percent of the total labor pool, and accounted for a whopping 11.7 percent of the gross state product. Health care expenditures per capita were between 27 and 29 percent higher than the national average from 1990 to 2000 (see Exhibits 6/2 to 6/9 for Massachusetts health care statistics). Consumers, health plans, and governing bodies tended to accept that heath care in Boston cost more in accordance with the high quality and cutting edge services the region provided.

Nationally, however, years of underfunding by federal and state governments and rising enrollment left Medicare and Medicaid payments lagging behind

Exhibit 6/2: Boston Comparative Demographic and Health Care Indicators

Demographics[a]			Health System Characteristics			Health Care Utilization[c]		
	Boston	**Metropolitan Areas 200,000+ population**		**Boston**	**Metropolitan Areas 200,000+ population**		**Boston**	**Metropolitan Areas 200,000+ population**
Population	4,579,137		Staffed Hospital Beds per 1,000 Population (2002)	2.2	3.1	Adjusted Inpatient Admissions per 1,000 Population	240	197
Persons Age 65 or Older	12.7%	10%	Physicians per 1,000 Population (2003)[b]	2.8	1.9	Persons with Any Emergency Room Visit in Past Year	20%	18%
Median Family Income	$39,182	$31,301	HMO Penetration (including Medicare/ Medicaid)[c]	37%	29%	Persons with Any Doctor Visit in Past Year	86%	78%
Unemployment Rate	5.2%	6.0%	Medicare-Adjusted Average per Capita Cost Rate, 2005	$768	$718	Persons Who Did Not Get Needed Medical Care During the Last 12 Months	3.6%	5.7%
Persons Living in Poverty	9%	13%				Privately Insured People in Families with Annual Out-of-Pocket Costs of $500 or More	33%	44%
Persons Without Health Insurance	5%	14%						

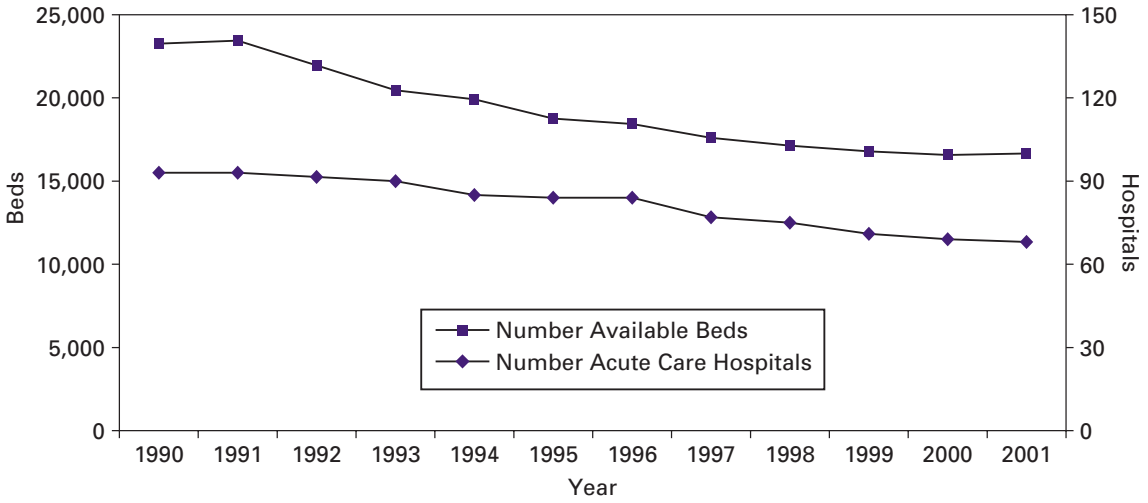
[a]Statistic for year ending 2003.

[b]Includes nonfederal, patient care physicians, except radiologists, pathologists and anesthesiologists.

[c]Markets with population greater than 250,000.

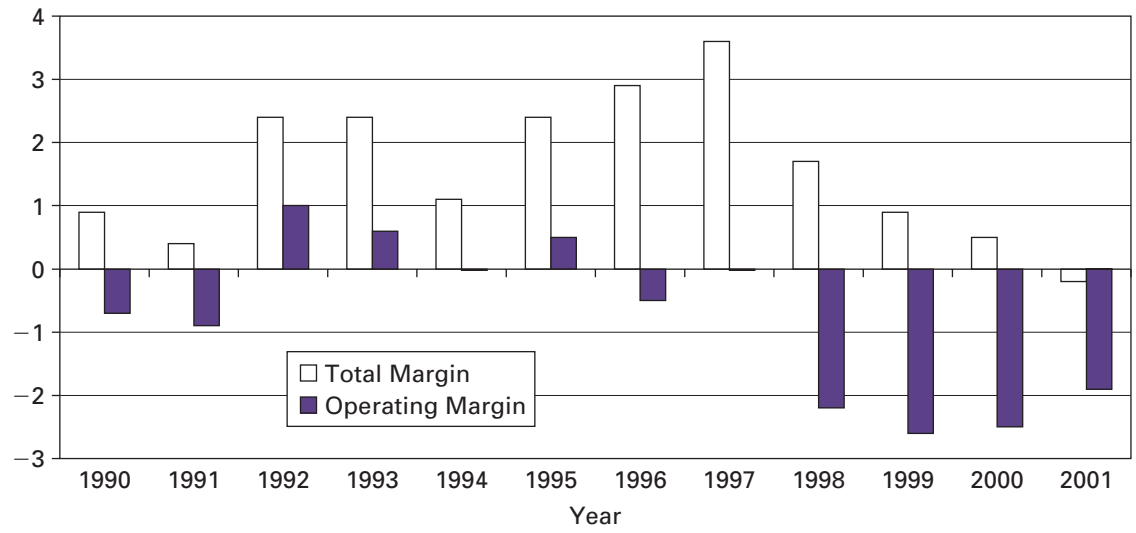
Source: Center for Studying Health System Change, Community Report Number 11 of 12, December 2005.

Exhibit 6/3: Number of Acute Care Hospitals and Available Beds in Massachusetts (1990–2001)



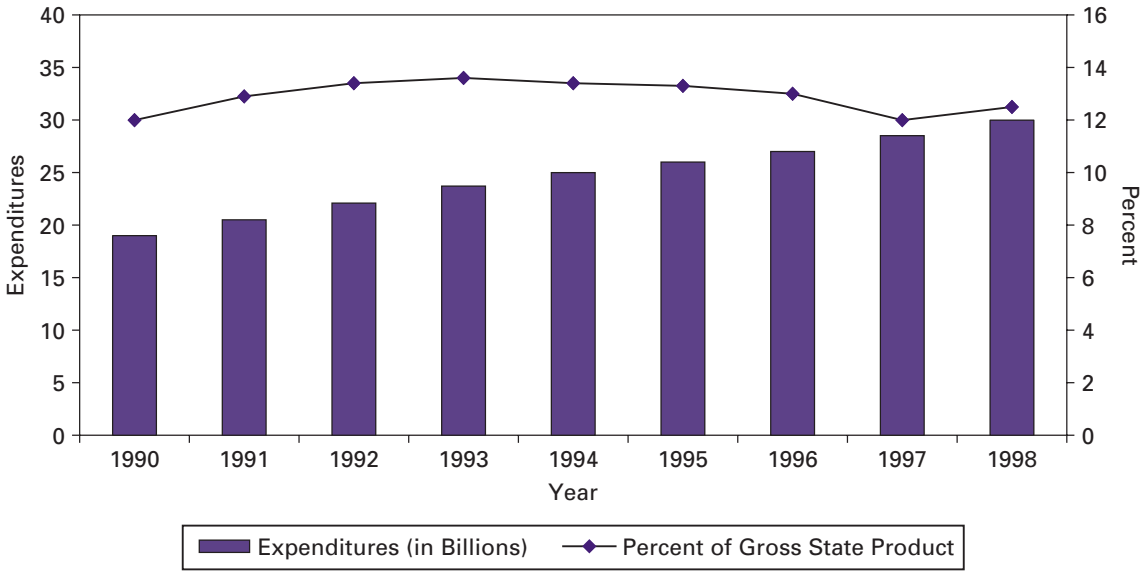
Source: Massachusetts Health Care Trends: 1990–2004.

