Leon Leach, M.B.A.

Interview #28

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Leon Leach, M.B.A., Ph.D.

Interview #28

Interview Profile

Interview Information:

Four interview sessions: 5 November 2012, 27 November 2012, 9 January 2013, 29 April 2013
Total approximate duration: 4 hours 50 minutes
Interviewer: Tacey A. Rosolowski, Ph.D.

For a CV, biosketch, and other support materials, contact:

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About the Interview Subject:

Leon Leach (b. 1948, Bridgeton, New Jersey) was serving as Executive VP and CFO for Cornerstone Physicians Corporation in 1997 when he came to MD Anderson to serve as the institution's Executive Vice President and Chief Financial Officer. In 2000 his role was expanded to include executive leadership for finance, business development, marketing, facilities, human resources, information systems, and technology commercialization: his title was changed at that time to Executive Vice President.

Under Dr. Leach's fiscal leadership to date, MD Anderson's revenue has increased from $900 million to $3.4 billion, its operating margin has grown from $25 million to $343 million, and the institution has developed numerous strategic business opportunities. Dr. Leach serves on the board of Proton Therapy GP Management, LLC, which manages the MD Anderson Proton Therapy Center. He also serves on the board of the University of Texas MD Anderson Services Corporation, non-profit responsible for MD Anderson's business development.

He earned an M.A. in Christian Education from Southwestern Baptist Theological Seminary (conferred 2001) and a Ph.D. from the University of Texas School of Public Health (conferred 2011).

Major Topics Covered:

Personal and educational background; faith

Career track in corporate insurance

Changing economic environment of healthcare, late nineties to 2013

MD Anderson as a fiscal institution: history of operations, bringing sophistication to

Tools and strategies for economic forecasting, growth, and fiscal stability

Fiscal leadership in an academic institution

Strategic initiatives: The Proton Therapy Center, sister institutions, satellite centers, capital campaigns

The MD Anderson presidents; Ronald DePinho; The Moon Shots

A note on transcription and the transcript:

This interview had been transcribed according to oral history best practices to preserve the conversational quality of spoken language (rather than editing it to written standards).

The interview subject has been given the opportunity to review the transcript and make changes: any substantial departures from the audio file are indicated with brackets [ ].

In addition, the Archives may have redacted portions of the transcript and audio file in compliance with HIPAA and/or interview subject requests.

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Research Medical Library: Historical Resources Center

Original Interview Profile # 28: Leon Leach, M.B.A., Ph.D.
Submitted by: Tacey A. Rosolowski, Ph.D.
Date revised: 30 June 2014

This interview of Dr. Leon Leach (b. 1948, Bridgeton, New Jersey) takes place over three sessions (November 2012 and January 2013) for a total of approximately four hours and fifty minutes. Dr. Leach came to MD Anderson in 1997 to serve as the institution's Executive Vice President and Chief Financial Officer. In 2000 his role was expanded to include executive leadership for finance, business development, marketing, facilities, human resources, information systems, and technology commercialization: his title was changed at that time to Executive Vice President. The interview takes place in Dr. Leach's office in Pickens Tower on the MD Anderson Main Campus. Tacey A. Rosolowski is the interviewer.

Dr. Leach received his BS in 1973 from Rutgers University and his MBA in 1976 from Widener University. His career with insurance companies began in 1967, when he began working full time for the Prudential Insurance Company of America in order to pay for college. He rose to the position of Senior VP and CFO, leaving in 1993 to work more directly on the provider side of health care. He first assumed the position of CFO and Senior VP of Managed Care with the California company, Candle SubAcute ('93-'94). He then moved to CareAmerica Health Plans, where he served as Senior VP and CFO from 1994 to 1995. Dr. Leach next served as Executive VP and CFO for Cornerstone Physicians Corporation from 1995 to 1997, when he made the move to MD Anderson. Under Dr. Leach's fiscal leadership to date, MD Anderson's revenue has increased from $900 million to $3.4 billion, its operating margin has grown from $25 million to $343 million, and the institution has developed numerous strategic business opportunities. Dr. Leach serves on the board of Proton Therapy GP Management, LLC, which manages the MD Anderson Proton Therapy Center. He also serves on the board of the University of Texas MD Anderson Services Corporation, non-profit responsible for MD Anderson's business development. In 2004 the governor of Texas appointed him to the Texas Health and Human Services Commission., and he has served as Chair of the Commission's subcommittees on Medicaid Reform and Uncompensated Care and Hospital Funding. While serving as Executive Vice President, Dr. Leach earned an M.A. in Christian Education from Southwestern Baptist Theological Seminary (conferred 2001) and a Ph.D. from the University of Texas School of Public Health (conferred 2011).

By virtue of his long experience in corporate insurance, Dr. Leach sees MD Anderson through a unique lens, and this interview sheds light on the fiscal workings of MD Anderson during its most dramatic period of growth. Dr. Leach is proud of bringing an "intellectual rigor" and system to the institution's fiscal plans. He analyzes the economic context in which the institution operated in late nineties and discusses the tools and strategies MD Anderson used to grow and achieve fiscal stability. Dr. Leach also addresses the financial challenges that arose in 2007/'08 and the measures taken to bring the institution back to profitability. He discusses the special challenges posed in an academic institution, where strategic changes are negotiated, rather than imposed from a chain of command, as in corporate America. He visualizes the impact of the current economic climate on the institution's organization, faculty roles, and research –

including Dr. Ronald DePinho's Moon Shots Program. He discusses the strategic value of opening national and international sister institutions, satellite care centers, and the Proton Therapy Center. Dr. Leach also reflects on the mission of MD Anderson and ties this to the institution's long-term success.

Leon Leach, M.B.A., Ph.D.

Interview #28

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Leon Leach, M.B.A., Ph.D.

Interview #28

Segment Summaries

Interview Session One: 5 November 2012, approximately 2 hours.

Segment 00A
Interview Identifier

Segment 01
A Dissertation Overview
A: Educational Path

Story Codes
A: The Researcher
A: Professional Path
A: Overview
A: Definitions, Explanations, Translations
C: Evolution of Career
C: Professional Practice
C: The Professional at Work
A: Personal Background
A: Professional Values, Ethics, Purpose
A: Character, Values, Beliefs, Talents
B: Beyond the Institution
D: On the Nature of Institutions

In this segment, Dr. Leach describes the subject of his dissertation (entitled "Academic Medical Centers: A Framework for Strategic Repositioning") prepared in completion of work for his Ph.D., conferred in 2011 by the University of Texas School of Public Health. (He worked on this degree while fully employed at MD Anderson.) Dr. Leach was interested in the factors that support the success of strategic initiatives. He explains that he built his dissertation around three case studies of strategic repositioning: The Baylor College of Medicine's decision to own and operate a hospital; MD Anderson's 2008/'09 attempts to improve operational efficiency; and The efforts of the UT Medical Branch at Galveston to expand service to additional locations. He lists the decision makers he interviewed and summarizes his findings.

Next, Dr. Leach clarifies why he pursued degrees beyond his M.B.A. while serving as Executive Vice President of MD Anderson. He sees both his Ph.D. and his M.A. in Christian Education (Southwestern Baptist Theological Seminary, 2001) as personal challenges. He describes the value of the process and discipline of working toward his Ph.D., which gave him an opportunity to serve on a restructuring committee at the Baylor College of Medicine. He gives examples of how the experience provided him with an appreciation for how different leaders view the same situation from different perspectives.

Segment 02
Education and Work Experience
A: Professional Path

Story Codes
A: Character, Values, Beliefs, Talents
A: Personal Background
A: Professional Path
A: The Administrator
A: Character, Values, Beliefs, Talents
C: Evolution of Career
C: Professional Practice
C: The Professional at Work
C: Faith, Values, Beliefs

Dr. Leach begins this segment with a brief overview of his modest family beginnings in Port Norris, New Jersey, where his father worked as an oyster fisherman. (He tells an anecdote about owning his own boat at the age of twelve.) He then shifts to the educational and professional path. He begins with his long relationship with The Prudential Insurance Company of America (1963 – 1973) where he began working while earning his Associates Degree from Cumberland County College in New Jersey (conferred 1969). Dr. Leach explains that he didn't have the money to go to college, so he worked full time at Prudential (with claims) and attended class at night for virtually all of his schooling, including his undergraduate work at Rutgers University (B.S. 1973) and his studies for his M.B.A. at Widener University (1976). Once he received his MBA, he was fast-tracked at Prudential, leading to an opportunity to serve as Vice President of Marketing in Nashville, Tennessee.

Segment 03
Moving to the Provider Side of Insurance
A: Professional Path

Story Codes
A: Professional Path
A: The Administrator
A: Character, Values, Beliefs, Talents
C: Evolution of Career
C: Professional Practice
C: The Professional at Work
A: Overview
A: Definitions, Explanations, Translations

Dr. Leach explains that his role as Vice President of Marketing for Prudential in Nashville (1980 – '85) gave him his first experience with the health-care provider functions of insurance companies. He describes his experience managing all parts of the health-care delivery system. He then explains that his career expanded once again when Prudential purchases Merrill Lynch's real estate division: he moved to California to become the Chief Financial Officer of the Prudential Real Estate Affiliates. When Prudential asked him to return to Newark, he says his family did not want to move again. At this point, he moved fully into the provider side of health care, developing the professional management of physician's offices.

Segment 04
Bringing Fiscal Sophistication to MD Anderson
B: The Finances and Business of MD Anderson

Story Codes
A: Professional Path
A: The Administrator
A: Character, Values, Beliefs, Talents
C: Evolution of Career
C: Professional Practice
C: The Professional at Work
A: Joining MD Anderson
A: Overview
A: Definitions, Explanations, Translations
B: The Business of MD Anderson
B: The MD Anderson Brand, Reputation
B: Building/Transforming the Institution
B: Growth and/or Change
D: The History of Health Care, Patient Care
D: Fiscal Realities in Healthcare

In this segment Dr. Leach explains that by the nineties, he had "turned into a serial entrepreneur" working in high-risk situations. Rethinking his career, he realized he had reached a point where he wanted to "give back" and, very near that time, Michael Myer called to tell him that MD Anderson was looking for a CFO. Dr. Leach then describes the fiscal context when he assumed the role at MD Anderson. He also talks about John Mendelsohn's vision for the institution and some of the changes made early in his role as CFO (e.g. shifting the institution from fund accounting to GAAP accounting; canceling managed care contracts as a shock tactic so HMOs would renegotiate).

Dr. Leach observes that Charles LeMaistre's downsizing strategy was the right approach for the situation. He also notes that the reports submitted by the consulting firm hired to evaluate MD Anderson's financial fate under HMOs (negatively) distorted the institution's importance to health care delivery in Texas. Dr. Leach knew that managed care was not going to be able to "squeeze" MD Anderson.

Dr. Leach goes on to assess the institutional situation when he arrived. The administrative team was in place; he developed a business modeling system to predict how the institution would need to grow. He explains the "Value Proposition," an equation that quantifies cost savings. As an example, he explains that the equation can show how much money MD Anderson saves patients by giving them a correct initial diagnosis (as opposed to having to correct a diagnosis given by a non-MD Anderson physician).

Dr. Leach discusses his economic forecasting model and talks about his goals as CFO.

Segment 05
Communicating about Finances in an Academic Setting
A: The Administrator

Story Codes
A: The Administrator
C: Professional Practice
C: The Professional at Work
A: Overview
C: Understanding the Institution
D: On the Nature of Institutions

In this segment Dr. Leach explains that he had to make some adjustments to work in an academic setting after years in the corporate world. He faced challenges communicating difficult financial and accounting information to MD Anderson faculty and did presentations on "weathering the storm." He talks about coming to respect the academic side of medicine and the need of faculty to understand the measures he was instituting.

Segment 06
A Role in a Global Institution
A: View on Career and Accomplishments

Story Codes
C: This is MD Anderson
B: Institutional Mission and Values
B: The MD Anderson Brand, Reputation
A: Career and Accomplishments
A: Character, Values, Beliefs, Talents

In this segment, Dr. Leach explains that his work at MD Anderson has been meaningful because the institution has an impact on people globally. He mentions the Dr. Ronald DePinho's Moon Shots Program will take the institution's mission "to a new level." He then lists the opportunities that the institution has afforded him.

Interview Session Two: 27 November 2012

Segment 00B
Interview Identifier

Segment 07
Strategic Decisions and Increasing Patient Numbers
B: The Finances and Business of MD Anderson

Story Codes
B: MD Anderson History
B: The Business of MD Anderson
C: The Institution and Finances
D: Fiscal Realities in Healthcare
B: Institutional Processes
A: Overview

A: Definitions, Explanations, Translations

Dr. Leach begins this segment by observing that strategic decisions evolve over a process. He demonstrates his point with examples from 2008-2009, when the administration addressed disturbing reports that MD Anderson was less productive than it should have been. He describes the metrics used to assess productivity and underscores the importance of bringing relevant information to the groups in a position to change matters.

He notes that a key indicator of the institution's success is the number of new patients seen: this number was slipping in 2008, and this fact was pointed out to the faculty leadership, initiating an eighteen-month difficult process of change that resulted in a broadening of "faculty templates" (the types of patients each faculty member sees). Dr. Leach comments on how academic and corporate contexts respond differently when changes are instituted and notes that MD Anderson no longer has the luxury of such long lag times given an economic climate that demands more responsiveness.

Segment 08
An Evolving Economic Context –and New Challenges
B: The Finances and Business of MD Anderson

Story Codes
A: The Administrator
B: Institutional Mission and Values
C: This is MD Anderson
C: Healing, Hope, and the Promise of Research
C: Understanding the Institution
A: Overview
A: Definitions, Explanations, Translations
D: Fiscal Realities in Healthcare
B: Growth and/or Change
C: Research, Care, and Education
D: On Research and Researchers

Dr. Leach states that MD Anderson is defined by its commitment to translational research, and in 2012 one half of funds for research come from operations, with over 250 million spent on research per year. He then talks about factors that shape the institution's balance between investments in patient care versus those in research. He notes that in the current economic climate, faculty may be required to find a different balance and spend more time in the clinic.

Dr. Leach then explains why the "triple threat" model of a faculty member (one equally devoted to research, patient care, and education) may no longer exist. The institution, he says, may have to depend more and more on specialists, as the economic context is evolving and the institution must respond to be successful. This will demand different faculty roles.

Segment 09
The Economic Forecasting Model: A Tool for Growth
B: Institutional Change

Story Codes

A: The Administrator
A: Contributions
A: Overview
B: Institutional Processes
C: Professional Practice
C: The Professional at Work
D: Fiscal Realities in Healthcare
C: Discovery, Creativity and Innovation
C: Discovery and Success

Dr. Leach begins this segment with comments on how MD Anderson grew under the leadership of Dr. John Mendelsohn and how they worked to balance resources in order to develop research.

Dr. Leach then discusses the Economic Forecasting Model he began to use on arriving at MD Anderson to predict the pressures that specific growth initiatives would place on operating margins. He describes the variables, limits, and uses of the model. In the former economic context, predictions were valid for six years. Now it is more uncertain.

Dr. Leach explains that the forecasting model was his brainchild, developed while he was in the insurance industry, and refined to suit MD Anderson and bring intellectual rigor to the budget for the first time. It is a key strategic planning tool.

Segment 10
Growth Initiatives: Capital Campaigns, Global Oncology
B: Building the Institution

Story Codes
A: The Administrator
A: Contributions
A: Overview
B: Institutional Processes
C: Professional Practice
C: The Professional at Work
D: Fiscal Realities in Healthcare
B: Philanthropy, Fundraising, Donations, Volunteers
B: Beyond the Institution
B: Institutional Mission and Values
B: MD Anderson Culture

Dr. Leach begins this segment by explaining that funds from the Capital Campaigns are all factored into the Economic Forecasting Model. He briefly mentions his role in keeping the Board of Visitors aware of what his office is doing to develop the institution. He then moves to the Global Oncology initiative, which was started because of data that indicated that the institution was paid more for patients who came from out of state. He then talks about the international sister institutions and MD Anderson Banner. He explains that the goal is not necessarily to bring these institutions to the level of care offered at MD Anderson, but to raise the level of care as high as it can go. In addition, quality of care at these other institutions is the primary considering; spreading the MD Anderson brand and increasing name recognition is a secondary consideration.

Segment 11
Financing the Moon Shots Program and Changes to MD Anderson Structure
B: MDACC in the Future

Story Codes
A: The Administrator
B: Building/Transforming the Institution
B: Multi-disciplinary Approaches
D: Business of Research
C: Healing, Hope, and the Promise of Research
D: On Research and Researchers
B: Philanthropy, Fundraising, Donations, Volunteers
C: Understanding the Institution
B: Ethics

Dr. Leach begins with general comments on Dr. Ronald DePinho's Moon Shots Program –a speculative and expensive initiative, he says, designed to move the bar. He notes his belief that the most exciting developments in cancer will be coming in the next four to five years.

Dr. Leach then explains that, with the complexity of research today, a new framework is needed to think about conflict of interest. He then notes that the Moon Shots will reorganize all of MD Anderson, moving the institution to more efficient structures that free faculty members' time so they focus on what they do best.

Segment 12
Bringing Structure to MD Anderson's Finances; Developing Spiritual Strength
A: View on Career and Accomplishments

Story Codes
A: The Administrator
A: Contributions
B: Institutional Mission and Values
C: The MD Anderson Ethos
D: On the Nature of Institutions
D: Fiscal Realities in Healthcare
B: Building/Transforming the Institution
B: Growth and/or Change
A: Career and Accomplishments
A: Character, Values, Beliefs, Talents
A: Personal Background
C: Faith, Values, Beliefs
C: Evolution of Career

In this segment, Dr. Leach summarizes his contributions to MD Anderson and the growth his work on higher degrees has offered him. He first stresses that MD Anderson has undergone exponential growth and moved to a more businesslike structure, and he underscores that an institution must be self-sufficient so it is free to reinvent itself.

Dr. Leach then says he has been pleased to have a role guiding the finances and structure for the institution's accomplishments, which have come through the efforts of fantastic doctors, scientists, and research support.

Dr. Leach then talks about the degrees he earned while serving as Executive Vice President: his Ph.D. in Public Health and his M.A. in Christian Education and what they contributed to his abilities to perform in his role for MD Anderson. The M.A., he explains, helped him develop patience, a quality that takes spiritual strength. He needed patience to deal with complex challenges in strategic positioning.

Segment 13
A Prescription for Fiscal Health: Be Pro-Active
B: MDACC in the Future

Story Codes
A: Overview
A: The Administrator
A: Contributions
B: Institutional Mission and Values
C: The MD Anderson Ethos
D: On the Nature of Institutions
D: Fiscal Realities in Healthcare
B: Building/Transforming the Institution
B: Growth and/or Change
B: Beyond the Institution
B: MD Anderson and Government

Dr. Leach begins with segment by explaining that institutions tend to hold onto the old rather than moving ahead into change. He then talks about activities that will enable MD Anderson behave pro-actively in the current and future economic context. He notes the importance of commercializing technology, of moving science to the bedside, and establishing relationships with other institutions. MD Anderson, he says, does well with managed care companies, as they recognize value, though he is not certain that the federal government will do the same. He says that health care is a current target of the federal government as health care represents 20% of the economy. He expects that the institution will create savings from a more streamlined organizational chart and continued strategic positioning. He discusses his roles with the state government in Austin.

Segment 14
MD Anderson Presidents, Values, and Teams
B: Key MD Anderson Figures

Story Codes
A: Character, Values, Beliefs
B: Institutional Mission and Values
C: The MD Anderson Ethos
C: Portraits
C: Giving Recognition

Dr. Leach begins this segment with the observation that John Mendelsohn and Ronald DePinho were the right leaders for their times. Dr. Mendelsohn had the courage to invest, he says, and turned MD Anderson into one of the few exceptions to the managed care rule. Now Ronald DePinho is building on John Mendelsohn's work. He talks about "moral suasion" and the importance of communicating.

Dr. Leach then talks about MD Anderson's values and the moral responsibility that the institution has to deliver on their promise.

At the end of this segment Dr. Leach names important members of his staff and says that the secret to success is hiring well so one can benefit from the strength created by building a team.

Interview Session Three: 9 January 2013

Segment 00C
Interview Identifier

Segment 15
Strategic Financial Initiatives: MD Anderson España
B: Building the Institution

Story Codes
A: The Administrator
B: The Business of MD Anderson
B: Beyond the Institution
D: The Healthcare Industry
C: Professional Practice
D: Fiscal Realities in Healthcare
C: The Professional at Work
C: Critical Perspectives
C: Understanding the Institution
C: Professional Practice
C: The Professional at Work

In this segment, Dr. Leach explains that the increasing costs of health care signaled that traditional reimbursements for medical services were going to come under pressure, creating the necessity to look for other revenue streams. The sister institutions created such a possibility as well as satisfying the institutions mission to eradicate cancer globally.

Dr. Leach tells the story of starting his first day on the job in September of 1997, meeting with President Dr. John Mendelsohn and then immediately going cold into a meeting with Spanish representatives to talk about opening a cancer center from scratch in Madrid. Dr. Leach explains why the Madrid location was selected and describes some of the challenges met. He explains the main lesson learned: that MD Anderson is best suited to guiding institutions to create new cancer centers, rather than itself owning and operating new centers. The España project gave rise to a new department for consulting services, Global Business Development.

Segment 16
Strategic Financial Initiatives: The Story of the Proton Therapy Center, Part 1
B: Building the Institution

Story Codes
A: The Administrator
B: MD Anderson History
B: The Business of MD Anderson
B: Beyond the Institution
B: Industry Partnerships
D: The Healthcare Industry
C: Professional Practice
D: Fiscal Realities in Healthcare
C: The Professional at Work
C: Critical Perspectives
C: Understanding the Institution
C: Professional Practice
C: The Professional at Work

In this segment Dr. Leach explains the rationale for building MD Anderson's Proton Therapy Center and describes the unusual financial partnerships that enabled it to be funded. He begins by noting that only a few proton centers existed with only one providing patient care –and that one, in Loma Linda, California, only treated prostate cancer. Dr. James Cox [Interview # 32] made the case that proton therapy was a next step in cancer care. He notes that he ran feasibility studies that confirmed that MD Anderson had the patient volume to support a Proton Therapy Center offering treatment for many different cancers. Dr. Leach then describes a first attempt to finance a center in partnership with Tenet Healthcare Corporation and why that failed. He explains the feasibility studies done regarding patient availability and the possibility for reimbursement, and other financial concerns at the time. (23:00) He then talks about the consortium that responded to the call for proposals: The Styles Company (a healthcare development company) and the Sanders Morris Harris Group (investment banking firm), both Houston based. He goes on to explains what these companies brought to the project, who eventually invested, and (25:00) sketches the innovative dimensions of the consortium/partnership between a government supported academic institution (not usually business friendly) and private investment. Next Dr. Leach explains why some technological challenges made it necessary for the Proton Therapy Center to open with only one of its four gantries in operation and outlines the financial implications this had on Hitachi, the company providing that technology. The delay opened the possibility that investors could return their shares to Hitachi, receiving back their money plus a percentage of their investment. The Center ran for a year with only one gantry. (The interview cuts of abruptly.)

Interview Session Four: 29 April 2013

Segment 00D
Interview Identifier

Segment 17

MD Anderson Banner and Satellite Care Centers
B: MD Anderson and Other Institutions

Story Codes
B: Institutional Mission and Values
B: Multi-disciplinarity, Teams, and Collaborations
B: The MD Anderson Brand, Reputation
B: Multi-disciplinary Approaches
B: Growth and/or Change
B: Obstacles, Challenges
C: Understanding the Institution
A: Overview
B: The Business of MD Anderson
B: Beyond the Institution

In this segment, Dr. Leach sketches the partnership established with Banner Healthcare in Gilbert Arizona, leading to the opening of MD Anderson Banner in 2011, the first fully autonomous center carrying the MD Anderson name. Dr. Leach explaining that the motive to expand beyond 1515 Holcombe comes from the MD Anderson mission –to cure cancer in Texas, the U.S. and the world. The center at Banner came about as MD Anderson experimented with a process of adapting MD Anderson care procedures to make them more universal. He notes that MD Anderson seeks out institutions with which there is a "meeting of minds" on how cancer services must be delivered.

Dr. Leach describes MD Anderson's multi-disciplinary approach to treating patients, giving the example of the wide range of options that teams consider for prostate cancer.

Dr. Leach explains that MD Anderson is open to establishing partnerships with institutions that embrace a multi-disciplinary approach. MD Anderson does not need to seek out partners, as institutions approach MD Anderson. Dr. Leach next talks about the many lessons learned by establishing partnerships. He mentions MD Anderson Orlando, Florida, which he says eventually morphed into a Banner-like situation. He explains some of the financial challenges setting up MD Anderson Espana, an initiative that also became more like Banner. Through these experiments, "We now know what a good partner looks like." Dr. Leach then discusses the regional care centers, explaining that they were created to offer patients more access to services.

Dr. Leach explains how MD Anderson insures the quality of care at satellite centers, giving an example of MD Anderson physicians in Houston confer via teleconference with colleagues at MD Anderson Espana.

Segment 18
Tools for Economic Modeling and the Budget at MD Anderson
B: Overview

Story Codes
B: The Business of MD Anderson
C: Understanding the Institution
C: The Institution and Finances
A: Overview

A: Definitions, Explanations, Translations
C: Professional Practice
C: The Professional at Work

In this segment, Dr. Leach explains how economic modeling and budgeting works for the entire institution, using a "current year plus six years" plan. This long view helps his team accommodate building plans, anticipating the financial effects of expansion. He explains several cost-saving measures that have been taken to bring the budget under control. He is also proud to report that administrative costs for the institution have dropped 4% (from 15% to 11%) since 2008 and there are 200 fewer employees in Business Affairs. Dr. Leach describes how financially-focused employees are imbedded throughout the institution, influencing the complexity of bringing these costs under control.

Segment 19
A New Economic Climate Will Shape MD Anderson's Fiscal Future
B: The Finances and Business of MD Anderson

Story Codes
B: Overview
D: The History of Health Care, Patient Care
D: Fiscal Realities in Healthcare
D: The Healthcare Industry
D: Politics and Cancer/Science/Care
C: Healing, Hope, and the Promise of Research
B: Philanthropy, Fundraising, Donations, Volunteers

In this segment, Dr. Leach explains that the Affordable Care Act will drive systemic economic changes that will have a dramatic impact on MD Anderson's finances. He anticipates that the sister institutions and regional care centers will help bring in patients and that it will be necessary to continue to seek out cost-saving measures. Dr. Leach also states that the Moon Shots will eventually generate technologies that the institution can commercialize: the Moon Shots have already created interest from donors and philanthropy has increased. He explains that unlike previous financial fluctuations, the current economic situation represents a "sea change" in which the country is now saying "We won't pay so much for health care." MD Anderson's financial health is connected to the nation's limited resources, and Dr. Leach explains that the institution must continue to be "a good steward" to be successful.

Dr. Leach explains that, with the new financial realities, MD Anderson will become more patient-centered. He then explains that that the MD Anderson mission to cure cancer will carry the institution through. He anticipates that the institution will become a leader in looking at patient outcomes, noting that the world already has confidence in MD Anderson and that "we have what it takes to thrive."

Dr. Leach acknowledges that academic institutions are slow to change and speaks about anticipated faculty responses to the need to change. He then describes the shift in thinking that everyone at MD Anderson has to embrace in order for the institution to move forward. He explains the paradox of getting individuals to accept that "We're number one and you want us to change."

Segment 20
The Proton Therapy Center, Part 2
B: Building the Institution

Story Codes
A: The Administrator
B: MD Anderson History
B: The Business of MD Anderson
B: Beyond the Institution
B: Industry Partnerships
D: Fiscal Realities in Healthcare
C: Understanding the Institution
C: Professional Practice
C: The Professional at Work

Dr. Leach explains that the 2008 financial meltdown resulted in a financial situation in which MD Anderson was able to purchase shares in the Proton Therapy Center previously held by other investors at a very good price. He lists the parties that came together to form the unique public/private partnership financing the Center and explains what the Center means to MD Anderson.

Segment 21
Streamlining the System
B: Institutional Change

Story Codes
B: Institutional Mission and Values
B: The MD Anderson Brand, Reputation
B: The Business of MD Anderson
B: MD Anderson in the Future
B: Critical Perspectives on MD Anderson

Dr. Leach describes the review of administrative processes conducted in 2012, shortly after Dr. DePinho's took over as president of the institution. He gives background on the review and explains why Dr. DePinho requested that MD Anderson perform it earlier than required. He describes the constitution of the committee in charge of the review and their recommendations: reducing administrative overhead and staffing, reducing redundancy in staffing.

Dr. Leach asserts that, despite the economically challenging times, the institution needs to continually invest in research to preserve what MD Anderson's leading thinkers and doers in care. Research, he states, is the "driver for who we are."

Dr. Leach repeats, however, that the institution must learn to operate differently or risk not being as robust as it is currently.

Segment 22
Communicating the Need to Change
A: The Administrator

Story Codes
A: The Administrator
A: Career and Accomplishments
A: Influences from People and Life Experiences
A: Contributions
C: Leadership
C: The Value of the Oral History Project
C: Professional Practice
C: The Professional at Work
A: Professional Values, Ethics, Purpose

Dr. Leach talks about how he communicates with faculty and staff at MD Anderson about the need to change. He explains that he has been influenced by Harvard leadership specialist, John P. Cotter, who wrote a book called *A Sense of Urgency*. Dr. Leach explains some basic concepts from the book, then describes how he goes about talking to heads of departments and divisions to create buy in from leading faculty members who will disseminate the message.

Leon Leach, M.B.A., Ph.D.

Interview #28

Notes on Material Lost Due to Equipment Failure, Session Two

LOST MATERIAL:
This became significant, Dr. Leach explains, with the economic meltdown of 2008, when many investors exercised this option. Hitachi did not want to run a proton therapy center, and MD Anderson, Harris, and Styles were able to purchase the center for pennies on the dollar. Dr. Leach then explains the legal and economic status of the Proton Therapy Center vis a vis MD Anderson and sketches what it represents financially to the institution.

Clip A: The Administrator
B: The Business of MD Anderson
D: Fiscal Realities in Healthcare
D: The Healthcare Industry
Lessons for Strategic Growth and Financial Health
Dr. Leach describes the lessons learned through the Proton Therapy Center: become more involved in varied aspects of health care deliver to control your destiny; MD Anderson should do what it is good at to further its; and remember, “no margin, no mission.”

Segment 18
B: Building the Institution
Approx. 14 minutes
Strategic Financial Initiatives: MD Anderson Banner, Gilbert, Arizona

In this segment, Dr. Leach sketches the partnership established with Banner Healthcare in Gilbert Arizona, leading to the opening of MD Anderson Banner in 2011, the first fully autonomous center carrying the MD Anderson name. He also talks about the satellite care centers around Houston. Dr. Leach begins by noting that such initiatives can only be successfully undertaken when there is a “meeting of minds” on how cancer services must be delivered.

Clip A: The Administrator
B: Evaluating the Institution
B: The MD Anderson Brand, Reputation
B: Institutional Mission and Values
B: MD Anderson and Other Institutions
D: On Leadership
Faculty and the “Employee Model”: A Guarantee of High Standards of Care
Dr. Leach explains it is important that MD Anderson’s partners share a vision –for example a vision of multi-disciplinary care as a key to successful cancer treatment. He explains the

"employee model" that guarantees that all MD Anderson faculty adhere to the same standards of care and contrasts this with systems outside of the institution.

Dr. Leach notes that Banner is a like-minded institution and explains what MD Anderson and Banner each brought to the partnership. He also says that MD Anderson will be developing more autonomous centers, probably in the west and south. President Ronald DePinho supports this long-range vision and under his direction McKinsey & Company was hired to do a growth analysis. Next Dr. Leach talks about the rationale for opening the satellite care centers around Houston.