Exhibit 6/4: Total and Operating Margins for Acute Care Hospitals in Massachusetts (1990–2001)



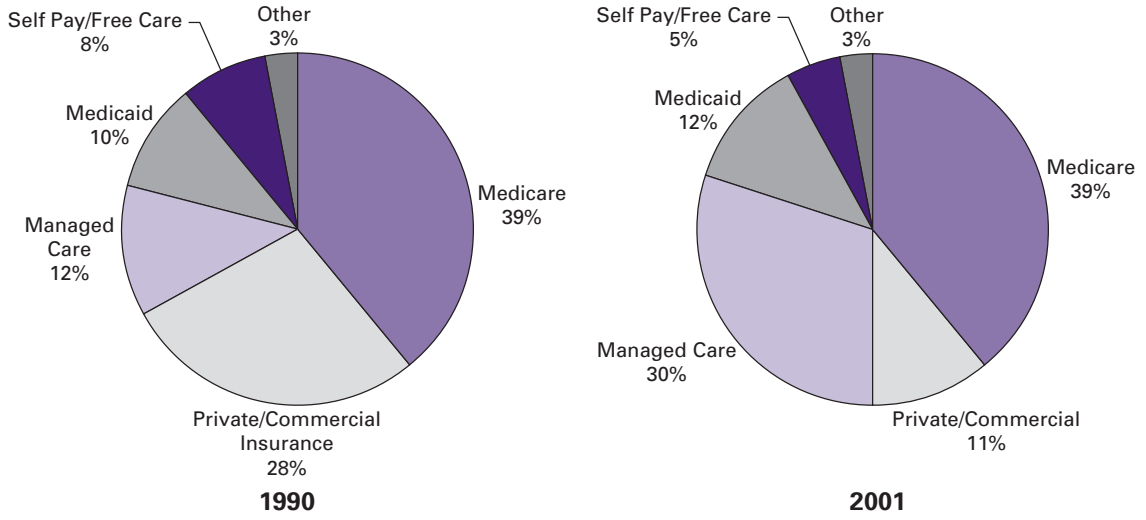
Source: Massachusetts Health Care Trends: 1990–2004.

Exhibit 6/5: Distribution of Health Care Expenditures in Massachusetts (1990 and 1998)



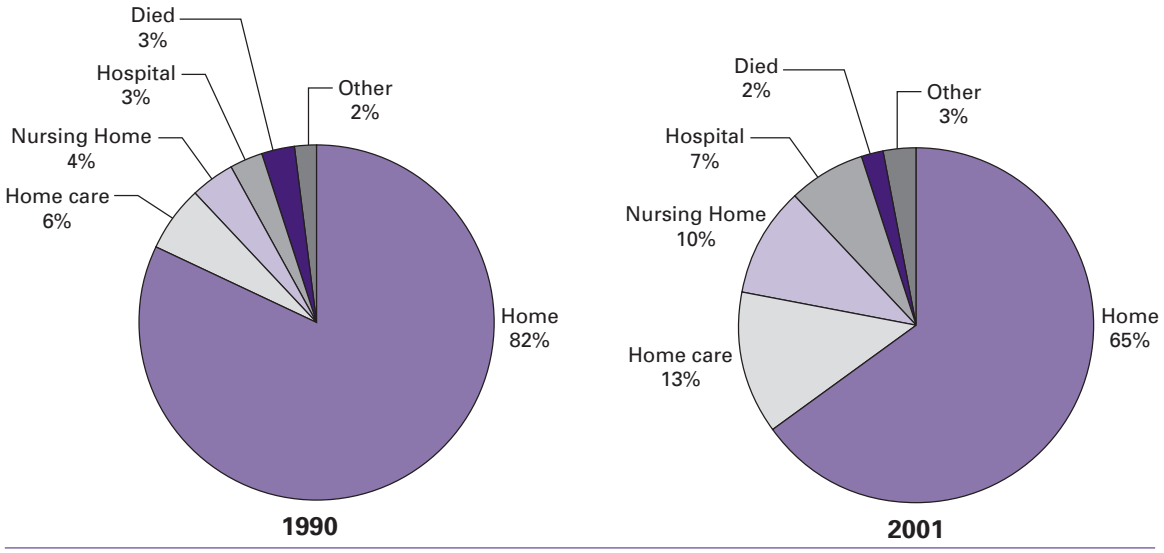
Source: Massachusetts Health Care Trends: 1990–2004.

Exhibit 6/6: Distribution of Acute Care Hospital Revenues by Payment Source in Massachusetts (1990 and 2001)



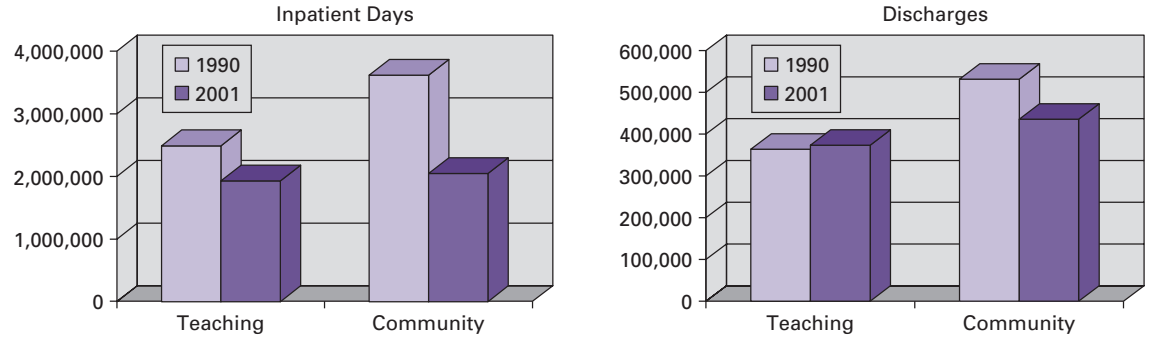
Source: Massachusetts Health Care Trends: 1990–2004.

Exhibit 6/7: Distribution of Patient Disposition at Discharge from an Acute Care Hospital in Massachusetts (1990 and 2001)



Source: Massachusetts Health Care Trends: 1990–2004.

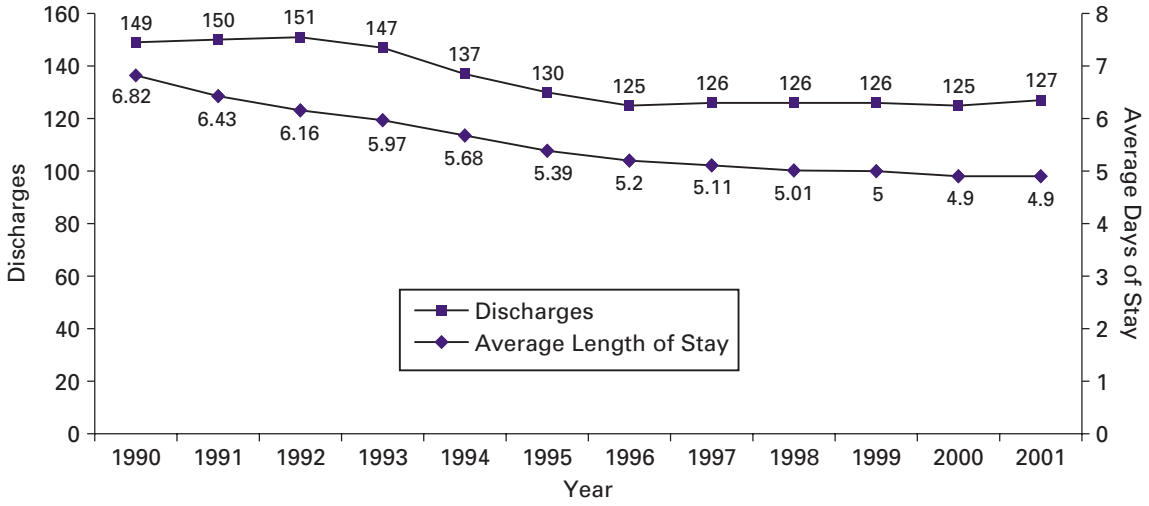
Exhibit 6/8: Inpatient Days and Discharges for Teaching versus Community Hospitals in Massachusetts (1990 and 2001)



Source: Massachusetts Health Care Trends: 1990–2004.

surging medical costs. Hospitals in Massachusetts and the rest of the nation amassed significant debt in the 1970s and 1980s as they refurbished older facilities, expanded services, and purchased expensive new technologies. While reimbursements fell behind rising costs, hospital discharges declined sharply in the 1980s, as did the average length of stay. In Massachusetts, a decrease in hospital births and non-resident discharges[3] led to an overall decline of 24 percent in total hospital discharges from 1991 to 1996. The increase in outpatient surgeries also affected hospitalizations.[4]

Exhibit 6/9: Acute Care Hospital Discharges per 1,000 Population and Average Length of Stay in Massachusetts (1990–2001)



Source: Massachusetts Health Care Trends: 1990–2004.

Throughout the 1990s, Massachusetts health care insurance plans followed nationwide trends when they merged into three large competitors: Harvard Pilgrim Health Care, Blue Cross/Blue Shield of Massachusetts, and Tufts Health Plan. These "big three" plans wielded increasing power in the marketplace, and their movement to managed health (HMO) plans resulted in lower payments to providers[5] and more oversight on costs and medical services. All three expanded regionally, to entice large regional and national companies to offer their plans to employees. HMOs used capitated payments, meaning they reimbursed providers on the basis of the number of 'covered lives' in the provider system. Thus, providers of health care services such as hospitals and doctors believed volume and efficiency of services to be the most important factors in future financial success.