Clip B: MD Anderson and Other Institutions
B: MD Anderson in the Regional/National/International Context
C: Understanding the Institution
Satellite Care Centers Address the "Complex" in the Texas Medical Complex
Dr. Leach quips that the Texas Medical Complex is 'complex' and daunting for many patients – one element of the rationale for situating care centers so patients have local access to MD Anderson care.

The local care centers, he notes, created a cultural change for faculty.

Clip B: MD Anderson and Other Institutions
B: MD Anderson in the Regional/National/International Context
C: Patients, Treatment, Survivors
The Challenge of Getting to the Texas Medical Center
Dr. Leach imagines a patient who lives in the suburbs driving in to Houston for an eight A.M. appointment.

Dr. Leach observes that it is cheaper for MD Anderson to build facilities outside the city and notes that the institution has just purchased property near Katy. He briefly talks about why the Woodlands will be the next location for a care center. He then touches on the importance of personalized care.

Clip B: Research, Care, and Education in Transition
B: MDACC in the Future
C: Healing, Hope, and the Promise of Research
The Promise of Personalized Care
Dr. Leach describes what personalized care will offer to patients.

Segment 19
B: MDACC in the Future
Approx. 10 minutes
Future Developments and A Secure Financial Future

Dr. Leach explains that President Ronald DePinho's Moon Shots Program will generate many financial opportunities that have not yet been imagined. He sees MD Anderson evolving into an institution where patients will come for specialized treatment or for specific cancers.

Clip A: Character, Values, Beliefs
B: The MD Anderson Brand, Reputation
B: Institutional Mission and Values

C: Funny Stories
C: Patients, Treatment, Survivors
MD Anderson Care: A Shop that Repairs a Lot of Trucks Every Day

Dr. Leach explains how he describes the value of MD Anderson care to the people who live in the town near his ranch. "If your pickup truck breaks down," he says, "you don't take it to the shop that only repairs one or two pickups a month. You take it to the shop that repairs hundreds of them."

Finally, Dr. Leach summarizes that MD Anderson will have to be more accessible in order to secure its financial health. He notes that very few of the faculty are clinicians only. While not advocating any change of the research-based culture, Dr. Leach explains that there must be a discussion about encouraging some faculty to serve only as clinicians and also for the institution to "open portals" to see a wider spectrum of cancers.

Leon Leach, PhD

Session 1— November 5, 2012

A note on transcription and the transcript:

This interview had been transcribed according to oral history best practices to preserve the conversational quality of spoken language (rather than editing it to written standards).

The interview subject has been given the opportunity to review the transcript and make changes: any substantial departures from the audio file are indicated with brackets [ ].

In addition, the Archives may have redacted portions of the transcript and audio file in compliance with HIPAA and/or interview subject requests.

Segment 00A
Interview Identifier

Tacey Ann Rosolowski, PhD
0:00:03.3
We're recording. I always check. I'm Tacey Ann Rosolowski interviewing Dr. Leon Leach for the Making Cancer History Voices Oral History Project run by the Historical Resources Center at MD Anderson Cancer Center in Houston, Texas. Since 1997 Dr. Leach has served as MD Anderson's executive vice president and chief financial officer. This interview is taking place in Dr. Leach's office on the twentieth floor in Pickens Academic Tower on the main campus of MD Anderson. This is the first of two planned interview sessions, and today is November 5th, 2012, and the time is 1:45. Thank you, Dr. Leach, for donating your time to the project.

Leon Leach, MBA, PhD
0:00:51.9
Thank you.

Tacey Ann Rosolowski, PhD
0:00:52.5

Interview Session: 01
Interview Date: November 5, 2012

We really appreciate it, and before we turned the recorder on, you were telling me about your dissertation research and beginning to give an example of three ways or three case studies in which medical centers reposition themselves, as you referred to it.

Leon Leach, MBA, PhD
0:01:11.3
Before I get back into that, let me just correct one thing that you said in the introduction. When I came here in 1997, I was executive vice president and chief financial officer. About three years after that we went through a reorganization where at the time it was principally the financial functions that reported to me, and we changed that about three years later when I became responsible for human resources, facilities, and information systems. I kept the title for maybe a couple more years after that, and then I dropped the title as we put someone else in that CFO position that reports to me. At the time, it was my right-hand person, Ben [Benjamin B.] Melson [CPA], who is now executive vice president and has basically my job at Texas Children's.

Tacey Ann Rosolowski, PhD
0:02:07.1
I see. Your title officially is—

Leon Leach, MBA, PhD
0:02:09.8
Executive vice president. Well, that's my title, and I am chief business officer for the university.

Tacey Ann Rosolowski, PhD
0:02:16.2
But it isn't given a separate title. It's all amalgamated into the one.

Leon Leach, MBA, PhD
0:02:22.6
Yeah, you can do it either way. What does it say on my business card? We'll go by whatever is on that. Executive vice president.

Tacey Ann Rosolowski, PhD
0:02:33.6

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Well, it's interesting. I mean, the story of people's titles and also just the story of departments and divisions and sections and how they've morphed over the years. Thank you for the correction.

THE UNIVERSITY OF TEXAS
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Interview Session: 01
Interview Date: November 5, 2012

Chapter 01
A: Educational Path
Doctoral Work Provides an Opportunity to Develop a New View of Academic Medicine

Story Codes
A: The Researcher
A: Professional Path
A: Overview
A: Definitions, Explanations, Translations
C: Evolution of Career
C: Professional Practice
C: The Professional at Work
A: Personal Background
A: Professional Values, Ethics, Purpose
A: Character, Values, Beliefs, Talents
B: Beyond the Institution
D: On the Nature of Institutions

Leon Leach, MBA, PhD
0:02:43.2
Well, it's minor. That's certainly not a news-worthy thing, because it was just that. It was morphing my—the only thing that really changed of substance was I picked up a lot—basically all the business functions rather than just the financial functions. But the dissertation was entitled *Academic Medical Centers: A Framework for Strategic Repositioning*. It was built around three case studies that I did, and how we got on to this topic was as you were setting up the recorder, I was reminiscing about interviews that I had done for this. But the three case studies were at Baylor College of Medicine, and specifically what I looked at was their decision to go into the hospital business. And what I was looking for were what I would call—a lot of people would call—the critical success factors. I didn't use that phraseology, but what is it that you really need to pay attention to to make these things work, or if you don't pay attention to them, they might not work as well? Baylor was their decision to get into the hospital business. With MD Anderson, it was some financial changes we made in the 2008-2009 period. Well, they were more than financial. They were strategic changes that we made then, and with the third case study it was the University of Texas Medical Branch in Galveston, and it was plans that they had to broaden their service area by moving a lot of components off the island that had been somewhat thwarted because of politics and some other things. But with the advent of Ike, and

Commented [T1]: Dr. Leach begins this segment by describing the subject of his dissertation (entitled "Academic Medical Centers: A Framework for Strategic Repositioning") prepared in completion of work for his Ph.D., conferred in 2011 by the University of Texas School of Public Health. (He worked on this degree while fully employed at MD Anderson.) Dr. Leach was interested in the factors that support the success of strategic initiatives. He explains that he built his dissertation around three case studies of strategic repositioning: The Baylor College of Medicine's decision to own and operate a hospital; MD Anderson's 2008/'09 attempts to improve operational efficiency; and The efforts of the UT Medical Branch at Galveston to expand service to additional locations. He lists the decision makers he interviewed and summarizes his findings.

Next, Dr. Leach clarifies why he pursued degrees beyond his M.B.A. while serving as Executive Vice President of MD Anderson. He sees both his Ph.D. and his M.A. in Christian Education (Southwestern Baptist Theological Seminary, 2001) as personal challenges. He describes the value of the process and discipline of working toward his Ph.D., which gave him an opportunity to serve on a restructuring committee at the Baylor College of Medicine. He gives examples of how the experience provided him with an appreciation for how different leaders view the same situation from different perspectives.

when Ike wiped out the island, and under a different administration, they had a great opportunity to go back and do that, which they did.

Our situation was we just needed to get more efficient at what we were doing. It wasn't that we were—we were expanding greatly, but it was pretty much in one location. We did do some—what we call regional offices that now are in Houston. But it was more about doing what we do where we do it but more efficiently. And then Baylor's was to build, own, and operate their own hospital. When you look at—if these were dives, the degree of difficulty, we were the easiest. We were doing what we were doing but just trying to do it more efficiently. The medical branch was more challenging. They didn't really change what they were doing, but they were doing it in different locations, a broader location off the island, and they were doing it in the face of a hurricane and in the face of some political challenges. Baylor basically—their college of medicine is a very good college of medicine, very well thought of, highly ranked. They decided to get into the hospital business. They'd always used hospitals. They'd had a long-standing partnership with the Methodist, which came apart, and that wasn't part of the study. I picked up after they made the decision or as they were making the decision, looking at the elements of their decision to build the hospital. But theirs was by far the biggest change, because being a college of medicine is one thing. It's kind of one strategic perspective. But owning and operating and building—a hospital—was at least another different perspective, and one could argue building it is different than owning and operating, and they were trying to do all three.

0:06:37.4
Getting back to the dives analogy, that was at least a ten to try to pull that off. When I looked through what's important—and I interviewed not quite thirty people. I think it was twenty-seven folks, and it included the folks that were responsible for strategic decisions and implementing strategic decisions. I interviewed the chairman of the board of Baylor, Marc Shapiro. I interviewed the chairman of the Board of Regents, who, at the time, when these changes were happening, was James[F.] Hofheinz [PhD]. I interviewed several board members at Baylor and their presidents, two presidents, because the shift actually started with Dr. [William] Bill Butler, and [Dr.] Paul Klotman came in. I interviewed their CFO. The same thing here. I interviewed John Mendelsohn, Dwain Morris. I had only interviewed the one board member here, but I did interview the executive vice chancellor of health affairs and the executive vice chancellor of business affairs, two different folks that were very much involved at the UT system level in those decisions. Several faculty leaders, and I interviewed faculty leaders in each of the three institutions, and at the medical branch I interviewed Dr. David Callender and his predecessor, Dr. [John D.] Jack Stobo, just to see what his thinking was. Then I used the tape recorder, and it was digital so I actually uploaded it to an Internet service that will—using voice recognition will give you a printed copy. Not 100 percent accurate. I mean, it's not like having the transcriber

person, but it's close. But what I relied upon more than that was that the actual tape itself is now stored on the Internet online, and I would listen to the interviews and you could actually annotate—it's almost like you're highlighting, only you're taking in and putting points in, and I was looking for, what are these people concerned of when they do this? The answers were 100 percent of the people that I interviewed mentioned leadership accountability or something very akin to that. But leadership accountability was the phraseology.

One hundred percent of the people mentioned the strategic repositioning itself, and what they were talking about is how big of a change is it, the degree of change? I just recited about the three different institutions and then the various degrees of change they went through, and there was a distinct correlation. The smaller the steps, the more likelihood for success. The big steps got tougher.

Tacey Ann Rosolowski, PhD
0:09:59.7
Did those responses surprise you in any way?

Leon Leach, MBA, PhD
0:10:02.6
No, actually, in the dissertation, you build a theory before you go into it, and before I even started the interviews, just based on the reading that I had done, I used different words to describe it. But what came out of the research was kind of a more refined version of what I was thinking going into it. But the other three things—there were five things that more than seventy percent of the people mentioned in the interviews, and of those five things, there was no other thing that got mentioned more than half the time. It gave me kind of a clean break for the critical few, and the other three were having the metrics to measure your success or failure, communication, communication, communication. You can't over-communicate. Most people under-communicate. The last one was a little bit tied to the first one. It was the sustainability of the change, and the thinking is if you're going to do it and expend that energy—and these can be pretty traumatic for organizations, the big changes. Don't expend it unless you can sustain it. Part of another way of saying that is, don't undershoot the mark. If you overshoot the mark, you may not be able to get there any how. This is what happened to Baylor. They wound up falling on their bottoms and boarding up their hospital essentially. Well, boarding up is probably too crude of a term, but they mothballed it. They never opened it as a hospital. They are now doing much better financially to stabilize the ship, and they are actually using that space for outpatient clinics, and they're starting to utilize that space. But when they were on technical default on the bonds, they didn't have the money to do that. That's the essence of the dissertation.
Tacey Ann Rosolowski, PhD

0:12:10.4
Why did you choose to do a graduate degree when you did?

Leon Leach, MBA, PhD
0:12:15.2
It was there. The Health Science Center has literally got—you can't see it because we're so close to it. It's right off the walkway as you come over from the Mays Clinic, so the convenience was one thing, but education is an ongoing process. My genetic makeup is the business side. I have an MBA. But I also have a master of arts in Christian education, and I have the PhD. But the skill set I utilize the most is the MBA, obviously.

Tacey Ann Rosolowski, PhD
0:13:03.4
Just for the record, I wanted to say the MA that you received was from—in 2001—Southwestern Baptist Theological Seminary.

Leon Leach, MBA, PhD
0:13:12.1
That's correct.

0:13:13.2
Tacey Ann Rosolowski, PhD
And then 2011 was the conferral date for your PhD from the UT School of Public Health.

Leon Leach, MBA, PhD
0:13:19.3
Yeah, you know, I didn't realize it was exactly a decade.

Tacey Ann Rosolowski, PhD
0:13:21.9
Yeah, I noticed that.

Leon Leach, MBA, PhD
0:13:24.0
I guess I could have read the diplomas and figured that out, but you're right.

Tacey Ann Rosolowski, PhD
0:13:27.7

Yeah, it's kind of interesting.

Leon Leach, MBA, PhD
0:13:27.6
It was about a five-year process for the PhD, and I did have a full-time day job so it was kind of—and I think it was easier because someone told me—I was actually thinking about a PhD in theology. Somebody told me it needs to be something that you really have a passion about, because if you don't, you'll never see it through. Well, the theological degree, it's very helpful. It's something where you can't take the knowledge away, and I've used it a little bit. But it was more for me to do as a personal thing, and I kind of approached the PhD in the same way. It was more of a personal challenge, but what I was living and breathing at the time were these restructurings. Repositionings is what I called them, because we had just gone through the process at Anderson, and I was very familiar with that. I was asked to serve on the restructuring committee of the Board of Trustees at Baylor, so I was very much involved in that, and I had the unfair advantage of knowing Paul, knowing their CFO, knowing the folks over there, knowing the board members. One of the more interesting things with my committee, one of the committee members was very concerned that I would not be able to get interviews to begin with, and he actually suggested I read a—it was a very well-done article about the reluctant interviewer. It said basically people in power who you're looking at and second guessing, they won't even agree to the interview. If they do, you really won't get the full story, that kind of thing. Well, these people that I worked with—Marc Shapiro sat on our Board of Visitors and was chairman of the board of Baylor and actually has a copy of my dissertation. They were very open and very willing to tell me what their thinking was at the time. There was nobody that said no to me interviewing them, and there was nobody that I felt was giving me cagey-type answers. You could tell the conversation was coming from the heart. These guys and gals lived it. They lived through it.

Tacey Ann Rosolowski, PhD
0:16:14.3
I think so often in interviews, when people think of an interview they think of the model of a journalist's interview, which is often kind of inflammatory, whereas the kind of interview that you were doing for research purposes, like the kind of interview I'm doing, let's take a critical look at this. Let's evaluate this.

Leon Leach, MBA, PhD
0:16:32.0
And I did stay away from the "have you stopped beating your spouse" question.

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Tacey Ann Rosolowski, PhD
0:16:36.2
That's always a good thing. (laughter) Save that for the drink afterwards, right? Well, it seems like you were really in the right place at the right time in terms of what was going on at MD Anderson and then what was going on in the other divisions that you looked at as case studies at the time. It seemed really, really fascinating.

Leon Leach, MBA, PhD
0:17:01.6
Yeah, it was one of those opportunities that—was it career oriented? Not really. But it was intellectually driven, and it was kind of the—if you're there at the perfect storm and have a chance to write about it or record it—and I'm not sure that mankind is going to be much better off because I did this, but to me it was worthwhile. It was very—just the discipline of going through the research—with interviews you actually have to go through the IRB. You do get an exemption. Well, I did because they weren't patient-care types of interviews, but I had to go through that process, and I had heard our faculty kind of complain, and I didn't have to go through MD Anderson's IRB. I actually had to go through the School of Public Health's IRB, which was a fourth entity, because the three other academic medical centers I was dealing with were the subject of a case study. And it wasn't—they were very nice. They actually helped me with the forms. They kind of walked me through it, because they knew they had a novice on their hands. But it was a lot more paperwork than you think of. It did give me an appreciation of what our faculty has to do, and the interesting thing in writing this is I lived through these, but I could never talk about my experience. This is a scientific document, so I had to interview people and get their experiences, and there are several different perspectives. I mean, the board of directors has one perspective. The executive leadership has another, and the faculty has yet another, and I'm sure there are others out there, but everyone is looking at the same situation but from a different angle, from a different degree. One of the things I tried to do was correlate what did the board see as being important—the governing board that actually had the responsibility—fiduciary responsibility—see as being the critical elements? What did the executive team see, and what did the faculty leadership see?

Interestingly, what they saw was pretty common. I mean, if you looked at each institution—I'm not trying to do a between-institutional thing, because the circumstances are different, but everyone saw the same five critical elements. The degree of importance that they put on this—and how I tried to measure the surrogate for the degree of importance was how many times a certain theme was mentioned. One hundred percent may have mentioned it, but the faculty member may have mentioned it once in passing, and the board member may have mentioned it a dozen times and dwelled on it. The only one that really surprised me was communication was

rated higher by the board, and it was rated second highest by the faculty, and it was rated least highest by the executive team. But it was still in the top five, and when you really looked at the comments and not just take the count of when they talked about it, what the board was concerned with was the public communication. Are we going to get a black eye here? What the faculty was concerned with was, why didn't somebody tell me? Of course they had been told. They just—and there was clear evidence of presentations that were made to faculty and the recall—something else on their mind. But the executive team, while they recognized it was important, they were more focused on getting it done, and that did vary by institution, because I did look at that one across institutional lines. Probably the one that did the best was David Callender at the medical branch. He took great pains to get out in front of people. To me, it's not an interesting read, because I wrote it, but if you're interested in that kind of thing, there might be some value to it.

Tacey Ann Rosolowski, PhD
0:22:09.9
Sure. It sounds as though it was an interesting—it was an occasion for you to refocus your perspective a little bit through doing this work.

Leon Leach, MBA, PhD
0:22:19.9
Yeah, I'm glad that I did it, and I certainly got the appreciation for different perspectives, because I was the reporter. My role in an interview was basically, you're going to do ninety-seven percent of the talking, and I'm going to do three percent, because I had five very broad, open-ended questions, and it was all designed to get the interviewee to talk. I got very good at going, "Uh-hunh (affirmative), uh-hunh (affirmative)."

Tacey Ann Rosolowski, PhD
0:22:56.7
Is that a natural part of your style anyway? Are you a listener?

Leon Leach, MBA, PhD
0:23:02.2
My wife doesn't think so. (laughs) I try to be. I really do try to be. First of all, when I came to MD Anderson I had to be, because while I knew the finance side, I had never worked in an academic medical center. I never worked for a state government or a university, and I had never worked for a hospital. I had the financial background, and it was healthcare. It was all healthcare. But I was usually negotiating against the hospital, because I spent a lot of my time in the managed care companies and started HMOs and that kind of thing. I was very familiar with the

environment, but again, it was a different perspective. I did have a lot to learn. You can't learn and talk at the same time, I don't think.

Segment 2

A: Professional Path

Education and Work Experience

Story Codes
A: Character, Values, Beliefs, Talents
A: Personal Background
A: Professional Path
A: The Administrator
A: Character, Values, Beliefs, Talents
C: Evolution of Career
C: Professional Practice
C: The Professional at Work
C: Faith, Values, Beliefs

Tacey Ann Rosolowski, PhD
0:23:57.4
Yeah, that's very true. Let's go back and pick up that, because I was really interested when I was looking at your background and that shift between moving from the setting up of HMOs to slowly moving into more of the health delivery side. That seemed like a really interesting change in your own career path. Let me just ask you some other background questions and then kind of get to that part of your own development. First, for the record, where were you born and when?

Leon Leach, MBA, PhD
0:24:30.1
I was born in Bridgeton, New Jersey, Bridgeton Hospital, in 1948.

Tacey Ann Rosolowski, PhD
0:24:39.7
And did you grow up in New Jersey?
Leon Leach, MBA, PhD
0:24:42.3
Yes.

Commented [T2]: Dr. Leach begins this segment with a brief overview of his modest family beginnings in Port Norris, New Jersey, where his father worked as an oyster fisherman. (He tells an anecdote about owning his own boat at the age of twelve.) He then shifts to the educational and professional path. He begins with his long relationship with The Prudential Insurance Company of America (1963 – 1973) where he began working while earning his Associates Degree from Cumberland County College in New Jersey (conferred 1969). Dr. Leach explains that he didn't have the money to go to college, so he worked full time at Prudential (with claims) and attended class at night for virtually all of his schooling, including his undergraduate work at Rutgers University (B.S. 1973) and his studies for his M.B.A. at Widener University (1976). Once he received his MBA, he was fast-tracked at Prudential, leading to an opportunity to serve as Vice President of Marketing in Nashville, Tennessee.

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Tacey Ann Rosolowski, PhD
0:24:43.6
And in that same town? What's the name of that town again?

Leon Leach, MBA, PhD
0:24:45.4
Well, no. Where I grew up is a little town called Port Norris, and if you can imagine Cape May, the cape coming out, it's right there in what us locals would call the armpit of the cape, right as the cape comes out. Bridgeton was the county seat. Port Norris was a port town, maybe 1,000 people or so.

Tacey Ann Rosolowski, PhD
0:25:10.6
And that's Richton, R-I-C-H-T-O-N?

Leon Leach, MBA, PhD
0:25:13.9
Bridge.

Tacey Ann Rosolowski, PhD
0:25:14.6
Bridgeton, okay.

Leon Leach, MBA, PhD
0:25:15.3
Bridge, B-R-I-D-G-E.

Tacey Ann Rosolowski, PhD
0:25:18.0
Okay, I'm glad I asked.

Leon Leach, MBA, PhD
0:25:19.1
Southern New Jersey. It's the county seat of Cumberland County.

Tacey Ann Rosolowski, PhD
0:25:23.3

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Interview Date: November 5, 2012

And tell me a bit about your family and what you feel in your family background kind of tracked you into leadership.

Leon Leach, MBA, PhD
0:25:33.6
Well, my father was an oysterman on the Delaware Bay. He had his own boat. I grew up on the water. I've always been partial to boating and do a lot of it. Well, I don't do as much as I'd like. I've got to work too. He was a quiet man. He worked outdoors. The months in which you harvest oysters are months that have Rs in them, so you're in the Delaware Bay anywhere from September through April. That's not the nicest time to be in the Delaware Bay.

Tacey Ann Rosolowski, PhD
0:26:17.2
That's hard work.

Leon Leach, MBA, PhD
0:26:18.3
And then when the oyster season was over, we'd go crabbing or fishing or whatever. There was a lot on the water. Neither of my parents is still alive. My mother lived to be ninety-two, and she was the spiritual backbone of the family. It's not that Dad wasn't, but it was very important to her that we all grow up in the church, and we had five of us. I was the oldest, and I had four sisters.

Tacey Ann Rosolowski, PhD
0:26:47.8
What was the denomination you were raised in?

Leon Leach, MBA, PhD
0:26:49.6
Baptist. I had a very Ozzie and Harriet type of family. It was blue collar. My dad—and by the time I was twelve, I was helping him on the boat, but it was a great life. It was a good town to grow up in. It was fun being on the water. I was never micromanaged by my parents. My mother was always skittish but my father—I had a boat when I was twelve and he had told me—it was like a dinghy only it was wood. It was about that size, and I had a 3.6-horsepower Scott-Atwater outboard motor. These are antiques today, and in the Delaware Bay if you go out of the river, the Maurice River, into the bay and the tide is flowing out, 3.6 horsepower isn't enough to get you back in. He had told me—he'd be down working on the boats on Saturday or Sunday, and I'd go out on the river and play around on my boat, and he would tell me, "Don't go out into the bay."

Of course, we used to go out all the time in his boat. He never explained to me why I shouldn't go out in the bay, so this one day I couldn't resist. I went out in the bay and I pretty quickly found out—there was an island where the river split, and instead of getting washed out I was able to get up behind the island, but I couldn't get back in until the tide changed, which was probably a couple of hours. I came back in, and I wasn't going to say anything to Dad. I figured out why I wasn't supposed to go out in the bay now because of the tide, so I tied the boat up and went over, and he's working on the engine. He's changing the oil or something, and he didn't even look up. He just said, "So how was the bay?"

I said, "Well, I figured out why you don't want me to go out there." He says, "Yeah. Let's not tell your mom about this, okay?" He was very enabling, and I had a lot of fun, a lot of great adventures. I went to this one men's retreat when I lived out in California, and it was one of these things where folks would talk about their childhood and all that, and I was shocked at some of the adversity that some of these adult men grew up with. It was one of those kumbaya things where they're expecting you to share, and I'm sorry, but I had a very normal childhood. It was Ozzie and Harriet.

Tacey Ann Rosolowski, PhD
0:29:33.8
Call me boring.

Leon Leach, MBA, PhD
0:29:37.8
I don't have any good stories to tell you.

Tacey Ann Rosolowski, PhD
0:29:42.9
That's funny. What did you major in when you went to college, and how did you track into your career?
Leon Leach, MBA, PhD
0:29:50.4
Business? I could not say I was driven to be a business person. I kind of looked at the choices, and I took some accounting courses in high school, and it was easy for me. I got it. I understood the theory. It's kind of a natural thing and I actually took enough—I needed three more credits to have a dual degree in accounting, and when I tell people that they're like, "Why didn't you do that?" The only good it would do me is if I wanted to sit for the CPA, but back then, and still very similar to today, you had to work in an auditing shop and audit, and that's not what I wanted to do. It was the business side that appealed to me.

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Tacey Ann Rosolowski, PhD
0:30:45.5
What did you see yourself—what was it that you visualized when you saw yourself thinking about that business side?

Leon Leach, MBA, PhD
0:30:52.8
A generalist. I didn't have—I knew the financials. Understanding the numbers was important, because that's what makes businesses differ. It's the bottom line. I knew that that came natural to me. I had a good feel for that. But I never really saw myself being an accountant. I never really saw myself being a CFO. I saw myself as being a business person. It was more general, broader, and in my career at one point in time I was an assembly language programmer. You tell anyone that, and that's almost before anyone in the computer age knew—

Tacey Ann Rosolowski, PhD
0:31:40.8
I've never even heard the term.

Leon Leach, MBA, PhD
0:31:42.5
It's a very arcane language. It's very close to machine language. It's very close to turning the bits and bytes off and on. It's a tedious language to write in. I did that for a while. It was kind of a process of, okay, that's not what I want to do. But it was all within the business structure, and most of it has been in healthcare. I spent three years as a CFO in Prudential's real estate subsidiary, but other than that, it was all healthcare. And your comment earlier about going to the delivery side, it's interesting, because when you track my career, that's what I did, but when we were starting HMOs, I saw myself as being part of a delivery system. These were health maintenance organizations. We primarily did group model HMOs where you—it's like Kaiser. Kaiser is actually a group model where the delivery side is very much connected to the insurance side. We call them integrated health plans today. That's a little bit broader. That includes the hospital and all. I was on the business side of those transactions, but we actually developed medical groups that we worked with. Miller Medical Group in Nashville was Prudential's second HMO. The first one was in the building that we imploded. I came down here to set up their financial systems.

Tacey Ann Rosolowski, PhD
0:33:28.6

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Okay.

Leon Leach, MBA, PhD
0:33:29.5
The big, distinct change was coming here, because that did get me more out of the commercial world and into a different environment.

Tacey Ann Rosolowski, PhD
0:33:36.7
Into an academic world. Now, you got your BS in '73 from Rutgers, and then your MBA was 1976 from Widener University. Am I pronouncing that correctly?

Leon Leach, MBA, PhD
0:33:46.9
Yes.

Tacey Ann Rosolowski, PhD
0:33:47.3
And where is Widener?

Leon Leach, MBA, PhD
0:33:48.1
Widener is Chester, Pennsylvania, just south of Philadelphia. It was freshly named Widener University. It had been Pennsylvania Military College, PMC. But during the Vietnam era, they ran into funding difficulties. The Widener family is a well-known, mainline Philadelphia family that donated a lot of money, and basically the school chose to change their name.

Tacey Ann Rosolowski, PhD
0:34:16.8
Interesting. Now, as I was looking at your background, you had a very long relationship with the Prudential Insurance Company.

Leon Leach, MBA, PhD
0:34:24.0
Twenty-five years.

Tacey Ann Rosolowski, PhD
0:34:24.7

Yeah, 1967 to 1993, so '67, that's even before you graduated from college. Tell me about that because I remember when I was reading some of the background materials—and actually, there was a letter that John Mendelsohn wrote to the faculty when you were going to come to the institution. He mentioned the long relationship with Prudential. Could you tell me about what you did for them? And part of the reason I'm asking is because obviously your long relationship with medically related insurance was part of the reason that you were so perfect for the position here. I'm interested in the development of that perspective and looking down the road to what you were bringing to MD Anderson.

Leon Leach, MBA, PhD
0:35:12.3
I actually—like I mentioned, we were a blue-collar family. There was an oyster blight in the Delaware Bay that basically killed off the oysters. They came back as I was a young man, so we didn't have a lot of finances for me to go to school. I worked, and I went to Cumberland County College and have an associate's degree from Cumberland County College, a two-year school, and then I transferred to Rutgers. I did one year—I had enough money to do one year full time at Cumberland County College, but all the rest of my schooling has been at night or part time. I went to Rutgers University in Camden, New Jersey. They have a branch there, and one of the things I discovered is I had some daytime professors, but it was mostly nighttime. The vast majority was evening school, and they had adjunct faculty for the evening school, and these are people that are out recruiting HR or information systems or they're the finance people, and they come in and teach the finance course or the human relations course. I found that the daytime teachers, it was a lot of theory, which was good. But the nighttime teachers had made it work. They put it into practice, and I thought I got a very good education, because it was primarily people that had done it.

And then I went on for an MBA at Widener, and that was in the evenings. That was over the bridge from Southern New Jersey. It was all working during the day and then driving to school and driving back. It was roughly about a forty-mile trip for both Rutgers and Widener. When I first started at Widener, the choice was either a ferry to cross the Delaware River, or you had to go through Wilmington, Delaware, and come up, which added about a half a dozen miles to the trip. But my favorite story as my—we have three sons—as our sons were growing up I would tell them that I had to drive through three states to get my degree. (laughs) Well, three states is like from here to Katy.

Tacey Ann Rosolowski, PhD
0:37:43.9
True dedication. Of course it was.

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Leon Leach, MBA, PhD
0:37:48.0
Fortunately they had just opened—I think it was the Betsey Ross Bridge the second semester I was going to Widener, and that made the commute a lot easier. But when I got the bachelor's degree, I was working with Prudential, and I was working in their Medicaid and Medicare office in Millville, New Jersey, which is where I went to high school. I thought, "Ah, a college graduate. I'll go find myself a good job." I went out and interviewed and stuff, and I found that I was further along in my career with Prudential than I would be just coming out of college, and Prudential had been good about moving me ahead. When I got the MBA I thought, "My ticket to Wall Street." They promoted me to manager of the Medicaid claim operation, and I was significantly ahead of what I would be doing as a freshly minted MBA—perhaps not if it was a premier degree, Harvard or something like that—so I wound up staying with Prudential. I only really tested the waters a couple of times, and when I got the bachelor's degree, they had put me on this kind of fast-track program for high-potential people. They would move you every two to three years so you'll see—I don't know how detailed the resume was that they sent you, but basically every two to three years I was doing something different, and it was great development for me.

Tacey Ann Rosolowski, PhD
0:39:33.0
What were some of the lessons that you learned there? How did that develop your skill set?