In 1991 Massachusetts deregulated hospitals for the first time in 10 years. These conditions succeeded in making an impact – threatening the financial viability of hospitals and moving them toward more efficient and cost effective management practices. Boston's health care leaders struggled for a strategy to survive in the new environment. Mergers, closures and conversions loomed.

The leaders of MGH and BWH made the first decisive move. Managers at both hospitals believed they needed additional leverage to hold their own in negotiations with the ever more powerful health insurance plans. They also envisioned building a network of community primary care and specialist providers who would refer tertiary[6] patients to the member hospitals, thus bolstering volume. In 1994, when the news of the merger of these two behemoths – forming Partners HealthCare System, Inc. (Partners) – became public, it was a seismic change in the landscape of the New England medical industry. Others quickly followed

suit. From 1990 to 2000, there were 47 acquisitions and mergers and 19 acute care hospital closures, not including the formation of 10 major hospital systems in Massachusetts.[7]

Following the market consolidations in the 1990s, the turn of the twenty-first century years were difficult ones for Boston's hospitals and insurers. Both Harvard Pilgrim and Tufts Health Plans were hindered by regional over-expansion. In 1999, Harvard Pilgrim went into receivership after posting a $226 million loss, while Tufts Health Plan lost $42 million. Community hospitals also continued to struggle from high debt, inadequate reimbursements, high labor and pharmaceutical costs, and failed merger or network integration attempts. In Massachusetts particularly, consumers began to migrate to the more expensive AMCs from the smaller regional or community hospitals, seeking what they perceived to be a higher quality of care. Cuts in payments from Medicaid, Medicare, and private insurance plans continued to plague many providers. To encourage more efficient management and cost containment practices among its providers, HMOs started to move away from capitated care and toward pay-for-performance plans.

Even some AMCs felt the pressure on their organizations. CareGroup – another Massachusetts-based hospital umbrella organization posted a loss of $215 million over 1999 and 2000 and lost market share and network physicians. Partners, however, grew and remained strong, reaching 5,600 doctors in its Partners HealthCare System, Inc (PCHI) network. In a seminal flexing of its market strength, Partners negotiated up to 30 percent increases from all three major health plans, at one point refusing to continue a contract with Tufts Health Plan until it agreed to higher payments.[8]

By 2005, the provider market was dominated by four major hospital systems: Partners, reporting a surplus of $30 million, Caritas Christi, CareGroup (which had decentralized most of its operations back to its member hospitals), and Boston Medical Center. See Exhibit 6/10 for provider descriptions. When the dust settled on the consolidation activity, there were approximately 25 acute care, five psychiatric, and five rehabilitation hospitals in the metropolitan Boston area, with Partners leading in market share.[9] On the insurer's side, the major health plans recovered, with Blue Cross/Blue Shield of Massachusetts coming out on top, Harvard Pilgrim regaining strength, and Tufts maintaining a third position.

According to one survey of the Boston health care industry, trends through 2005 were:

- AMCs faced lack of capacity from years of merging and downsizing, while admissions moved to AMCs from community hospitals;
- pay-for-performance (quality incentive) programs were gaining in popularity, using measures such as cost, efficiency, IT capacity, admission rates, and patient satisfaction to bolster reimbursements;
- hospitals struggled to recruit new doctors and nurses – with AMCs poaching from each other;
- nationally, the growing number of uninsured and underinsured people increased the amount of bad debt hospitals carried. Although mitigated in Massachusetts by strong safety net programs, collections were still a rising concern.[10]

Exhibit 6/10: Major Provider Networks and Other Care Institutions in the Greater Boston Market

Name	Acute Care Hospitals	Physician Networks	Other Facilities	Medical School Affiliation	Employees (FTE)	Revenues/ Net Assets[a]	Admissions (2004)/ Discharge % (2003)
Partners HealthCare System	Mass, General Hospital Bighamt Women's Faulkner, Newton-Wellesley, North Shore Medical Center (NSMC), McLean (mental health)	PCHI	Spaulding Shaughnessy-Kaplan, RHCI, Partners Home Care, 2 Skilled Nursing homes	Harvard Tufts (Faulkner & NSMC)	35,300	$395 million $1.5 billion	87,616 20.8%
Boston Medical Center (BMC)		Boston Health Net Quincy Medical Center		Boston University	4,429	$752 million $1.06 billion	28,173 6.0%
CareGroup	Beth Israel Deaconess, Mt. Auburn Hospital, New England Baptist, Beth Israel Deaconess-Needham	Community Care Alliance	Joslin Diabetes Center	Harvard Medical School	5,000 (Beth Isreal Deaconess)	$24 million $95 million	33,640 9.0%
Caritas Christi Healthcare	Caritas St.Elizabeth's St. Anne's Fall River, Holy Family Hospital and Medical Center, Caritas Norwood, Caritas Carney Hospital Dorchester, Caritas Good Samaritan Medical Center Brockton	Caritas Physician	St. Joseph Nursing Care Center, Neponset Valley Nursing Association, Good Samaritan Hospice, St. Mary's Women & Infants Center of Dorchester	Tufts Medical School	12,000	$90 million $20 million	15,781 11.6%
New England Medical Center	Tufts-NEMC Floating Hospital For Children	NEQCA		Tufts	3,000	$487 million $389 million	17,000 2.7%
Hallmark Health System	Lawrence Memorial, Melrose-Wakefield Hospitals	Ell Pond Medical Association	Malden Medical Center, other long term care, home health and diagnostic services.	Tufts (family practice), Hallmark School of Nursing		$225 million $180 million	2.7%

[a] From IRS Form 990 fiscal year ending 2003. Available at: www.guidestar.org/findocuments/2004.

Sources: Massachusetts Health and Educational Facilities Authority. Accessed from: www.mehfa.org August 7, 2006. WebMD Quality Services. Accessed from: www.webmdqualityservices.com August 7, 2006.

History of Tufts–NEMC

New England Medical Center, originally the Boston Dispensary, was one of the oldest hospitals in the United States.[11] Started in 1796 by the philanthropic activities of historical Boston figures Samuel Adams and Paul Revere, the Boston Dispensary was the first permanent medical facility in New England. First envisioned as a community medical service for the poor, the hospital quickly gained a reputation for innovation. It was the first US hospital to assign nurses to patients, to form a visiting nurse association, and establish dental, rehabilitation, venereal disease, lung, food and nutrition, and evening pay clinics. It pioneered employer-paid clinic treatment, well-child services, and moving x-rays. The first modern test for syphilis, the first group psychotherapy experiment, the first human growth hormone and immuno-suppression therapies were developed at the Boston Dispensary. In 1929 New England Medical Center was formed by the merger of the Dispensary and Tufts College Medical and Dental Schools. By 1965, it added the Floating Hospital and the Pratt Diagnostic Clinic–New England Center Hospital.[12]

In recent years, the tradition of innovation continued, with strong programs in cancer treatment, transplants, and neurosurgery. In 1992, with the addition of a maternity service, Tufts–NEMC became the first full-service, private teaching hospital in Boston. The Neely House, opened in 1997, was a unique bed and breakfast style home located within the hospital for cancer patients and their families. And in 2001, Tufts–NEMC opened a transplant exchange program, the first of its kind in the US, which allowed family members of transplant patients to donate kidneys to patients on the global waiting list, thus increasing the number of organs available for transplant.

Financially, however, Tufts–NEMC was struggling. Although in the 1990s the hospital had posted gains, it was largely due to a write-down in assets, and not improved efficiency or an enhanced revenue cycle. The hospital had fallen prey to the same negative market forces that had taken their toll on other non-affiliated hospitals in the 1990s. By 1996, it was $240 million in debt (up from $130 million in 1990) and was losing physicians, market share, and hospital acquisitions to Partners and CareGroup. Like many AMCs, Tufts–NEMC was slow to react to market pressures, and ineffective in improving processes and cash flow. In a particularly devastating blow to the hospital, Harvard Pilgrim Health Care discontinued coverage to Tufts–NEMC in 1995, citing high costs. As Zane explained:

> Harvard Pilgrim HC had taken Tufts–NEMC out of their network and it had almost killed the place. A doctor in Hyannis wants to send a patient to Boston. He or she has to ask "does this patient have Harvard Pilgrim?" The situation caused doctors to have to think too much about insurance. It was just easier to send everybody to the Brigham. So, for Tufts–NEMC, not being in that contract was incredibly hurtful.

The Lifespan Merger

In the mid-1990s, Tufts–NEMC began to actively look for a partner to remedy its fiscal dilemmas. It needed more clout against the health plans, more referrals from community hospitals, and a partner with deep enough pockets to help pay for growth to compete with Partners, CareGroup, and the other Boston systems. It was in talks with Columbia/HCA, a for-profit hospital chain from Tennessee that wanted to expand its presence in New England. If the merger went through, it would be the first AMC owned by a for-profit company in New England. This did not sit well with some of the board members, faculty, and community, who strongly wanted to preserve Tufts–NEMC's non-profit nature.

In late 1996, the hospital was treating a high-ranking official from the Lifespan Corporation, a regional non-profit hospital system formed in 1994 with a merger of the Miriam and Rhode Island hospitals.[13] One of Tufts–NEMC's physicians explained the hospital's dilemma and talks began between Lifespan and Tufts–NEMC to merge. Tufts–NEMC leadership saw benefits to joining with Lifespan, such as needed capital, a chance to gain back the Harvard Pilgrim Health Care contract, and the potential referrals from the Rhode Island system. On Lifespan's side, Tufts–NEMC was enticing for its status as an AMC, its base in Boston, and its expertise in high-level care. The merger would create, as one journal wrote, "a $1.5 billion, 14,500-employee health care giant with the ability to serve 70 percent of the entire New England market" and would rival the $1.8 billion Partners system and $1.1 billion CareGroup.[14] In January 1997, Tufts-NEMC and Lifespan officially announced the merger, which became effective in November of that year. Ed Schottland, Senior Vice President–System Integration at Lifespan and appointed COO at Tufts-NEMC at the time of the merger, explained:

> Lifespan was interested in Tufts-NEMC because it gave them instant access into Boston and made them the regional system they wanted to be. The plan was to create Lifespan of Rhode Island and Lifespan of Massachusetts – of which Tufts–NEMC would be the hub – both overseen by an overarching corporation.
>
> Tufts–NEMC is a tertiary and quaternary[15] medical center, we do bone marrow, solid organ transplants, and we have a neo natal intensive care unit. They didn't do any of those things in Rhode Island. The only BMT[16] program allowed in Rhode Island was at Roger Williams Hospital. So Lifespan got instant access to highest levels of care. The merger filled out the service complement with a high class, well respected organization with great outcomes and great medical care. Everyone assumed that we would be able to direct our patients here from Rhode Island. We would have a system of care, just as Partners was trying to do with their North Shore hospitals.

The marriage was not a happy one, however, the hoped for synergies never materialized. Rhode Island regulators objected to large amounts of capital migrating to Boston and required Lifespan to reduce the amount Tufts–NEMC was to receive to $8.7 million a year for 10 years, down from 30 years as originally planned. Although Harvard Pilgrim did eventually re-contract with Tufts–NEMC, some in

the industry believed that legislation or litigation would have forced that outcome regardless. The referrals also did not pan out. As Schottland explained:

> Physicians make their own decisions about where they refer. Physicians like to refer primarily based on personal and professional relationships. A secondary reason they didn't refer to Tufts–NEMC was they felt that if they started to support a program here they might never get approval within the Lifespan system to get that program down in Rhode Island.
>
> This was a unique system since there were two medical schools–Brown and Tufts. The Brown faculty wanted to have the programs, like bone marrow transplants, in Rhode Island. So there was a certain reluctance to cooperate at times.

Another problem with the merger was the 'brain drain'. Lifespan took many of the administrative and support functions out of Tufts–NEMC and centralized them in Rhode Island. Tufts–NEMC lost their human resource, finance, purchasing/supply chain, and IT– an area where Tufts–NEMC had been ground breaking in the past. The anticipated growth in acquisitions also failed to take place. Hospitals that had previously affiliated with Tufts–NEMC, such as Faulkner, another Tufts Medical School teaching site, joined Partners instead, while Tufts–NEMC was busy finalizing its merger with Lifespan. In 2000, Lifespan/Tufts-NEMC also lost Hallmark Health System in Malden. As one industry journal wrote:

> Every time a decision had to be made, Tufts–NEMC President and Chief Executive Officer Tom O'Donnell, MD, traveled 55 miles across the state line to Providence, RI. There he conferred with the 21-member board of his parent system, Lifespan Corp. He would return to meet with his own 21-member board, then respond to Hallmark. […] The extra corporate layer proved to be too much. Hallmark, at the time a four-hospital system, walked away from the deal.[17]

Adding insult to injury, Quincy (Mass.) Medical Center and Metro West Medical Center spurned Tufts–NEMC, citing that the "local hospitals did not think of Tufts–NEMC as a Massachusetts hospital."[18]

But perhaps the worst thing about the merger was that insurance contracting was done in Rhode Island. Lifespan did not understand the cost of doing business in the Boston market and therefore settled for reimbursements rates far below the average for an AMC in Boston. Lifespan, struggling to keep control of five acute-care hospitals, suffered an operational loss of $34.1 million on total revenue of $1.3 billion ending fiscal year 2001. Zane explained her take on the Lifespan merger:

> When Partners came together it freaked out the whole market and everybody was looking for a partner. Long story short, Tufts–NEMC hooked up with the Lifespan system in Rhode Island. I could not understand why they did it. It was an ill fated, ill conceived, ill constructed, and ill-implemented merger and it had no meat on the bone. The health care market in Rhode Island might as well have been Siberia, it was so different from eastern Mass.

In the summer of 2002, five years after they merged, both Lifespan and Tufts–NEMC agreed to separate at a cost of $30 million to Tufts–NEMC. Financial results

for Tufts–NEMC for fiscal year 2002 were dismal – a loss of $12.3 million on revenue of $476 million; and 2003 was looking worse – a loss of $38.5 million on revenue of $582 million. The Massachusetts Attorney General's office stepped in to ensure that the hospital would meet bond covenants. O'Donnell and the chairman of Tufts–NEMC's board called Ed Schottland and enticed him to come back as COO. Schottland took the job and set about recreating the administrative departments lost in the merger. He also started initiatives to stem the millions of dollars that Tufts–NEMC was losing monthly. Schottland targeted improvements of $30 million in cost savings in the supply chain and human resources. He began a year of initiatives designed to improve the bottom line. In the first nine months of 2003, Tufts–NEMC reduced staffing levels by 200 FTEs through attrition and consolidation and made improvements in supplier contracts. The hospital also began to look at selling some of its 1.5 million square feet of prime real estate to gain needed capital. The board, meanwhile, set about looking for a leader who could take Tufts–NEMC out of the shadow of Lifespan and orchestrate a true turn around.

Ellen Zane

Ellen Zane was educated at Waltham Public Schools, and later graduated from George Washington University and Catholic University in Washington, DC, with masters in both audiology and speech-language pathology. She spent her entire career in health care, starting in 1975 as a speech language pathologist at Lawrence (Massachusetts) General Hospital. In 1979 she took a job as director of speech and language pathology and audiology at Morton Hospital in Taunton. Under the mentorship of the COO of Morton, Zane worked her way up to vice president of professional services until taking the COO job at Quincy (Mass.) Hospital in 1987. When Quincy's CEO left in 1990, both Quincy's board and the city's mayor convinced Zane to take on the task of turning the hospital around as it was on the brink of closure. Like many community hospitals, Quincy had taken out bonds to renovate its ailing facilities. When the Medicaid/Medicare and HMO reimbursement rates lowered drastically, Quincy found it almost impossible to meet payroll and other expenses. Hampered by years of nepotistic and political hiring practices and high competition in the surrounding area, the hospital was in danger of defaulting on its bonds. Zane recalled her decision to take the job at Quincy as the most difficult in her career:

> It was the hardest decision I ever had to make, since I really felt that failure was not an option. Closing a hospital as the result of my first CEO job would have been awful. However, at the same time, women weren't getting CEO jobs. I needed an underdog job to try to prove myself, since it wasn't likely that a woman was going to get a job at what I called a 'Bloomingdale hospital' – Mt. Auburn, Newton Wellesley, Beverly, or South Shore. Those weren't coming to women in those days. But the main reason I took the job was that I could see the steps it would take to fix it. When I had a very quiet, private conversation with myself, I knew that if I could figure out the road map of what to do, then I would just need the grit to do

it. And I *could* see the way. So I jumped off a cliff and took the job. It was the best decision I ever made.

From a grass roots point of view, the opportunity I got at Quincy was the bedrock foundation to my management prowess. And it was really hard. It taught me not only the value of risk, but it taught me that if you took a job that no one else wanted to do because it was too hard, then all the benefits accrue back to you. If you are successful at it, you are only better because it was harder. All these good old boys with the cushy jobs around me at richer hospitals – I believe – aren't as good at managing simply because they didn't have to be.

Quincy was unique in that it was managed by HCA, a for-profit hospital management chain that owned and managed hospitals across the US. In addition, Quincy had a strong union and civil service workforce. Working for HCA honed her business acumen and decision-making abilities. Working with unions helped Zane to understand the need for clear, open, and honest communication and financial transparency. As Zane recalled:

I sat down with stewards of all the unions and showed them the financial statements and highlighted all the things I wanted them to learn – like days cash on hand and cash reserves. I taught them the meanings of those things and explained that we had no money and that I was worried about meeting payroll. One of the biggest joys of my career came when I left Quincy hospital and met with the stewards for the last time and one union steward said to me: 'How many days cash on hand do we have?' The fact that they had learned that and appreciated it taught me the value of transparency, the value of admitting that I needed help and I couldn't do it alone.