Leon Leach, MBA, PhD
0:39:38.8
Well, I think it made me a much broader person. I'll give you an example. I guess I was still in my twenties. I was probably twenty-eight or twenty-nine. I was just about thirty, and I was working in the corporate office in Newark, New Jersey, and I was a similar language programmer, but I did a lot of systems design work. I did our first online system where you used the cathode ray tube that Prudential had. I was on this fast-track program, and I was literally just down the hall from the senior vice president of the group department, one of maybe twenty people that ran the company. The program was every so often he'd call you in, and it would be more like three to six months, how are you doing, are you happy, what are you working on, that kind of thing. At twenty-nine at one of these discussions, I said, "I think I'm being stereotyped. I think people were thinking that I'm just an IS guy and that I enjoy it." I didn't want to be stereotyped. I'm only twenty-nine years old. It was more my imagination than anything else, I think, so he asked me, "What would you like to do?" I said, "I really don't know. I mean, you know the company. I want to be a generalist." By now, the vision was coming more into focus. I

didn't want to be the techie. I didn't want to be the one putting the numbers on, the debits on the left and the credits on the right, but I wasn't sure what I wanted to do, and businessman was too nebulous. I said, "You know the company better than I do. You know me. You know what my talents are and what my limitations are. What do you think I should do?" And of course, this flies in the face of never asking a question with a question, and also, the corporate America structure back then was very much the idea of looking for people that—I want to be a—you know. He said, "Well, let me give it some thought," and we left it at that. Two weeks later on a Friday he walks into my cubbyhole. He would have closed the door if there was a door to close, I'm sure, and he said, "How would you like to be the vice president of marketing in our new HMO in Nashville, Tennessee?"

And I got a look on my face. It must have been a shocked look because he watched my body language, and the next thing he said—I didn't say anything. The next thing he said was, "You said you wanted something different. This is about as different as I could find." I thought about it over the weekend, and I came back in on Monday and told him, "Yeah, I'll do it." Someone who grew up in Southern New Jersey finally made it to Newark, New Jersey, of all places. This is where Prudential's headquarters were. I'm going to Nashville. What I was doing—I'd done two things, basically. I was in charge of the financials for approved care, but we had one HMO right here. Our first one was right here in Houston, and I'd flown down here and set up the books and that kind of thing, and I'd done some of the systems work, or they were done under my design. Now I'm going to be the VP of marketing. Really? Of HMO? They sent me to—it was called—the acronym was GROC, the GROC place. It was Group Rep Orientation Course. One of my classmates is now one of the four executive vice presidents at Prudential. Another one—she wasn't really a classmate. She was a lawyer, but she is off that genre. We were kind of in the same program at Prudential. She's now their general counsel. It was a good training, a good group, and that's an example of how it broadened me as the boy who grew up on the Maurice River running around in a dinghy to somebody who had more experience.

Tacey Ann Rosolowski, PhD
0:44:24.1
Well, it took a little—I don't know—courage or throwing caution to the wind—

Leon Leach, MBA, PhD
0:44:30.3
Courage or stupidity, one or the other.

Tacey Ann Rosolowski, PhD
0:44:32.0

—to ask the question, to kind of go against traditional corporate wisdom and ask the question. But it ended up being a great opportunity.

Leon Leach, MBA, PhD
0:44:40.7
Yeah, it did. It opened the doors. It's almost one begets another. One opportunity leads to the next.

Segment 3
A: Professional Path
Approx. 26 minutes
Moving to the Provider Side of Insurance

Story Codes
A: Professional Path
A: The Administrator
A: Character, Values, Beliefs, Talents
C: Evolution of Career
C: Professional Practice
C: The Professional at Work
A: Overview
A: Definitions, Explanations, Translations

Tacey Ann Rosolowski, PhD
0:44:50.1
Tell me about some of the other experiences that were really key in rounding out the generalist and person interested in strategy who came to MD Anderson in '97.

Leon Leach, MBA, PhD
0:45:04.3
I spent a year as the vice president of marketing, and then I became the vice president of PruCare of Nashville. We were growing rapidly. The person who went there at the same time I did—we were just starting it up—he went on to Chicago to start another one in Chicago. He's retired now but he was president of—I think it was Florida Blue Cross Blue Shield.

Tacey Ann Rosolowski, PhD

Commented [T3]: Dr. Leach explains that his role as Vice President of Marketing for Prudential in Nashville (1980 – '85) gave him his first experience with the health-care provider functions of insurance companies. He describes his experience managing all parts of the health-care delivery system. He then explains that his career expanded once again when Prudential purchases Merrill Lynch's real estate division: he moved to California to become the Chief Financial Officer of the Prudential Real Estate Affiliates. When Prudential asked him to return to Newark, he says his family did not want to move again. At this point, he moved fully into the provider side of health care, developing the professional management of physician's offices.

0:45:34.0
What was the year that you went to Nashville? Well I guess the year is probably—

Leon Leach, MBA, PhD
0:45:41.1
I think it was 1970. Is that right? I think it was ’70 to ’75. It’s probably on the resume someplace.

Tacey Ann Rosolowski, PhD
0:45:49.2
Yeah, let me see if I’ve got that. I’m just curious because I was wondering how you were seeing the sort of—because when you came to MD Anderson there was a serious financial issue happening with HMOs, and I’m wondering how early you began to see some of those things accumulating.

Leon Leach, MBA, PhD
0:46:12.9
You know, I think it wasn’t ’70. It was ’80, I think, ’80 to ’85.

Tacey Ann Rosolowski, PhD
0:46:24.8
Group department sales and managed care? That’s Northeastern office.

Leon Leach, MBA, PhD
0:46:28.6
That’s when I came back. That was ’85.

Tacey Ann Rosolowski, PhD
0:46:31.2
Oh, here we go, ’84 to ’85, the senior vice president, Prudential Healthcare Plan Inc. Built Southeastern HMO operations and then also the vice president—this is ’80 to ’84—vice president of Prudential Healthcare Plan, PruCare of Nashville and then various positions of increasing responsibility. That’s it. It was really looking like ’80 to ’85 sort of the period—

Leon Leach, MBA, PhD
0:46:56.5
And I didn’t get that granular in the resume, but there were really three jobs I had there. I went there as the director of marketing. I then became the vice president as we went operational, and within a couple of years I became a senior vice president for the Southeastern region. That was

the first one you read. But that kind of really solidified the financial bit. I designed the systems and all, but I had responsibility for the bottom line, and we had profit and loss statements, and we were expected to be profitable. That's where it all came together, plus I now had some experience with marketing, although not a whole lot. But I did sell—the biggest account they ever sold was the City of Nashville. The other thing was that's where I got some personal experience with the provider side, because we did business with Hospital Corporation of America, and we did business with the Miller Medical Group, which was a freestanding physicians group. We used one of HCA's hospitals as our main hospital, but we established relationships with Vanderbilt. They were our tertiary care center, Baptist Hospital in Nashville. That was really a good job, because I could see all the pieces coming together.

Tacey Ann Rosolowski, PhD
0:48:24.0
And what was it that you were seeing? I mean, you have to understand, I think, you're talking to someone, and there are going to be a lot of people listening to this interview who probably don't even know what questions to ask. They just don't have any kind of window into the systems that you're talking about. Could you explain more about what it was that you were working with in setting up the HMO and then why the provider side added such a different piece to that puzzle?

Leon Leach, MBA, PhD
0:48:49.8
Well, what I brought to it already was the financial background, but that's just one piece. Even of what I had on the administrative side, finance is one thing, but it takes so much more. At Anderson it's clinical operations, it's research. All those things have to come together. Well, the piece that I pretty much owned was the business side, and that job with the HMO with PruCare told me I had the sales side, which we really don't have here. We have a marketing area but you're not selling—one of the major pool groups, say, Shell or Exxon, although we do arrangements with them, you're not selling them on getting all their care through an HMO. I had that experience. Then as the vice president of the HMO, we had to negotiate contracts to arrange for all these services. We had to have the physicians, and we went with a multispecialty group. They're in Nashville. They provide primary care and a lot of the surgery, and they were attached to an HCA hospital. We had to have a contract with them, because while they were a corridor or two to get down to the hospital, they were physically attached. They were two different legal entities, and then you had to make arrangement for tertiary care. Neonatology was done at Vanderbilt. Saint Thomas did a lot of the cardiology. Baptist did the OB-GYN. There were specialty things that you wouldn't necessarily have done at what was a general care HCA hospital. You had to arrange for all those services. It was a Kaiser-like model, so everything that Kaiser does on a much bigger scale.

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Tacey Ann Rosolowski, PhD
0:51:01.8
I actually don't know what you mean when you say Kaiser-like model. What does that mean?

Leon Leach, MBA, PhD
0:51:06.0
Do you know who Kaiser Permanente is?

Tacey Ann Rosolowski, PhD
0:51:07.4
Yes.

Leon Leach, MBA, PhD
0:51:08.4
Well, they're an integrated healthcare delivery system, because the doctors aren't in their employ. They're in the employ of the Permanente Medical Group. It's called Kaiser Permanente. Permanente Medical Group has a contract with Kaiser to deliver the services. Now, at MD Anderson, the doctors are in our employ, and we own the hospital, so we're more integrated than they are. But what we created was based—in PruCare—was based on the Kaiser Permanente model, which when people today point to the successful entities, you usually hear Kaiser, because it's integrated, and they also control the health plan.

Tacey Ann Rosolowski, PhD
0:51:54.3
What are the advantages of that kind of a system?

Leon Leach, MBA, PhD
0:51:56.9
Well, you control all the aspects. You have responsibility for all of the aspects. PruCare was an HMO, but what we specialized in at Prudential was the insurance end. The thing that made us different from Prudential Insurance, and the reason PruCare was a subsidiary, is we were an HMO company. We arranged for the delivery of care. We didn't own the doctors. There is a model called a staff model that the doctors would actually be in the employ of the HMO. It's a fine difference, because Kaiser Permanente allowed people to think Kaiser owns the doctors as well. Not really. They actually have their own medical group, and they have a contractual relationship. The thing that I got out of this was how to pull all those things together, how to

integrate, and it was on a reasonably manageable scale. I mean, Nashville was not L.A., thank God. From there—what did I do then? I think I went back—

Tacey Ann Rosolowski, PhD
0:53:13.7
I have subacute ’93 to ’94.

Leon Leach, MBA, PhD
0:53:16.9
I think you skipped over—I went back to Newark. Well, actually, it’s more of the process than the steps. The experience I got there was in managing all parts of the healthcare delivery system. Prudential grew up as a separate subsidiary. When it got to a certain critical mass, we integrated it with Prudential Insurance Company, and when HMOs first came out, you had to get your services there. There was no benefit if you went outside a certain area. If you had a life-threatening emergency, you could go to an emergency room, and they would pay the emergency room. But if you had any other thing wrong with you, you had to use the HMO doctors. Then they came up with—we called it PruCare Plus, and all we did was we married the HMO with an insurance plan. If you choose to go outside the HMO, you’re covered by insurance. You get the best of both worlds. It costs you a little bit more, because back then the costs for the insured side was higher than the HMO side, but when we integrated those two, it was kind of like musical chairs.

There were four senior VPs of PruCare, and there were five group insurance regions, and what wound up prevailing was the parent company of the five regional structures. I was heading the Southeastern region out of Nashville. There was no Southeastern. There was a Southeastern region within Prudential. It was in Jacksonville, and long story short, when the music ended I was the person who headed up the combined—the vice president of group insurance in Newark for the Northeastern region, which was geographically the smallest, but dollar-wise the biggest. It went by where corporations were headquartered, so Citicorp was one that we had. But as a client, I’d go to Fargo in the Dakotas, because they had a credit card place out there that had 4,000 employees.

0:55:42.8
That was interesting, because it gave me experience on a different scale. That was a much bigger national scale. The next thing in my career was Prudential bought Merrill Lynch’s real estate company. The gentleman I was telling you about who asked me what I wanted to do, he was the senior vice president of the group department, but there were four executive vice presidents, and he reported to one of those four. The individual—by then I was a full vice president with

Prudential, so I was one level below the guy who asked me, "What do you want to do?" The gentleman who was my—actually, I reported directly to the executive office in my—I'm skipping a job here. I went back to Newark in the regional job, and the office I started in in Southern New Jersey in Millville, they had grown to 2,000 people, and they did all the Medicare claims for New Jersey, North Carolina, and Georgia, and they had offices in North Carolina and Georgia. We actually had two in Southern New Jersey. The one in Millville, my old hometown—not my old hometown, where I went to high school—was about a dozen miles north of Port Norris, and there was one in Linwood, New Jersey, which is over by Atlantic City, just across the Lakes Bay.

Anyhow, there was a promotional opportunity to run that office, and I was asked to do that, and I reported to the executive committee. I was a full vice president, not a senior vice president, because by Prudential standards, it wasn't really big enough to warrant a senior vice president. I did that for—again, it was two to three years. All these things were two to three years, and the gentleman who I was reporting to in the executive office decided if I wanted to make the next step I needed to know something other than healthcare. What I got out of that job was Medicare and Medicaid. I've had experience with the insurance aspect, with the managed care aspect, the HMOs, Medicare, and Medicaid, and it wasn't as though I was thoughtfully or consciously building this portfolio. I mean, the decisions were being made jointly by myself and whoever I worked for at Prudential at the time as to what's the next logical step. I wasn't sitting there thinking, "If I do X, Y, and Z, I'll wind up in Houston, Texas." Actually, that was the last thing I would have thought. The next opportunity was actually a real estate company. It was Merrill Lynch's national real estate company, and we had gotten into the business—we started our own "national" company. It was considerably smaller than Merrill Lynch's. It was based in Southern California, right outside Newport Beach. When we acquired Merrill Lynch's company, it was like David swallowing Goliath. They were a player. We were just trying to get into it. We automatically became a player, but whenever one company buys another, they want to have control of the finances, so they asked if I'd go out there and be the CFO.

The common theme here throughout all this is that know something about the numbers. I got Medicare and Medicaid, commercial insurers, the delivery side, putting together delivery systems, and when I got to the senior vice president level in PruCare, that's primarily what I would focus on in other cities. Nashville, I think there are five HMOs that reported to me in that region, but I started a bunch in the Northeast too when I went back up there. I think I started twenty of them. I moved to Newport Beach. Well, I moved to California and lived in Newport Beach and worked in Mission Viejo and was the CFO of their real estate company. I did that for three years, and the master plan was I would come back to corporate. In three years I'd go someplace else, most likely back to corporate, because that's where they had the generals, and I

was kind of getting to that rank, so to speak. Pretty much like clockwork, they asked me to come back three years into it, and I was a good corporate soldier. Instinctively I said yes. I went home. It was a Friday. I went home and talked it over dinner to the family and told them how we're going to move back to Newark. Of course, we didn't live in Newark. We lived in—oh, I had three tours up there. Summit, Berkeley, and Chatam is where we lived. They were all very nice communities, but we had three sons. The oldest was a senior in high school. No, that's not right. He was in college. No, I'm getting confused with when I came back here. The oldest was a senior in high school. Bill was a senior. Dave was a sophomore, and our youngest, he was in the seventh grade.

1:01:53.6
We had this kind of thing in the family. If one of them happened to be misbehaving, I'd invite them out to breakfast on a Saturday and talk to them about their behavior. That Saturday the three of them got together and invited me to breakfast. They did not want to go back to Newark, New Jersey. They loved California. They loved Newport Beach. They wanted to stay there. Well, this was back when if you said no to a corporate move, you were damaged goods, back in the IBM days. Fortunately, I had well enough respect that I claimed to the executive vice president that I really can't do this to the family, a senior in high school and all that. I knew it was time for me to do something else. I liked what I was doing, but I didn't want to be a career CFO in a residential real estate company because I trained all my life in healthcare. Basically I did that job for maybe another year, and we had an orderly transition where we brought somebody in, and when I left, I stayed in Newport Beach, and I did a couple start-up companies. That was the sub acute care company.

Tacey Ann Rosolowski, PhD
1:03:11.4
And that was '93 to '94.