She also learned the importance of reaching out to the community. As Zane explained:

I got in my car and drove out to community doctors who weren't referring many patients to us. I asked them: "What would it take for you to use Quincy Hospital?" They said simple things like parking. All the construction had closed the parking lots. It was not that intellectually complex. The doctors also complained that employee work ethic was dismal. The employees didn't smile or pick up a candy wrapper off the floor. They treated the hospital as though it existed solely for them and their paychecks. They didn't believe the day of reckoning was coming. Hearing that from the community doctors was incredibly valuable for me.

After a successful run at Quincy, she was tapped in late 1993 for a groundbreaking job with the nascent Partners organization. As Zane recalled:

I got a call from Dr. Richard Nessen. He was the CEO of Brigham and Women's Hospital. He told me they had just gotten permission from the Attorney General to merge General [MGH] and Brigham [BWH]. This was huge, giant, gargantuan news. He told me they wanted to build a vast network of physicians throughout eastern Mass. And that he wanted me to come run it.

I told him I had no idea how to do that job, but he said that no one did, it was completely new. He said he needed a leader. He told me that he had academic physicians

> who were lining up at his door to do this job, but that he didn't want to give it to any of them. He felt that academics wouldn't understand community doctors or community hospitals, and would turn them off. He was right about that.

Zane was successful at building what came to be called PCHI (pronounced "peachy"), Partners Community Heathcare, Inc. At Partners, she gained expertise at negotiating affiliation agreements with physicians and contracts with health plans, and with building consensus with disparate groups. Zane recalled her time at PCHI:

> I went from this incredibly resource poor environment at Quincy, where I was plugging holes and trying to meet payroll, to this environment that was so resource rich. There were so many smart people around, but there was no trust between the Brigham [BWH] and the General [MGH] people; they were fierce competitors for years. So each committee had to have counterparts from each organization. Trying to develop a strategy in that environment was a challenge. The committees were made up of type A personalities who wanted me to build a network overnight. I felt this intense need to get the strategy going very, very quickly. So we spent the summer of 1994 building the strategy. The most incredible thing for me is, when I go and talk to investment bankers or health plans now, PCHI is all they talk about. PCHI was the most formidable market-transforming activity other than the [MGH/BWH] merger itself. PCHI is the 800-pound gorilla in this market. And I knew it and started it before it even had a name. It was very rewarding, and very hard.

As Partners grew, so did their clout in the marketplace. Zane was the lead negotiator in the famous clash between Partners and Tufts Health Plan, which culminated when Partners decided to no longer accept Tufts subscribers due to the plan's low reimbursement rates. Her bargaining skills and strategic planning won the day for Partners. In the end Tufts agreed to substantial rate increases. After that encounter, Zane's reputation as a tough and savvy negotiator became legendary.

Zane Moves to Tufts–NEMC

In late 2003, after 10 years with Partners, Zane was thinking of slowing down. Her husband had sold his successful business and had retired and Zane was hoping to do the same. She was getting ready to give her notice at Partners when she received a call from Lawrence Bacow, the President of Tufts University. Bacow was on the board of Tufts–NEMC, which had recently decided to dissolve the merger with Lifespan. He was looking for a new leader for Tufts–NEMC, and felt that Zane had the right mix of skills to build and implement a successful strategy for the hospital. Met by her initial reluctance, Bacow reminded Zane of the hospital's historical significance, its importance for its 5,000 employees, Tufts University and Chinatown's economy. Zane recalled her reaction after the meeting with Bacow:

> There were two enormous feelings that came over me. One was on the positive side: wow this could really be important. To help this ailing organization means to really

help a lot of people in their careers, their lives, the economy, and the University. The other feeling was: this is so daunting – I'm frozen. It was so scary.

In July 2003, O'Donnell announced his resignation, clearing the way for Zane, the first non-physician and female permanent CEO in Tufts–NEMC's history. Reaction from both industry pundits and employees at Tufts-NEMC was uniformly positive. As one expert wrote:

> At this time and in this place, there is no one better for the top job than Ellen Zane. The first non-physician chief executive, she comes onboard at a time when tough decisions need to be made. Yes, she has the necessary management skills, but she also has demonstrated a passionate commitment to preserving the relationship that exists between physicians and patients and between this hospital and the community it serves.[19]

John Greenwood, VP of Finance, explained some of the things he felt Zane brought to Tufts–NEMC:

> We lost our identity during the Lifespan merger. We also lost touch with the Mayor's office and Beacon Hill,[20] and making sure our concerns were being heard. So when Ellen came on board, for the first few months we spent a lot of time on Beacon Hill. She brought visibility and a very recognizable name in the market.
>
> Accountability was also a big leadership trait that came on board with Ellen. She and the consultants she brought in assisted the leadership in diagnosing what the issues and root causes were, as well as prioritizing them. Then she held someone accountable for fixing it. We'd done a lot of diagnosis before, so we had an idea of what the problems were, but Ellen provided the leadership to drive the projects to completion.
>
> She also provided unity to the physicians throughout the hospital. There used to be two autonomous physician corporations with faculty/staff physicians. Both groups were completely separate. The first year she came, Ellen pursued merging the two boards into one entity and eventually made it happen. So now there is input and a synergy between the faculty at the hospital. They speak with one voice.

Michael Burke, senior vice president and CFO added:

> Ellen is so acutely aware of what's going on in the market – she's been in this market her whole life; she built PCHI. She knows all the players. She knows whom to call and she has the personal relationships so that people are willing to work with her.
>
> Ellen is also the kind of person who takes action. She gets 80 to 90 percent of the information she needs and then she does something. Most academic medical centers have what I call "analysis paralysis." You can accept the status quo, but the reality is things never stay the same – they either get better or they get worse. And if you are not actively working to improve them, they will get worse. This place was constantly assessing what to do, but not doing anything. And things got worse, year after year after year. Now what we're doing is assessing the data, assessing the market, and acting, and doing, and getting things done.

Diagnosis: Critical (2004)

When Zane came on board, she brought in a consulting group called BDC Advisors, Inc. They gathered data to determine why Tufts–NEMC was losing an estimated $3 million a month. Zane sat down with Schottland who gave her the bad news: Tufts–NEMC was not losing $3 million a month; since the split with Lifespan the number was closer to $6 million. Zane recalled how the new reality changed her priorities:

> Although I had done a fair bit of due diligence before taking the job, I was still shocked to find out that we didn't have two years of cash on hand: we had 10 months. So it changed everything overnight. Because strategy was the last thing I could worry about – I had to worry about payroll. This place was hemorrhaging millions every month. It was incredibly important to begin to think about how to stabilize.

Zane and BDC conducted what she called a "rapid diagnostic" to quickly determine how to stem the losses. BDC concluded that, although Tufts-NEMC was on the right path with Schottland's initiatives, they were still behind industry benchmarks for many areas, such as days in accounts receivable, accounts payable, average length of stay, operating margin and days cash on hand. There were also more savings to be had in the supply chain (see Exhibit 6/11 for BDC analysis). After reviewing the managed care contracts, Zane also realized that Tufts–NEMC was woefully underpaid.

Another challenge for Tufts–NEMC was its size. In any other market, Tufts–NEMC would be considered one of the biggest players. But in Boston, it was dwarfed by Partners, CareGroup, and Caritas. Tufts–NEMC fundraised $10 million in 2005, up from $5 million the year before but impossibly behind the $200 million Partners raised. Tufts–NEMC was the smallest teaching hospital in the Boston area, but it was the primary teaching site for Tufts Medical School and was the 11th highest paid in NIH research funding. Underwriting that research cost Tufts–NEMC $15 million a year. Maintaining the level of services and research required for a major medical center was extremely difficult for an organization without the

Exhibit 6/11: Tufts/NEMC Operational Indicators versus Industry Benchmarks

	Industry Benchmark	NEMC (FY 2006)	Translated Impact on Budget ($)	Impact on Cash ($)
Days in Accounts Receivable	48.8	55.6	775,416	7,049,234
Accounts Payable Days	60.0	51.2	1,203,061	10,936,918
Average Length of Stay	5.5	5.79	2,085,627	2,085,627
Operating Margin	1.9%	0.4%	10,169,579	10,169,579
Days Cash on Hand	110.7	89.4	609,468	5,540,621
Commercial Insurance Contracts			40,000,000	40,000,000

Source: Company records.

volume of cases or endowments enjoyed by its competitors. Zane realized early on that however difficult it may be, it was absolutely crucial for Tufts–NEMC to remain an AMC:

> We made a conscious decision to keep funding research because we are an AMC with a tripartite mission, which includes clinical excellence, research and teaching. If you take one of the legs off that stool we are no longer an AMC and I would venture to say that no fewer than 80% of the doctors who practice here would leave. They are here because they want to work in an AMC.

Treatment (2004–2006)

Zane set to work on building her management team and reopening the managed care contracts. Along with Schottland and BDC, she pushed hard on cost cutting and efficiency initiatives to bring Tufts–NEMC in line with industry best practices. Zane continued plans to sell real estate in order to get the hospital on some solid financial footing while giving these initiatives time to take hold. She also felt the need to re-establish Tufts-NEMCs brand in the Boston market place, to set about rebuilding affiliations and networks, to reverse the trend of hospitals poaching Tufts–NEMC's physicians, and to retain the talent it had.

Staff Changes

Once Zane assessed the mission, she set about evaluating the senior staff. She greatly appreciated the experience and expertise of people like Shottland and Deeb Salem, Tufts–NEMCs chief physician. But others, she felt, needed to be replaced. Within two weeks she replaced the senior vice president of strategy with Deborah Joelson, a network building expert who Zane recruited from Partners; and the vice president of fundraising and development with Deb Taft, who had been extremely successful at the Dana Farber/Jimmy Fund. In all, she replaced seven members – half of the senior management team. Zane shared her thoughts on the senior staff turnover:

> One of the people I fired was a favorite of one of the board members. I spent a lot of time listening to that board member telling me that I had no right to fire his guy. But in the end he supported me. There was no question that I had to do it.
>
> If you ask most people about me they will tell you I'm very good at picking people. I really do believe that is a skill I have – it's gut level for me. I'd like to get credit for picking good people, not for a brilliant turnaround, strategies, or anything like that. I'm only as good as the people around me, and I do pick great people. I have a sixth sense. I can tell when I go into the waiting room for interviews whether they have a shot. For most of these characters here I knew it wasn't going to happen. There were a couple of other positions in the administrative round that I changed pretty fast. The COO Ed Schottland was very solid. He was only here about nine months.

He came from Lifespan and I am very grateful to this day that he was here and that he stayed. I would be toast without him.

Schottland added:

It was chaos here before. I think it's easy to disrupt the COO's role, especially in an organization this size. People used to go around the COO to the CEO – it doesn't take long before you are neutralized.

Ellen has been very supportive of my role. She'll either say: "You really have to talk to Ed about that" or she'll just have me in the room when they talk to her. Now, most people in the organization don't attempt to go around me. I appreciate that … that's important to me. Ellen's let me continue to run the operations in an appropriate way. We understand our roles and we know when to ask each other for help and advice.

Deb Taft, the new vice president for fundraising and development, talked about why she joined Tufts–NEMC:

If I could be a part of creating a fundraising department that was vibrant and strong, this would be a career moment for me. I had people stopping me in the street saying "I can't believe you are taking this job." But what greater thing could there be than helping this place survive? It deserves to be here. Keeping this place alive was important enough for Ellen Zane not to retire. Ellen recognized that I had what she called fire in the belly. That was her number one criteria in bringing me in.

Communication and Outreach

Ellen is a remarkable communicator of good news and bad news. She was somehow able to be fully transparent about what was going on and have people appreciate that she was being honest with them about the situation. And no one felt that they had to bail out of here because the place was going down the tubes. I don't know how she did that. – **Deborah Joelson,** senior vice president for market development and planning.

Very early on, Zane led a series of "town meetings" where she presented financial facts, specifics on new initiatives, and areas targeted for growth. Because the hospital worked around the clock, Zane scheduled a series of meetings at various times throughout the day and night, to ensure that everyone had a chance to attend. The meetings worked so well to disseminate information that Zane continued to do them twice per year on all shifts. She also augmented them with regular emails updating the staff and physicians on finances and other topics. As Deeb Salem, Tufts–NEMC's chief physician explained:

The things that she and Ed do are quite remarkable. Periodically they have town meetings for the entire staff. They go out of their way to talk to everybody, even the housekeeping staff. They have sessions in the middle of the night so they can talk to the night shift.

Taft agreed:

> Ellen does the town meetings in every shift, and she wants the senior staff and VPs there because every shift matters. I've been at employee parties and holiday parties helping her to serve dessert from midnight to 2 a.m., and we've brought desserts to the emergency department when they are so busy they can't get there. Ellen greets people and introduces herself and says "thanks for coming." That is a big thing for an employee who's never met the CEO. So the staff starts to feel like she belongs to them. She laughs and says she gets more emails from the staff than anybody. But the fact is, she does.

Zane explained what she saw as the benefits of the town meeting format:

> I did a lot of town meetings. I was new – I had to get to know employees and I had to tell them what was going on. I put up this chart, which turned out to be a wonderful chart. It had all the losses this place experienced during the Lifespan era. The $40 million loss in 96, the $20 million loss in 97. Loss after loss after loss after loss. That adds up to $250 million. I threw the chart up at my first board meeting. I threw it up at the board. And I said a lot of people have got egg on their face. That's what I said to my board. I used the same chart with the employees.
>
> Then after those town meetings – to my utter shock – I would come back to my office and I would have 20 emails from employees who had been sitting in the audience and they were saying thank you. It was so incredible. People would say: "I want to help. I knew something was wrong but no one was ever honest enough." It was really encouraging. And that was the pearl I learned – that you *can* tell people bad news. But you have to do it in such a way that you are viewed as being honest, open, credible, and consistent.

Zane explained that the culture of Tufts-NEMC made it easier for her to effect change:

> The one thing about this place that is so fabulous – that I can take no credit for – is that it has a different, better, unique culture. I had been used to the Harvard culture where there was all this bravado and testiness. This culture is much warmer – much more collegial – much more cooperative. And I call it an "Avis – we try harder culture." I tell them: "Guys, we have to go left," and they say "ok." At Partners you'd need a committee and two years to get a decision. Maybe it's because this place is smaller, I don't know.
>
> I've never, ever worked in a place where employees who've been there for decades, physicians who've been here a long time, will spontaneously, unsolicited, come up to me and say "I love this place. And I'm sorry to see what's happened." Even physicians who have left – and it hemorrhaged doctors in the tough days – felt that way. I called up a lot of them and asked them to have a cup of coffee with me and tell me why they left. All of them – to a person said – I didn't want to leave.

Zane used a variety of media to get the word out and to manage the turnaround effort. She held weekly senior staff meetings with Schottland, the general counsel,

the CFO, the vice president of external affairs, the vice president of development, and the senior vice president for market development and planning. The focus of the meetings was mostly external, with Schottland providing updates on internal operations from his weekly meetings with the operational vice presidents, the CIO, the vice presidents of clinical services and the vice president of human resources. Zane also met regularly with the board of trustees.

She reached out to physicians in an attempt to both spread her message for change and to retain them in the face of active poaching from other AMCs. She worked hard on both retention and recruitment. In 2005 she convinced three neurosurgeons to move from Beth Israel Deaconess Medical Center to expand Tufts-NEMC's minimally invasive neurosurgery department. Schottland described the outreach that he and Zane conducted to physicians:

> When Ellen came, she came with the reputation, credibility, and ability to deliver a hopeful message that prompted people to change and gave them more hope.
>
> One thing we've done since she came here – that I've never done anywhere else – is spend an incredible amount of time talking to physicians, both recruiting and retaining them. Ellen leads that charge, although I spend a lot of time with her on it. It's one of our challenges being in Boston – it's so hard to recruit from out of town – and everyone is stealing from everyone else.
>
> The neurosurgery department was a great example of an Ellen coup. She led the negotiations on recruiting those new doctors. Our group, which was split between Beth Israel and Tufts–NEMC, announced that they wanted to consolidate to a single hospital. We gave them a better deal and they are doing a great job here. They are young and aggressive – great surgeons. Ellen is very good at recruitment and retention. She knows it's important. You can't run a hospital without physicians and they are very expensive to replace. A lot of hospitals have recruitment and retention programs, but most times the doctors don't get to talk to the CEO. This is a smaller and friendlier place in a lot of ways. It's not hard to get to Ellen or me. For physicians, that's a big deal. To have access to Ellen in particular is enticing for them, and she's very good at talking to them.

Not only did Zane work with physician groups, she began a monthly tour of different wards in the hospital to get in touch with patients and nurses. Salem explained:

> Once a month Ellen and I tour a ward together and she speaks to patients. She'll ask them: How's Tufts-NEMC treating you? Why did you come here? What can we do better? The patients who understand it are shocked that the CEO is talking to them. She also learns from the patients and the floor nurses. They see that she really cares because she'll walk around their floor. When she's done touring, she'll talk to the head nurse and say, "You guys are doing a great job."
>
> When you talk to the patients yourself, you get a whole new feel for things. We found that a lot of people liked the intimacy at Tufts-NEMC as opposed to one of the larger hospitals like Children's. We're thinking about how to use that fact in our marketing. Another thing we learned was that a lot of people didn't like the food here. So now the food service is working to change the whole menu.