Leon Leach, MBA, PhD
1:03:13.8
Right. I did that, and we sold that to a Fortune 500 company. At the time, it was Vencor Hospitals, and that was venture backed. Then I was the chief operating officer and chief financial officer of Caremark Health Plans. I had a combined title. They had a doctor, a great guy. He's now the number two guy in Kaiser. He was the president, and he was a talented businessman himself, but I kind of ran the place from the business and the operating side. Kind of a good model for how John and I worked together—John Mendelsohn—not knowing that was in my future, of course. Once we sold the company, Caremark Health Plans, I worked for them, but then there was another venture capital firm actually in Newport Beach that I was neighbors with

a partner in the firm. Not next-door neighbors, but we lived in the same neighborhood, and they were starting a physician practice management company, which was kind of the rage back then.

Tacey Ann Rosolowski, PhD
1:04:28.1
What does that mean exactly?

Leon Leach, MBA, PhD
1:04:29.7
Well, we did it differently. There were three major players in the field. It was Vencor, FPA, and Med Partners. They were like Ford, Chrysler, and General Motors. Unfortunately, more like them than what they should have been. They were buying physician practices, and they were buying them for equity, stock in their company. They were doing great, because the concept was, we're going to bring professional management to physicians, and most physicians, they want to practice medicine. They don't want to have to worry about staffing their office and payroll and appliances and all that stuff. It was a receptive market. The company that we started didn't buy the practice. We just offered management services, and we saw a different market opportunity. The Vencors and FPAs and Med Partners, what they were doing, they were appealing to the ones who predominantly had doctors in the mid fifties, and they were looking to retire and didn't want to keep running their practice. When they sold the stock, instead of playing golf on Wednesday afternoons, it was maybe Wednesday and Thursday afternoons. They didn't do as well as they thought they were going to do financially. They had the professional systems and all that, but the practices that they were buying once they bought them, the doctors lost incentive. It was an older group of doctors that they were appealing to. We actually went with younger doctors who wanted to grow their practice and run it. We would just manage it for them, and we did it for a fee.

Tacey Ann Rosolowski, PhD
1:06:29.9
Did you also contribute certain strategic elements?

Leon Leach, MBA, PhD
1:06:34.2
We had common systems. We had things like that, but we had kind of a menu. If you want to manage soup to nuts, we can do that. It's going to cost you a little more. If you want us to just do your billing and eligibility and manage your staff, we can do that. We did custom-type work depending on who the customer was. We would only do it if it was big enough. We looked for multispecialty groups and that kind of thing. But the way it worked financially is when you buy

the practice, you get to recognize 100 percent of the revenue, even though you're spending it all out. When you sell your services, you don't buy the practice, you get to recognize whatever that piece of revenue was that they paid you. In general, we charged about ten percent of what their total revenue would be, and it could be eight. It could be twelve. It was, again, depending on exactly what they wanted you to do. But it made a big difference, because on Wall Street, they looked at the growth and income, and the ones buying practices, we had to sell ten service contracts to get the financial effect on the top line, but on the bottom line, there wasn't much difference. We were much more efficient from a financial standpoint, but Wall Street was in a lather about revenue and the growth and all that, so the others looked much more attractive.

Leon Leach, MBA, PhD
1:08:12.5
We sold our company to FPA, which was based in San Diego. We were based in Newport Beach. We knew each other obviously. We were in the same sector, but it was a different approach, and FPA was waking up to the fact that they didn't have a good doctor mix, and they weren't managing it as effectively as they could have. They saw our model, and they liked it, so we wound up selling the company to them, which turned out to be a nice deal.

Segment 4

B: The Business of MD Anderson

Bringing Fiscal Sophistication to MD Anderson

Story Codes
A: Professional Path
A: The Administrator
A: Character, Values, Beliefs, Talents
C: Evolution of Career
C: Professional Practice
C: The Professional at Work
A: Joining MD Anderson
A: Overview
A: Definitions, Explanations, Translations
B: The Business of MD Anderson
B: The MD Anderson Brand, Reputation
B: Building/Transforming the Institution
B: Growth and/or Change
D: The History of Health Care, Patient Care
D: Fiscal Realities in Healthcare

Commented [T4]: In this segment Dr. Leach explains that by the nineties, he had "turned into a serial entrepreneur" working in high-risk situations. Rethinking his career, he realized he had reached a point where he wanted to "give back" and, very near that time, Michael Myer called to tell him that MD Anderson was looking for a CFO. Dr. Leach then describes the fiscal context when he assumed the role at MD Anderson. He also talks about John Mendelsohn's vision for the institution and some of the changes made early in his role as CFO (e.g. shifting the institution from fund accounting to GAAP accounting; canceling managed care contracts as a shock tactic so HMOs would renegotiate).

Dr. Leach observes that Charles LeMaistre's downsizing strategy was the right approach for the situation. He also notes that the reports submitted by the consulting firm hired to evaluate MD Anderson's financial fate under HMOs (negatively) distorted the institution's importance to health care delivery in Texas. Dr. Leach knew that managed care was not going to be able to "squeeze" MD Anderson.

Dr. Leach goes on to assess the institutional situation when he arrived. The administrative team was in place; he developed a business modeling system to predict how the institution would need to grow. He explains the "Value Proposition," an equation that quantifies cost savings. As an example, he explains that the equation can show how much money MD Anderson saves patients by giving them a correct initial diagnosis (as opposed to having to correct a diagnosis given by a non-MD Anderson physician).

Dr. Leach discusses his economic forecasting model and talks about his goals as CFO.

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Leon Leach, MBA, PhD
1:08:12.5+
By then, I had a sailboat in Newport Beach Harbor, and I'd become a Californian. My career plan at that point was to—I had a forty-foot sailboat. I was going to sail it down to Cabo San Lucas and just hang out. We kind of cashed out of the company, and the venture capitalists were happy with us. They made money. They were going to—it was so long ago, they were going to fax me business plans, not email them or scan them to me, and when I found one I liked, I'd come back and do it. That was kind of the deal. By then, I was just staring the big fifty in the face. I was forty-nine or something. I had discussions with my wife about, I'm not sure—I was turning into a career entrepreneur, or a serial entrepreneur. I was starting and selling businesses. I had done two of them, and it was almost the opposite concern that I had when I was twenty-seven or twenty-nine, twenty-nine being pitch and hold as an IS guy. That's really a younger man's game, the churning businesses, and it's high risk. I was fortunate that we did good with a couple companies, but I was thinking that I don't know if I want to do this the rest of my life. I think I'd like to find something where I can feel more like I'm giving back. It's not that I didn't feel that way working in the healthcare sector, because I thought we were giving back, but it was more the financial play.

1:10:33.4
I got the boat as far as Ensenada. I got a call from Mike Myer, who Dr. Mendelsohn had employed to find him a CFO. Mike was a partner with (???) (inaudible) **1:10:51.0** a national recruiting firm. Mike wanted to tell me about MD Anderson. I'm in healthcare. I know who MD Anderson is. I think highly of them. I'd never been out here. Well, I'd been to the building right across the street. I knew who they were, but I'd never been in the facility here. Those outer windows are the Prudential building. I wasn't sure why they were even interested in me, because I'm thinking career entrepreneur, and even if they're looking for a CFO, there are plenty of hospital CFOs that I had negotiated against building HMOs that I could put them in touch with that know more about the inner workings of the hospital. I came out and interviewed with folks and met with John and really liked the environment. You can sense—this was before we picked caring, discovery, and integrity as our values, before we emphasized that, but you could feel the caring when you walked in the door. You could feel that. They were trying to help you, little boy lost type of thing. That was here in '97 when I got here, and it's one of our greatest assets.

Long story short, John saw exactly what you were talking about, the blend of skill sets that I brought, and it was very diverse. You don't find somebody who was on the marketing side and built systems and has the common thread of financial understanding and knows something about Medicare and knows something about Medicaid and knows something about traditional insurance, has started and put together healthcare delivery systems and HMOs and had a

physician practice management company that he was CFO of. One of the questions I got asked was, "How do you do that? How do you manage physicians?" It was very simple. These were fee-for-service doctors that have managed care contracts and all that, but the patients that they saw and billed for, that's what they collected. This is last year's summary profit and loss statement for MD Anderson. We had one of these for each doctor, and I can show them this is what you're doing, and I can show them this is what the guy down the hall is doing. If the guy down the hall is producing better returns than you are, you might want to invest in lunch and see how he's using his physician assistant or his nursing staff. It was just about giving them the data. You give them the data, they'll figure out what to do with it and do the right thing.

Tacey Ann Rosolowski, PhD
1:13:36.7
Tell me more about this introduction. How long did you spend when you came here for these conversations?

Leon Leach, MBA, PhD
1:13:44.3
Longer than I would have thought. I came out for just a day visit, and they had a whole structure, but I think I came back two or three more times, and one time they were getting serious they had a real estate agent, and I brought my wife, and they showed us around. It progressed from who is this guy and who is MD Anderson to—it's almost like matchmaking in a way. Is he a good fit for us?

Tacey Ann Rosolowski, PhD
1:14:18.5
What were you picking up on about what the situation was and what they wanted you to do?

Leon Leach, MBA, PhD
1:14:25.2
Well, that's a good question, because when you ask what about the interviews, one of the interviews I had was with a group of about ten faculty leaders at the time. One of them asked me—it was almost like the market thing. If you were the CFO, what would you do? What would you change? I said, "I would move you away from the fund accounting and move you to GAAP accounting."

Tacey Ann Rosolowski, PhD
1:14:55.0
What does that mean?

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Leon Leach, MBA, PhD
1:14:55.7
Fund accounting was at that time more or less cash accounting, and it doesn't give you a true picture of where you're really at, and it was antiquated and still is and is insisted upon by the state. It's how the government does their accounting. Fund accounting is governmental accounting. Non-profits use it, but they've changed fund accounting a lot now to make it look more like GAAP accounting.

Tacey Ann Rosolowski, PhD
1:15:26.2
And cap means—

Leon Leach, MBA, PhD
1:15:27.2
GAAP, G-A-A-P, generally accepted accounting principles. That's an acronym. What I said to them was, I'd move you away from fund accounting to the GAAP accounting, but you'd still report to the state on a fund accounting basis, but this statement I just showed you is GAAP accounting. He got this blank look on his face and said, "Why would you do that? We have enough gaps in our accounting already." (laughs) Okay. Now I know what I'm getting into.

Tacey Ann Rosolowski, PhD
1:16:12.2
So we needed to raise the level of sophistication about fiduciary matters.

Leon Leach, MBA, PhD
1:16:15.8
A little bit. Yeah, raise that bar a little bit. That was part of it, and of course, the Sharp study, and the managed care is going to eat your lunch type of thing. John told me about this all up front. I probably had a copy of the Sharp study at one point in time. Anderson had cut back at that point in time. They laid people off. My assessment of it was—and the Sharp study, that was a consulting firm out of San Diego. They basically said gloom and doom, managed care is going to eat your lunch. The whole reason—I mean, what John really saw in me is this guy has dealt with this from the other side, and that's what I want on my side, because he knows what the hell they think and what they do, and it was true.

Tacey Ann Rosolowski, PhD
1:17:10.5

And what were your conversations with John Mendelsohn about what he was envisioning for MD Anderson? What were your conversations about that?

Leon Leach, MBA, PhD
1:17:19.8
He had already started investing in MD Anderson. He was starting to put money back after they had contracted, and I think it was more visceral. He's a researcher and world class, and he wanted to grow the institution. But he wasn't sure of how do you do that in the face of these studies, and the take I had on it was Anderson—today the phrase is "too big to fail." It wasn't that Anderson was too big to fail, but it was too big of a name not to have in your managed care portfolio. One of the things that we did within the first year that I was here was we canceled a number of the managed care contracts, which scared the bejeezus out of people, but there was a method to the madness. The way you communicate, so to speak, in that world is you have so much notice if you're going to cancel the contract. You can't get the managed care companies to negotiate with you on a serious basis unless you send them a shot. That's how it was back then. It's changed now. It's much more sophisticated. That was just standard operating procedure, and it's a way of letting them know that we're going to renegotiate the contract, and we didn't do it with all of them. We did it with ones where it was pretty clear that we're losing money, and we would talk to them and say, "We want your business. We want your patients. We don't intend to be disruptive, but we can't have them and lose money. Like you, you make money in this business. We need to make money in this business." That kind of turned the financial fortunes a little bit and got us back on the right track. We've not had a year in which we've lost money at MD Anderson since 1997. We've been positive every year, and it's given us the wherewithal to invest as we have in the buildings and the facilities and the science, all of that.

Tacey Ann Rosolowski, PhD
1:19:50.7
What perspective can you bring to the strategy of the previous administration and their way of dealing with the financial crisis, if you will? I mean, that's the phrase that people use. What were the pros and cons of the downsizing mentality that was in place when John was in—

Leon Leach, MBA, PhD
1:20:15.6
In the late 70s?

Tacey Ann Rosolowski, PhD
1:20:16.6
Yeah. I'm thinking under Dr. LeMaistre.

Leon Leach, MBA, PhD
1:20:20.1
I think Dr. LeMaistre fixed the fundamental problem. The fundamental problem was people couldn't self refer, and I think that given the information that they had at the time, they probably made the right decision, even though that was a bitter pill for everyone. No one knew if people would self refer even when they were allowed to self refer. Getting the state legislature to enact legislation where we could accept patients as self refer was key. I think the consulting reports that they based their decisions on to reduce staff—I think they were done with good intent, but I think it did discount MD Anderson's importance to healthcare systems and healthcare delivery systems in Texas. I think that managed care wasn't going to be able to squeeze Anderson as hard as what they'd squeezed folks out in California, and that was the lens at the time, but that's twenty-twenty hindsight. I think with the information they had at the time it was probably the right decision.

Tacey Ann Rosolowski, PhD
1:21:54.2
Coming back to the situation that you entered into, what were—you've set the scene of some of the context. Now, what were some of the first steps that you took when you set up—because I understand you had a management team that you were part of. I'm remembering—let's see. There was a specific group that you led that was responsible for changing the handling of all financial matters here basically.

Leon Leach, MBA, PhD
1:22:32.0
You're talking back in 1997?

Tacey Ann Rosolowski, PhD
1:22:33.0
In '97 when you arrived.

Leon Leach, MBA, PhD
1:22:36.2
When I arrived, like most new people on the job, I just tried to assess what I had in more detail.

Tacey Ann Rosolowski, PhD
1:22:42.1
And how did you go about doing that?

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Leon Leach, MBA, PhD
1:22:43.4
Well, talking to people, much like John went around and took copious notes. I didn't have quite the circuit to make that John had to make. I was more on the business side, but I think we had used the title chief financial officer with two other folks at the time, and we needed to consolidate that. It was pretty clear to me we needed to move to a GAAP accounting system that got good numbers. The stories I heard—and I wasn't here for it, but the stories I heard were that more time was spent arguing over what the right number was versus what are we going to do about it, because they couldn't get agreement on what the data was showing them. We went to a GAAP system, and that standardized a lot. That gave us the database that we needed to make good business decisions, and we did all that in the first year. It wasn't really—there was a team involved, but they were here. The players that were here—I did recruit Ben Melson. Ben brought Dwain Morris with him, and Dwain was the vice president of financial services at Hendrick Healthcare System in Abilene where we recruited them from. Ben came out here—he was the CFO there. He came out here to be the vice president of financial services. It was a lesser title but a much bigger playing field. I brought Ben in as my right-hand person with Dwain and a guy by the name of Weldon Gage. They were kind of the core team.

1:24:35.0
Dan was here before I was. He was a lawyer, but there has always been a strong chemistry there as far as—in today's world the business and legal decision are so intertwined. We worked closely together to make those decisions for years. But most of the fundamental stuff we did in a year's time. I mean, we got to the point where the numbers were right, and there was agreement on the numbers. Then where you have the discussion is forecasting forward, which there was no real tool to do that before I got here, and what we did within the first year—it might have taken a little longer than that. It might have been the first couple of years. We developed a financial model. It was more than a financial model. We developed a business model of how MD Anderson worked, and it started out as a spreadsheet. It became a gigantic spreadsheet. We've now gotten more sophisticated, and it predicts things like square footage needed, staff size. It's more granular today. But it was relatively easy over most of those—it's been fifteen years. Until the last few years the model has been amazingly accurate and the system relatively easy because there were periods of pretty much constant growth. There were some ups and downs, and the model would show you where that was happening, because we'd use it both to model out, but we'd take the prospective look during the budget. But the world is a lot less predictable today as far as healthcare. There is more uncertainty, how is the Care Act going to affect us and all that. Those questions—they still aren't answered definitively, and they may change tomorrow or on Tuesday with the election.