Agenda for Change

In 2004, Zane, Shottland, and BDC initiated a second round of cost-cutting and efficiency plans designed to improve Tufts–NEMC's processes. It was called the Agenda for Change. Along with improving the reimbursements, it included restructuring, and basic 'blocking and tackling' as Zane called it:

> Blocking and tackling means the day-to-day gritty operations. The eight areas we wanted to improve were: length of stay, managed care contracts, accounts receivable, FTEs, supply chain, real estate, ambulatory clinics, and research costs. We focused really hard on those things. I think a lot of people in my job like the limelight – they want to give speeches. But the fact is if your house isn't in order, the limelight is fleeting. My first year here I resigned from most of my boards, backed off from a lot of things. I had to stick to my knitting. At the very beginning, I really hunkered down, and then I slowly started to come up for air.

The latter half of 2004 Joelson and Schottland, along with the vice president of human resources, and the director of business planning, developed a restructuring plan. The plan created eight product lines that were essentially business lines: cardiac, cancer, surgery, general medicine, transplant, OB/GYN, pediatrics, and psychiatry/neurosciences. Every service in the hospital was included in one of these product lines. This was different from the past, when some services were left out of the product lines. As Schottland explained:

> It's very hard to be all things to all people. That is one of our greatest challenges programmatically and financially. But, because we are committed to doing that, we really can't afford to have key constituents feeling they are unimportant. We can't deliver care in transplants, for example, without infectious disease or internal medicine. The product lines here give everyone an opportunity to have a forum to talk about their programs. It is also a way to drive decision making down to the physicians and give people who deliver the service control of that service.

The chief of cardiology was the clinical head of the cardiac product line, for example. He partnered with a clinical vice president – an administrator. Together, they were responsible for developing and implementing annual business plans, with goals, objectives, and budgets for the product line. The CFO and COO approved the budgets every year and reviewed the business plans monthly. The business plans were the venues by which decisions were made on investments in staff, facilities, infrastructure, and technology. The plans directed decisions regarding whether, and how much, to grow and how to accomplish that growth. Some of the areas Tufts–NEMC hoped to grow were core services, such as cardiac and cancer programs, pediatrics and maternal health, psychiatry, bariatric/obesity surgery, and organ and bone marrow transplants.

Support services such as pharmacy, nursing units, and radiology, however, were outside the management structure of product lines. Schottland explained why:

> A lot of hospitals have tried product lines in different ways. One way is the matrix structure that we have and the other way is a purer structure. We weren't big enough to be pure. We can't have a free-standing heart hospital or cancer center. We can't afford to never put a medical patient on the cardiac unit. If we don't have a cardiac patient we need that bed to put someone else in. We have to have the flexibility. So that's why the product lines can't control the nursing units. The head of cardiac would want to keep those beds just for cardiac patients and we can't afford to do that.

Length of Stay

On the operations side, one of the most important cost-saving initiatives was to reduce length of stay (LOS). The consultants that Zane brought in identified that Tufts–NEMC was keeping patients a day and a half too long, compared to other AMCs. David Fairchild, Tufts–NEMC's new chief of general medicine, chaired the 30-person Care Management Committee, which was charged with reducing LOS. Fairchild and his committee set about educating the staff about the importance of reducing LOS, changing attitudes about patient care, and attacking and identifying procedural failures called 'unnecessary delays' in various ways:

- The team set up a special internal email address – LOS delays – where staff could send a complaint or description of an unnecessary delay that impacted length of stay. This delivered useful information directly to hospital leadership regarding causes of delays.
- The BDC consultants identified areas where Tufts–NEMC could improve, such as use of tracheotomies and blood transfusions.
- Use of data, which drilled down to individual physicians' LOS statistics year over year, and presenting that feedback to physicians frequently.

One major issue that the email address identified was the use of PICC lines. PICC lines were more durable IV lines that allowed patients to continue their medication at home. Specially trained nurses had to insert the PICC lines, but the doctor often discharged the patient too late in the day when these nurses were not available. Another problem with PICC lines arose when the nurse was unable to insert the line and needed fluoroscopy to aid the insertion. In the old system, the nurse informed the doctor that the PICC line was unsuccessful, then the doctor arranged for the patient to go to the fluoroscopy suite. Doctors conducted teaching rounds between 10:30 a.m. and 1 p.m., so if the nurse was unable to insert the PICC line, the patient often had to wait until the next day for the fluoroscopy suite to become available.

Fairchild and his committee came up with new procedures to remedy the situation. They required doctors to make decisions on discharges before they

went on teaching rounds and they gave the nurses who inserted PICC lines the authorization to send patients directly to fluoroscopy if the PICC line could not be inserted by the nurse. Within a year of raising awareness and using more efficient procedures, the committee was able to reduce LOS by a full day, saving Tufts–NEMC $2 million per year. Fairchild explained how Zane's leadership helped with the LOS project:

> Ellen brought a sense of urgency. She and the consultants identified a few key initiatives. One was the contracting initiative that she was heading, and another was reduction in length of stay for hospitalized patients. Ellen brought a compelling vision supported by compelling data for where we needed to go. One of the most compelling pieces of data was a graph showing our LOS compared to all our competitor hospitals. We were an outlier, above the line by a day and half! A one-day reduction in the average length of stay across our hospital is worth millions of dollars. I took that graph around to every department meeting I attended. After that it was just a matter of identifying what was causing the delays. There was almost no resistance to changing procedures, since everyone understood that length of stay was crucial to financial turnaround, and that financial improvement was the first step toward fulfilling the vision for the future of NEMC. That is where good leadership came in.

Contract Negotiations

The hospital had just completed a round of contract negotiations with insurers when Zane joined Tufts-NEMC. She realized how critical it would be to immediately increase rates, so she went to the major health plans and asked them to reopen negotiations. Zane discussed her talks with the insurance companies:

> Because I went toe-to-toe with the insurance companies when I was at Partners, I was afraid they would think "it's payback time" since I no longer had the same leverage. To my utter delight none of them did that. They all had the attitude that it wasn't personal, it was a business decision. My argument to them about why Tufts–NEMC should get higher rates was simple. I said to them – look if you guys want the strong to get stronger and the weak to get weaker, then don't open these contracts. But if you want competition in this market, you need to open these contracts. And they did. It wasn't a cakewalk, they didn't just write me a check. We fought about it. But the truth is they all stepped up to the plate and I will always be grateful to Blue Cross, Harvard Pilgrim and Tufts.

The improvements in the contracts were absolutely critical to the financial bottom line. As Shottland explained:

> After Ellen arrived, we discovered that we were getting paid really poorly. We improved our reimbursement by $20–25 million. That was the missing piece. That's what brought us from where we were – which was a $10 million loss – to actually making some money last year. That was Ellen's guidance and leadership that did that.

Network Building

Zane went to work bringing back the affiliations and networks Tufts/NEMC had lost in the past. By October of 2004 the hospital announced plans to affiliate with Children's Hospital in order to augment the services of the Floating Hospital for Children, which was fragile and had lost sufficient scale over many years of neglect and poor management. Zane was able to move quickly on affiliation agreements, not allowing deals to get bogged down in red tape. Deborah Joelson, senior vice president for market development and planning, related one example of this:

> One of the first things I had on my desk when I arrived here was an affiliation agreement with a community hospital. I finished negotiating the deal and went to Ellen and said, "Ok we have an agreement." She said "Great, let's do it." I said, "What, just sign it? No committees? No … nothing?" At Partners, an agreement like that would take months, if not years, if it were ever to get done, because of all the internal constituencies that needed to approve everything. It was just a lot more complicated. So I always laugh when I think that she said "just do it, trust your instincts and just go ahead." With the sense of urgency and lack of resources that we have here, we don't have the time to spend noodling over every little decision.

A year later, Tufts–NEMC won a major coup when they affiliated with Primary Care, LLC, (PCLLC – pronounced "pickle"), one of the state's oldest and largest primary care independent networks. The new network became part of Tufts–NEMC and was called New England Quality Care Alliance (NEQCA). Zane recruited Jeffrey Lasker, the former chairman of the Partners physician network, to run it. PCLLC had for nine years negotiated contracts (a large percentage of which were Medicare risk products, such as Secure Horizons) for its 164 physicians, which served 500,000 patients. The group felt that they needed to become affiliated with an AMC and sent out a proposal request to systems in the Boston area. Joelson recalled how Tufts–NEMC closed that deal, when every other hospital was vying for the practice:

> We had almost no network, and few people to manage the network we had. We didn't have the infrastructure here to deal with payer contracts. That had been done at Lifespan. The PCLLC physicians wanted a seat at the table–that was most important to them. We saw an opportunity to integrate PCLLCs infrastructure into Tufts–NEMC, and not only give them a place at the table, but *make* them a table. We created an organization – NEQCA – that they ran, that provided something to Tufts-NEMC that we didn't have.
>
> This is also an example of where Ellen is so good. If you need her at a meeting she goes. We literally met every week for two months with PCLLC and Ellen was there every week to meet with them. Quite frankly I don't think many CEOs would have sat down once a week to make this happen. She is willing to get her hands dirty, but she's a leader when she does. She doesn't micro manage the process, but she makes herself available and it's clear to everyone that this is important and that it matters to her.

Working with Tufts University

Zane cultivated a close working relationship with Bacow and Michael Rosenblatt, the new dean of Tufts Medical School. She recognized the importance of the hospital and the University to each other. She sat on the board of overseers for the medical school and worked to build joint initiatives in research and fundraising. As Zane described:

> It is very famous in AMC cultures that Deans and hospital CEOs don't get along. There is usually a tremendous amount of tension. One of the things I'm proudest of – and I think the Dean would say this too – is that we get along extremely well. He started his job three weeks before I started mine, neither of us owns a lot of the problems here or at the medical school so we started with a clean slate. The relationship is so strong between us. We have now developed a joint fundraising plan. We're better together than apart. That gives Larry Bacow a great deal of pleasure. He really is vested in Mike's success and mine.

Taft explained the disconnect that Tufts-NEMC had with Tufts University in the past:

> Some years ago, Tufts–NEMC actually took the Tufts name off of its signs and logos. That was a big mistake. They were not building the Tufts name, or building that relationship. In a Harvard medical town, Tufts–NEMC was not leveraging one of the top trump cards they had: the terrific and growing reputation of Tufts University, their nutrition school, medical, dental, veterinary schools. So they had all of that at Tufts–NEMC, and it wasn't being leveraged.

In the real estate arena, Tufts–NEMC held many buildings on and around the Tufts University campus on Kneeland Street in Chinatown. When Tufts–NEMC decided to sell one building it made sense for the University to purchase it. In one local business journal, Zane explained her thinking:

> If you drive down Huntington Avenue, you know when you're at Northeastern University. When you're at Commonwealth Avenue, you know you're at Boston University. But if you drive down Kneeland Street into Chinatown, you don't know you're at Tufts. You don't get the feeling you're in an urban campus.[21]

The University and Tufts–NEMC were in the "preliminary stage of looking at how to make the area more like a traditional urban university campus. The university held 'town meetings' to discuss the issues and is hiring planners to develop possible scenarios" the magazine reported.[22]

Prognosis: Short-and Long-Term Outlook

> *Leadership is about what's next. A lot of initiatives were started before Ellen got here, but she added the extra "umph" to make it happen. Now it's about what is next. What is the*

strategy. We're still a small hospital, we're still challenged every day because of our size to meet the financial basics to succeed. – **Ed Schottland, COO**

In 2006, with her leadership team established, the sale of a building to Tufts University for $28 million adding needed capital, cost savings initiatives in place and improved managed care contracts, Zane was starting to move to the next phase: building a strategy for the future. Zane and her team were working with the board in a major strategic planning initiative. In addition, Joelson was doing marketing research, the first Tufts–NEMC had conducted in years. They were trying to answer questions such as:

- What scale should Tufts–NEMC be?
- How can we best market ourselves?
- How can we differentiate ourselves in the marketplace?
- What is the best way to work with community hospitals and physicians?

As Joelson explained:

> We are trying to create an alternative. Our goal is to be big enough to have the scale we need to operate efficiently and to be able to provide sufficient sub specialties to be an academic medical center – the principle teaching hospital of Tufts University School of Medicine. We don't want to be as big or expensive as Partners. We have 3 percent market share; Partners has 25 percent market share. We're at best a 400-bed hospital; Partners has 2,000 beds. We see ourselves as a network of some physicians and some community hospitals, and as a lower cost alternative in the market. We can be effective with the new pay for performance contracts. It is more efficient and less expensive to keep the care local, so our strategy is to try to move the care that can be moved to community hospitals where we have relationships.
>
> On the marketing side, we are implementing what we call an anti-invisibility advertising campaign. Our market research determined we had no identity in the market. We also learned that we were a house of individual brands – the doctors – rather than a brand in itself. As a result, we are building a physician-to-physician marketing campaign, using NEQCA as that the starting point. We also plan to grow NEQCA from 600 to 1,000 doctors by 2010.

Perhaps the biggest plan to come out of the strategic initiative was the partnership with New England Baptist Hospital, another Tufts Medical School affiliated teaching hospital, to build a new 190-bed hospital in the Boston suburbs. If the plan came to fruition, it would be the first hospital built in Massachusetts in 25 years. Although the site had not yet been selected, Zane was quoted as saying that:

> In the past, hospitals have asked people in the suburbs to come to them and pay more for parking than the co-pay on their health insurance. Our view is: Wouldn't it be a good idea to take sophisticated academic medicine and bring it to the people?[23]

This type of bold planning gave the employees at Tufts–NEMC confidence about the future. Deeb Salem gave his viewpoint on where the hospital stood in mid-2006:

> I've never been more optimistic. There are still a lot of problems. But the main source of anxiety is what happens if Ellen decides to leave. That's the problem having somebody that good. We've seen how well she runs things. But with her in charge I do have a lot of hope.

Zane finally saw the light at the end of the tunnel she had entered in January 2004, but she knew that her work had only just begun. She needed to find a way to keep the staff on track for the turnaround. She needed improved efficiency and cash flows to keep wind in the sails in order to move the rudder in the right direction. She also knew that Tufts–NEMC was far from a safe harbor:

> I have lots of friends at Partners – but business is business – if they could steal my best bone marrow transplant surgeon they would. It's the way it is. That is the deal. I can't let down my guard for a minute.
>
> I am able, now, to spend much more of my time on strategy, on the future, on where this place is going. That is, frankly, why I took the job. I didn't come here to pull down accounts receivable, I came here to do something to position this place for the future.

NOTES

1. Tufts–NEMC employed roughly 5,000 people, who accounted for 3,000 full-time equivalent (FTE) positions in 2006.
2. Christine C. Ferguson, "Massachusetts Health Care Trends: 1990–2004," Massachusetts Division of Health Care Finance and Policy, March 2003, page 5. Accessed from: www.state.ma.us/dhcfp, August 7, 2006.
3. Non-resident discharges refer to number of patients from out of state.
4. "Analysis in Brief – Massachusetts Inpatient Hospital Trends," Massachusetts Division of Health Care Finance and Policy, Number 6, April 2004, page 1. Accessed from: www.state.ma.us/dhcfp, August 7, 2006.
5. Provider refers to any hospital, AMC, or ancillary service that provided medical care.
6. Those patients who needed high levels of care, such as surgery.
7. Christine C. Ferguson, "Massachusetts Health Care Trends: 1990–2001," Appendices iii–vi.
8. Community Report – Boston, Mass. Third Visit 2000–2001. Center of Studying Health System Change, Report 11 of 12, summer 2001. See: http://www.hschange.org
9. The Boston metropolitan area was generally described as being inside Interstate 495. Statistics provided by Massachusetts Health and Educational Facilities Authority, Revenue Bonds, Partners HealthCare System Issue, Series F (2005). Accessed from: www.mehfa.org, August 7, 2006.
10. Community Report–Boston, Mass. Center of Studying Health System Change, Report 11 of 12, December 2005. See: http://www.hschange.org
11. Information in this section derived from www.nemc.org and www.bostonhistory.org/m_china.php, accessed June 7, 2006.
12. The Boston Dispensary archived records. A summary available online at: simmons.edu/resources/libraries//archives/char_coll/char_coll_027.htm, accessed August 9, 2006.

13. The Miriam and Rhode Island hospitals were the two largest hospitals in Rhode Island and affiliated with Brown Medical School.
14. "NEMCs bold move," *Boston Business Journal*, January 17, 1997; and Van Voorhis, Scott, "NEMC discusses hospital network," *Boston Business Journal,* (January 24, 1997). Accessed online at: http://boston.bixjournals.com, July 21, 2006.
15. Quaternary refers to most advanced level of care, such as bone marrow and organ transplants.
16. Bone marrow transplant.
17. Susanna Duff and Cinda Becker, "Here we go Again," *Modern Healthcare*, (Chicago: Sep 9. 2002, page 8). Accessed online at: http://proquest.umi.com, July 20, 2006.
18. Ibid.
19. Ellen, Lutch Bender "A New Chapter for the Venerable Tufts–NEMC," *Boston Business Journal*. (December 26, 2003). Accessed online at: http://boston.bizjournals.com, July 21, 2006.
20. The Massachusetts legislature.
21. Mark Hollmer, "Tufts-NEMC Wants a More Campus Feel in Chinatown," *Boston Business Journal* (June 30, 2006). Accessed online at: http://boston.bizjournals.com, July 21, 2006.
22. Ibid.
23. Christopher Rowland and Steve Bailey, "Tufts Affiliates Plan Hospital in Suburbs," *The Boston Globe* (September 8, 2006) page A1 Section: Metro/Region. Accessed online at: www.boston.com/news/bostonglobearchives, September 13, 2006.