But the model that we built is flexible enough to accommodate those changes. It's just the linear projections that come out of that you want to be very careful about, because the curves are changing in different ways. It takes more insight now into what does that mean strategically? It kind of gets back to the dissertation. Where do we need to be positioning ourselves strategically? Anderson is, I think, very well positioned today with Ron's vision and with the financial strength we've built up, but it's a very fragile world, so we can't take anything for granted. The one thing that we do know about the future is nobody is talking about paying us more. We are going to have to think about that. How can we be more efficient? Tom Burke has done a lot of work on the value proposition working with Michael Porter, and I think that's going to be very important, because that's what people are going to be looking for, the value.

Tacey Ann Rosolowski, PhD
1:28:03.8
Tell me more about that value proposition.

Leon Leach, MBA, PhD
1:28:07.3
Well, the best person to talk to there is Tom, because he's worked very closely with Porter on this, but it's basically an equation that says you get your money's worth. You get the right outcomes. Not necessarily the cheapest, but the most cost-effective. We change—it's surprising to me how many diagnoses we change when people come in here. If you start thinking about how would that model out on a macroeconomic basis, how much money are we saving people? There are patient safety issues. There are personal comfort and discomfort issues. But if you can come here, and we get it right the first time versus having a diagnosis that needs to be changed, there is huge value in that. That's part of our value proposition. It's that concept, doing it right the first time, patient safety, the quality of our care. It may not be the cheapest, but if you're misdiagnosed, that's going to be a lot more expensive in many ways.

Tacey Ann Rosolowski, PhD
1:29:33.9
Tell me more about the process that you went through in those first years when you were here, and I know I'm kind of going back, but it was such a complex time, a lot going on, because John Mendelsohn not only needed you to find ways to make the institution much more efficient and sophisticated financially but also to grow with these unprecedented rates. It's really this amazing balancing act. I'm interested in some key points or some key things that involved both of those.

Leon Leach, MBA, PhD

1:30:07.2
A couple of key points is one—the economic forecasting model helped us very much with that. We had a long-term capital plan that we would refresh. I tried to do it annually, but sometimes we'd do it as frequently as quarterly.

Tacey Ann Rosolowski, PhD
1:30:27.8
Why was that?

Leon Leach, MBA, PhD
1:30:29.7
Because demands were changing. Markets were changing. We had a different idea about what we wanted to do. Some things were becoming more important, and some things were becoming less important. We do refresh the economic forecasting model quarterly. Oftentimes we don't do a whole lot with that, because everything is okay. But if you have bumps in the road, then you need to move faster. Part of—to be brutally honest with you, part of what helped me was my apathy. I had never worked in an academic medical center and didn't really understand the politics and wasn't terribly interested in the politics. I'd become educated through the school of hard knocks, but I made decisions that were probably somewhat incredulous in this setting, because I kind of viewed it as I'm going to be held accountable for the financial performance, and therefore, we have to have good reports so I understand the numbers and so I can brief the president to make the right decisions. There wasn't a whole lot of discussion about what are the reports going to look like?

Tacey Ann Rosolowski, PhD
1:31:41.0
What were some of the decisions that you made that people would find—or that you made out of naïveté?

Leon Leach, MBA, PhD
1:31:46.4
Well I think a lot of the—moving away from fund accounting and people thinking of their fund as their money. It's not. It belongs to the state. It belongs to the taxpayers, and we have a fiduciary responsibility to manage it. It was a different way of looking at it and acting on the different way and doing it relatively quickly. I know there are times that we made decisions that I feel needed to be made that you don't have time to talk to everybody and build a consensus. And that didn't so much occur in the early days. I mean, in the early days I think the amount of—if there were people nervous about what I was doing—and there were some—the amount of clarity

that came out of it and transparency—I mean, today there are probably 1,000 people that go in and look at our financials, and anybody can on the Internet here at MD Anderson. It's very transparent. But I think the rate of change was just alarming to some people because academic medical centers usually don't change that quickly, and that wasn't on my mind. On my mind was—and it wasn't a desperate, "Oh, they're going to wonder." When you started looking at it from a GAAP accounting basis, there was more money there than people realized, because they were taking a look at a particular frame instead of looking at the whole movie. But I think it was the rapidity at which we moved, and to me, that was the pace I was used to.

Segment 5

A: The Administrator

Communicating about Finances in an Academic Setting

Commented [T5]: In this segment Dr. Leach explains that he had to make some adjustments to work in an academic setting after years in the corporate world. He faced challenges communicating difficult financial and accounting information to MD Anderson faculty and did presentations on "weathering the storm." He talks about coming to respect the academic side of medicine and the need of faculty to understand the measures he was instituting.

Story Codes
A: The Administrator
C: Professional Practice
C: The Professional at Work
A: Overview
C: Understanding the Institution
D: On the Nature of Institutions

Tacey Ann Rosolowski, PhD
1:33:46.4
And that is the difference between the business world and an academic setting. Tell me about your learning curve.

Leon Leach, MBA, PhD
1:33:55.4
My what?

Tacey Ann Rosolowski, PhD
1:33:56.4
Your learning curve with the academic setting. Did you find that your way of doing things differed? How did that work for you?

Leon Leach, MBA, PhD
1:34:03.7

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Well, I'm still on it. I'm still on the learning curve. Communication has become so much more important to me, being able to communicate difficult financial concepts. I usually don't anymore slip into GAAP accounting, something that people may not be familiar with. But I've done a series of presentations about weathering the storm, so that's a way of using an analogy that people in Houston can relate to as to what we have to do. It's really about what they used to call the KISS method, keep it simple stupid. What was the phrase? It's the economy. It's trying to get to the heart of the matter, and with the academic world, you've got to respect the academic part of it. There is a thirst to understand why we're doing something that we're doing, and there are several balancing points. One of the critical balancing points in the early years was, how much do we spend? How much do we invest in research, and how much do we invest in clinical studies? One begets the other, and in the short term, the clinical side funds the research. In the long term, the research is critically important, because that's what keeps you on the leading edge. If you neglect either, there are problems. I think that was one of the things that John and I did pretty well together was balancing the need to grow the two entities, and I actually did some studies—it's been a while ago—that showed that they did pretty much grow in tandem. There were times when one got a little ahead of the other and vice versa. You could feel some vibration in the machinery when that happened, but it is a bit of a balancing act.

Segment 6

A: View on Career and Accomplishments

A Role in a Global Institution

Commented [T6]: In this segment, Dr. Leach explains that his work at MD Anderson has been meaningful because the institution has an impact on people globally. He mentions the Dr. Ronald DePinho's Moon Shots Program will take the institution's mission "to a new level." He then lists the opportunities that the institution has afforded him.

Story Codes
C: This is MD Anderson
B: Institutional Mission and Values
B: The MD Anderson Brand, Reputation
A: Career and Accomplishments
A: Character, Values, Beliefs, Talents

Tacey Ann Rosolowski, PhD
1:36:25.5
I want to pick up a question that I neglected to ask you earlier which was, after all the conversations that you had with people when you first came here to interview, why did you decide to take the position? What did you feel MD Anderson offered you?

Leon Leach, MBA, PhD
1:36:46.7

It gets back to staring at fifty and giving back. It gave me—I mean, MD Anderson affects people globally, what we do here, the science and translational research, and I guess in the early years I felt that financial thing. In the later years, it's been more of the return on that investment, if you will, the giving back. But it was probably really that. I felt great things, and I still believe this. I believe this. I think there is a whole other level that we can take MD Anderson to with the Moon Shots, but it's a neat thing to be part of. Starting a company and building it up and selling it, that's neat too, but I did that a couple times. What's surprising about Anderson is when you look through my resume, you'll see two or three years, two or three years, two or three years, even though in the greater context Prudential was twenty-five years, but it was about a dozen two- to three-year jobs. Here it's not so much. I've always ultimately had the responsibility for the financial performance, and except for three years—the first three years—I had all the business infrastructure, if you will. But it's very fulfilling. The other dreams I have to chase don't really have to do with business accomplishments. They have to do with a boat or a ranch, other things. That was probably one of my best decisions, if not the best. Well, I'll have to be careful saying that around my wife. (laughs) The second-best decision.

Tacey Ann Rosolowski, PhD
1:38:50.2
I'm curious too, taking on a position like the one here at MD Anderson. It was using your skills at such a different scale. The putting together of pieces seemed as though it was taking place at a different scale, maybe in a more complicated context, and with much higher stakes in terms of developing an institution that was going to make the kind of impact on patient care that MD Anderson had already and could do if given the right jolts of money to research and patient care and prevention and education. It seems like a very exciting opportunity, and I'm also wondering in terms of your personal vision when you came here. You were in conversation with the faculty and with John Mendelsohn about what he saw, but what did you want to accomplish here? Did you have goals for the institution?

Leon Leach, MBA, PhD
1:39:55.0
The first part of that question, the answer is yes. It's a huge scale. I had national level jobs before with Prudential, but this is huge, impactful. It was probably high risk. There was a company that I worked with out in California that people were taking bets on how many months it would be until I came back, because they didn't see me fitting in to academic medical centers. I had a friend of mine who was on the board of—I forget which company it was now. Cornerstone, the physician practice management company. He ran Hopkins. He took me to lunch and kind of forewarned me about all the politics and everything. It's a different world. But I didn't really focus on that. I think things happen for a reason and that there is a master plan for your life, if

you will, and if you choose to dwell on the negative, those prophecies probably become self-fulfilling. It's rare that I have all the answers on any given day when I come in here. Events occur, and okay, so what do we do now? The other thing is I enjoy working in healthcare, and I enjoy the aspect of giving back, and I enjoy the fact that I'm not a surgeon. I don't have somebody's life in my hands. If something doesn't work out just so, we can probably fix it and get it there. There is a reason why I'm a PhD and not an MD. I don't want that kind of responsibility. We have great faculty, world-class people, and I don't have the temperament for what they do. I have total respect for what they do. It's admirable, but that's not what God gave me. I understand numbers, and I understand the business and how you position a business, the generalist thing.

Tacey Ann Rosolowski, PhD
1:42:32.6
It's creating the framework in which other highly skilled people can do what they do.

Leon Leach, MBA, PhD
1:42:37.7
That a good way of putting it is creating the framework, and that's a lot of what I looked at on the dissertation is, how do you create that framework? I think there is a multi-faceted response there. So many things go into creating that, and I guess during my career, I had a lot of good things happen that positioned me for that. But I can't say—what I talk about in the paper, I talk about strategic repositioning, and I'd be lying to you if I sat here and said, "Oh, yeah. When I came out of high school I was—" I mean, in fact, if somebody was to tell me, "When you're sixty-four, you're going to be the chief business officer at the world's greatest cancer center, and you're going to have a Longhorn ranch in central Texas," I'd say, "No, no, no. You've got the wrong Leon Leach. This is the little boy who grew up on the Delaware Bay." If you'd told me how to build it, I might have believed you there, but other than that—

Tacey Ann Rosolowski, PhD
1:43:42.3
I don't think people do set out—most people I don't think have that prize they've got their eye on. Often it kind of evolves.

Leon Leach, MBA, PhD
1:43:51.5
I think some of our doctors, actually, they've always wanted to be doctors. Oftentimes I think they come from a family of doctors. I always loved boating and wanted to have a boat. I didn't really want to make a living off of that.

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Tacey Ann Rosolowski, PhD
1:44:13.8
I saw that. That was a hard life.

Leon Leach, MBA, PhD
1:44:15.2
That was a pretty tough life. It would be nice to have one just to play on.

Tacey Ann Rosolowski, PhD
1:44:21.6
Well, shall we stop for today and then revisit some more specifics next time?

Leon Leach, MBA, PhD
1:44:28.5
I'm good. I'll see you next week some time.

Tacey Ann Rosolowski, PhD
1:44:35.8
I think it's Thursday, actually.

Leon Leach, MBA, PhD
1:44:39.5
Oh, that's right because we had to—

Tacey Ann Rosolowski, PhD
1:44:40.4
Yeah, we had to reschedule. I'm turning off the recorder at 29 minutes after 3:00.

1:44:46.8 (End of Audio Session 1)

Leon Leach, PhD
Session 2—November 27, 2012

Segment 00B
Interview Identifier

Tacey Ann Rosolowski, PhD
00:00:05
This is Tacey A. Rosolowski, and today is November 27, 2012. The time is about 3:06, and I am in Pickens Tower on the twentieth floor in the Office of Business Affairs interviewing Dr. Leon Leach for our second interview session. So thank you for agreeing to talk to me again.

Leon Leach, MBA, PhD
00:00:24
Thank you.

THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
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Interview Session: 02
Interview Date: November 27, 2012

Segment 7

B: The Business of MD Anderson

Strategic Decisions and Increasing Patient Numbers

Story Codes
B: MD Anderson History
B: The Business of MD Anderson
C: The Institution and Finances
D: Fiscal Realities in Healthcare
B: Institutional Processes
A: Overview
A: Definitions, Explanations, Translations

Tacey Ann Rosolowski, PhD
00:00:25
We were just starting to talk about some decision-making that happened in—I think you said 2007?

Leon Leach, MBA, PhD
00:00:33
2008 or 2009.

Tacey Ann Rosolowski, PhD
00:00:34
Okay, you were going to take me through a decision.

Leon Leach, MBA, PhD
00:00:36
Yep, your broader question before we got into this was, how are decisions made, and you asked me to kind of point to an example.

Tacey Ann Rosolowski, PhD
00:00:49
Uh-hunh (affirmative).

Leon Leach, MBA, PhD
00:00:49

Commented [T7]: Dr. Leach begins this segment by observing that strategic decisions evolve over a process. He demonstrates his point with examples from 2008-2009, when the administration addressed disturbing reports that MD Anderson was less productive than it should have been. He describes the metrics used to assess productivity and underscores the importance of bringing relevant information to the groups in a position to change matters.

He notes that a key indicator of the institution's success is the number of new patients seen: this number was slipping in 2008, and this fact was pointed out to the faculty leadership, initiating an eighteen-month difficult process of change that resulted in a broadening of "faculty templates" (the types of patients each faculty member sees). Dr. Leach comments on how academic and corporate contexts respond differently when changes are instituted and notes that MD Anderson no longer has the luxury of such long lag times given an economic climate that demands more responsiveness.

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Well the big strategic decisions are much more of a process than a given point.

Tacey Ann Rosolowski, PhD
00:00:59
Uh-hunh (affirmative).

Leon Leach, MBA, PhD
00:01:00
And if you were to trace the history of the changes we made in 2008 and 2009, why they occurred, and the various decision points, it would start with some concerning financial reports that surfaced—gosh, probably early in fiscal year 2008 probably around the turn of the calendar year—where it appeared that we were getting a little less productive on an FTE equivalent, and we brought that data to the attention of various groups that could effectuate change in that.

Tacey Ann Rosolowski, PhD
00:02:01
And what was the source of that report, by the way?

Leon Leach, MBA, PhD
00:02:03
Those were our financial reports—our monthly financial reports.

Tacey Ann Rosolowski, PhD
00:02:05
Okay.

Leon Leach, MBA, PhD
00:02:07
And we share them with anybody who's interested. It's very transparent—the numbers are out there. The numbers are the numbers. And we, you know—there's so many numbers that sometimes you have to add the analysis to it to give color to what the numbers are trying to tell you. We do try to interpret that. We do try to give the analysis. There's a monthly report that goes out from the CFO. When we become concerned about the trend line with certain indicators and certain metrics that we know our performance is driven by—like the number of initial visits, number of new patients seen, number of consulting services—if we see that going in the wrong direction, we don't rely just on the people reading the financial reports because frankly a lot of people—well, it's not what they're all about. They would rather read the *New England Journal of Medicine* in the evenings than our monthly financial report. So we will make a concerted effort to make sure the groups that can change these things are aware of what's happening. And

we do that usually through standing meetings that are already scheduled on a monthly basis, but our presentation will be more focused on what we see as being a particular challenge.

Tacey Ann Rosolowski, PhD
00:03:38
Can I interrupt you just for a second to ask you for a list of those metrics that you pay really close attention to—you said that there was a list of several that—

Leon Leach, MBA, PhD
00:03:49
Well, the ones that we pay the most attention to I just mentioned. They are initial visits and consultations. They drive so much of our business that if they get—there's a whole bunch of metrics that are available that we look at. It's kind of like running a blood test—you know, it has so many different components—an SMA-12 or an SMA-16. And if you're looking for a disease, it may only be the white blood cell count or one component of those sixteen that you really focus on. Well, these are the couple of components that we really focus on of the major drivers. There's almost an inverse correlation between how well we do financially and how many new patients we see. I shouldn't say inverse—it's direct correlation. We do much better financially when we see more new patients. So in 2008, that was slipping off, and we started pointing that out to faculty leadership. But there are so many other indicators, and there are so many other areas when you're in an organization as complex and complicated as MD Anderson that the numbers can be confusing. And there are other things you could look at and say, "Well isn't this a problem" or "Isn't that a problem." Well, they may be, but they're not going to have the effect on your bottom line that the major drivers can, like number of new patients seen. If we order too many paperclips, that's an expense that perhaps we didn't have to incur, but it's not going to be of the same magnitude as not seeing enough new patients. So we went through probably an eighteen-month period before we actually got traction with that—that action had to be taken there, because it was not a pleasant action. What we did to fix that was we broadened faculty templates so they would see more patients—

Tacey Ann Rosolowski, PhD
00:06:25
What does that mean, "broadened faculty templates?"

Leon Leach, MBA, PhD
00:06:26
Well the templates are—you know, "I see this kind of patient." The analogy I use when we're talking about this to non-faculty folks is, we have people that are so specialized they only see left-handed Australians. You know—well, we think that maybe you could see some right-handed

Australians and maybe even some people from New Zealand. So it takes you maybe a little bit out of what your real specialty is and what you really like to do, but you're equipped to do this—you can see somebody that's right-handed from Australia. So we changed the templates so that they did have a broader approach due to patients that would qualify for their care.

Tacey Ann Rosolowski, PhD
00:07:12
And how is that done? Who made the decision on how the template would be expanded for each—?

Leon Leach, MBA, PhD
00:07:18
Well, ultimately the department chairs have to work with their individual doctors to get this done. It's not something that you just throw a switch and it happens. Another lever that was used at the time was faculty travel. It wasn't that the faculty wasn't working hard. They were working hard, but they might be away making speeches about their science, which is—that's a legitimate part of what we do—we're here to educate. But if you're doing that forty percent of the time instead of maybe twenty percent of the time, that becomes more problematic because the financial support really comes from the operations of the hospital and clinics, so we have doctors there to see the patients. So those types of macro-level changes were made—

Tacey Ann Rosolowski, PhD
00:08:12
So you put a cap on faculty travel? Is that what happened?

Leon Leach, MBA, PhD
00:08:15
Yes, we basically put limitations on faculty travel. That was very unpopular as you can imagine, but it solved the financial problem. And there were other things that we did, but they were the two main ones that addressed seeing more patients. That decision wasn't made in one meeting where we said, "Okay, this is what we're going to do." That decision was a process of getting the folks that had to do it to do it, and it took eighteen months. Once the faculty understood the necessity and accepted the necessity intellectually to make these changes and be stronger financially, it got done in about six months' time. It was relatively quick, but it was eighteen months of moral suasion to fix a problem that was fixable in six months' time—that's what our faculty fix was in. You wouldn't see that kind of thing in corporate America. Corporate America has much more command and control. When the problem was identified, it would have been fixed shortly thereafter by throwing a switch, whereas academic medical institutions take a lot more time to massage the—to get to the right answer. That was a luxury that we no longer have.

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With the managed care organizations and the changes that are coming about, stricter payment controls, and folks wanting to pay less not more, we're not going to have the luxury of debating decisions like that over an eighteen-month period when they can be fixed in six.

Tacey Ann Rosolowski, PhD
00:10:25
What do you see coming in that situation?

Leon Leach, MBA, PhD
00:10:30
I see the time period for discussion—and I think there has to be a time period for discussion—being greatly shortened and starting to mimic what would happen in a business situation when you are faced with these kinds of challenges. Because the world is not going to wait for academic medical centers to change. CMS, the folks that run Medicare, are going to make the changes on their time schedule and not what's convenient for academic medical centers.

Tacey Ann Rosolowski, PhD
00:11:06
For the record, CMS is?

Leon Leach, MBA, PhD
00:11:08
Center for Medicare Services, I think. That's the entity that governs Medicare at the federal level. And you're going to have managed care companies that are going to get a lot more heavy-handed in negotiating because they're under pressure, too. So we've got to be much more responsive to our environment and the factors around us than what we have been. There are always two ways to fix a financial problem. One is to increase the revenue, and the other is to reduce the expenses. We have a particularly difficult time reducing expenses. The easier answer for us seems to be increasing revenue, but you can only do that so much and so far. It's got to be—you've got to use both sides of the sword.

Segment 8

B: The Business of MD Anderson

An Evolving Economic Context: New Challenges for Faculty and Administration

Story Codes

Commented [T8]:
Dr. Leach states that MD Anderson is defined by its commitment to translational research, and in 2012 one half of funds for research come from operations, with over 250 million spent on research per year. He then talks about factors that shape the institution's balance between investments in patient care versus those in research. He notes that in the current economic climate, faculty may be required to find a different balance and spend more time in the clinic.

Dr. Leach then explains why the "triple threat" model of a faculty member (one equally devoted to research, patient care, and education) may no longer exist. The institution, he says, may have to depend more and more on specialists, as the economic context is evolving and the institution must respond to be successful. This will demand different faculty roles.

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A: The Administrator
B: Institutional Mission and Values
C: This is MD Anderson
C: Healing, Hope, and the Promise of Research
C: Understanding the Institution
A: Overview
A: Definitions, Explanations, Translations
D: Fiscal Realities in Healthcare
B: Growth and/or Change
C: Research, Care, and Education
D: On Research and Researchers

Tacey Ann Rosolowski, PhD
00:12:03
Yeah, what I'm thinking—of course, what's in the back of my mind, and I'm sure what's one of the many things in your mind too, is the issue of research. The faculty part of what they do or the reason they want to travel is not just education, but obviously they're making connections, they're finding collaborators, and they're contributing to their national profile, which is helping the research piece and which is helping MD Anderson be what MD Anderson is. So what are the discussions like when you're balancing that, because that certainly is not going to go away?

Leon Leach, MBA, PhD
00:12:38
Yeah, and you certainly—MD Anderson is who we are today because of our research and because of our ability to translate that research and get it into care. Because ultimately the research serves no end if it doesn't result in patient care—better patient care. So you do have a balance. The money that we spend on research—this year for the first time ever, half of it will come from MD Anderson, and that means from the operations of the hospital and clinic. So one feeds the other. If you cut down too much on research, you're compromising your future because that's how we stay leading edge—stay at the leading edge—and bring our science to bedside and be who we are and have the clinical trials that we do. If you over invest in research without the financial support from the hospital and clinic, you're not going to be able to do that because you're not going to ultimately have the money to pay for it. You may be able to start it, but you won't be able to finish it. You'll have to come back at some point if you don't have the funds to fuel it. So you've got to grow them both in a balanced fashion.

What determines that balance is going to be somewhat the external environment, because if the external environment is saying, "I'm not going to pay you any more money" in terms of the per-unit basis for care and you're costs are going up, even if it's just at the rate of inflation which has

not been the history with healthcare—it's been double the rate of inflation with healthcare—so if your costs keep going up at double the rate of inflation and your revenue doesn't, then you've got a problem. That means that bolus of money—that 250 million dollars a year that we spend on our own research from our own resources—250 million plus—that could dry up. So you have to take a balanced approach. A balanced approach in today's environment may mean having to spend a little bit more time in the clinic, or it may mean going to more specialty type of providers.

Folks that gravitate to education and research—they've used the term triple threat, a term from sports—but they could do research, they could educate, and they could treat patients in the clinic, and they would divide their time between such. Well, I was at a forum put on by the Health Science Center right across the street two years back when Larry Kaiser was president there and John Mendelsohn was still president here, and there were a couple of other players, and they had a debate at the forum about, does triple threat still exist? Has science gotten so sophisticated, has education become so specialized, and has the clinical side become so specialized that it is impossible to be a master of all three of them, to be the triple threat? Is a more realistic model somebody spending most of their time in the clinic and someone else spending most of their time doing inside research and the translation of that in between? Which is what we tend to do—we tend to have people who are eighty percent clinicians and twenty percent research and people who are eighty percent research and twenty percent clinicians, and they have educational responsibilities woven in there too. But more and more, the emphasis is going to be on being one or the other. I think we are still strategically advantaged because we have folks that are triple threats, but our triple threats aren't anymore one-third, one-third, one-third. They're more skewed towards one end or the other. And maybe we need more on the clinician side to support the critical few on the research side—that are really good with the research. So we've got to be able to be nimble and evolve with a changing environment.

Tacey Ann Rosolowski, PhD
00:17:24
I'm putting this conversation in the context of others that I've had with other interview subjects about that kind of rare and important creature, the physician scientist, who has been really, really important to MD Anderson. I'm curious how you see that kind of individual fitting into this scenario that you just described where there's got to be a choice made between one or the other.

Leon Leach, MBA, PhD
00:17:57
Yeah, well I'm not saying it's absolute. I'm not saying you can either be left-handed or right-handed. But what I am saying is more and more, you're going to be more research or you're going to be more clinical, because it is getting so difficult to be credibly the triple threat, to have

that kind of credibility in those different dimensions. And why isn't it the quadruple threat? Why don't we have tremendous business people who are scientists, clinicians, and educators also? Because without the financial side and without the business acumen, it's what a Catholic nun once said, "no margin, no mission," if you can't produce a margin out of it. So why don't we have the quadruple threat? The reason is very simple working around people like that—it's a bridge too far. It's a range too far. We do have some physicians and faculty members that are talented business folks in their own right, and they probably could be quadruple threats if there were thirty-six hours in a day. It depends on how granular you want to get on any one of these as far as— To really—I believe—to really be the true great scientist, you've got to be pretty granular. To really be truly a great business person, you've got to be pretty granular. Well, you can't be pretty granular in all four of those—education, research, clinic, and the business side. So you're going to have to depend more and more on specialists, and we do that on the business side. Anderson looks to us as specialists in that area. Yet we tend not to deal with the other critical functions that you need for an academic medical center.

So why would the business side be different? There's a valid reason for it. It's you can't be that Renaissance man in all those topics at the granularity that is needed for that. As a society, we have chosen to specialize. We have school teachers. We have businessmen. Academic medical centers bring those together. You can bring those talents together without having them all embodied in one person. And then it would be very difficult to bring them together if you had them all embodied in one person. So this is a challenge that academic medicine is going to have to face because there is an evolution in our external world. And for us to not be cognizant of that and not address that, then we would be the equivalent of the dinosaur.

Segment 9

B: MDACC Expansion and Retrenchment

The Economic Forecasting Model: A Tool for Growth

Story Codes
A: The Administrator
A: Contributions
A: Overview
B: Institutional Processes
C: Professional Practice
C: The Professional at Work
D: Fiscal Realities in Healthcare
C: Discovery, Creativity and Innovation

Commented [T9]: Dr. Leach begins this segment with comments on how MD Anderson grew under the leadership of Dr. John Mendelsohn and how they worked to balance resources in order to develop research.

Dr. Leach then discusses the Economic Forecasting Model he began to use on arriving at MD Anderson to predict the pressures that specific growth initiatives would place on operating margins. He describes the variables, limits, and uses of the model. In the former economic context, predictions were valid for six years. Now it is more uncertain.

Dr. Leach explains that the forecasting model was his brainchild, developed while he was in the insurance industry, and refined to suit MD Anderson and bring intellectual rigor to the budget for the first time. It is a key strategic planning tool.

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C: Discovery and Success

Tacey Ann Rosolowski, PhD
00:21:37
So I understand what you see coming and the nimbleness that has to—the kind of nimble quality that MD Anderson has to acquire and perpetuate to address that. What about the situation when you first arrived—various key points during the amazing growth that took place during John Mendelsohn's presidency? What were some of those processes like in this academic medicine context?

Leon Leach, MBA, PhD
00:22:14
Well, they weren't terribly different than what I just described. While we did make a lot of progress, it was because we were able to balance those things. We didn't go—we spent a lot of money on research, but we spent a lot of money on growing the clinics and hospitals very profitably that could seed the growth in the research. If one of those wheels get out of balance or had gotten out of balance, we wouldn't have had the growth that we did. And feeding the research comes back in dividends that let you further feed the hospital and clinic side. We're the ones who develop the next new treatment or can get it to the bedside. It's not always our science, but we get it to the bedside. That was one of the— I think part of the magic that made it work with Dr. Mendelsohn was we were able to keep those competing resources somewhat in balance.

Tacey Ann Rosolowski, PhD
00:23:16
And how did that happen? How were you able to do that?

Leon Leach, MBA, PhD
00:23:20
Arm wrestling. No, John understood the business needs. But John's first love was research, and the business function was a means to an end, to feed research. John understood that, but John also understood that we had to keep the financial side healthy in order to feed research. We would have intimate discussions about, how fast can we grow or how much money can we spend on this. We have a planning process that would tee those discussions up.

Tacey Ann Rosolowski, PhD
00:24:05
So tell me about that.

Leon Leach, MBA, PhD

00:24:07
We have an economic forecasting model that is a model of how MD Anderson works.

Tacey Ann Rosolowski, PhD
00:24:16
Is this the Enterprise Forecasting Model?

Leon Leach, MBA, PhD
00:24:173
Yeah.

Tacey Ann Rosolowski, PhD
00:24:18
Okay, yeah.

Leon Leach, MBA, PhD
00:24:18
Well, it's actually called the Economic—I think the patented name—and this was patented—The Economic Forecasting Model. But what that does—there's about 200—as I recall—200 variables, and there are probably about somewhere in the teens of what I would call—what we call primary variables—they're the ones that you change them a little bit, and they move model a lot.

Tacey Ann Rosolowski, PhD
00:24:46
What are some of those variables?

Leon Leach, MBA, PhD
00:24:48
Excuse me.

Tacey Ann Rosolowski, PhD
00:24:48
What are some of those key variables?

Leon Leach, MBA, PhD
00:24:50
Well, the two key ones I just gave you—the new patients seen—

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Tacey Ann Rosolowski, PhD
00:24:54
New patients, okay—

Leon Leach, MBA, PhD
00:24:55
—and consultations, and there are a bunch of other variables. One would be the deductions from revenue—how much you can actually—the difference between what you charge and what you actually get. And they're all documented. We can pull that out for you and give you a list of them. And then there's a bunch of secondary variables where it's more or less a one-to-one type of relationship. Then there's a whole slew of tertiary variables where you change them a fair amount and not move the model that much, but still they're important. So we have a model that we could say, "Now if we spend this for a new research building and hire the staff we need and all of that, what kind of pressure does that put on our operating margin? How many patients would we have to see to support that type of thing?"

So each year we would go through a planning process for the next year that would—actually for the next six years. The Economic Forecasting Model looks out over six years. And it's more than just financial. It will give you a balance sheet, an income statement, and cash flow statements. But also it'll give you, through ratios, the faculty needed to handle that kind of volume and space needed to handle that kind of volume. So we used it—and we ran it out past six years for purposes of new buildings—what's going to be the facility needed? But frankly, the credibility of the model is pretty crystal-ballish if you get it out much past six years. And even at six years, you can pretty much bet money on the first year and second year, but after that you start—and that's why we would refresh it each year because things would become clearer as to what's going to happen. We still use that. The model has gotten increasingly more sophisticated year after year.

We still use it, but it's probably a little less reliable now. It's not that the model is any less reliable, but the model looks a lot at trend lines and says, "This is what it was, and this is what we would like it to be." The purpose of the executive committee was to have a subjective interference in that where we would say, "No, what's happening out there in the world is going to look more like this." Today we're becoming more reliant on that subjective interference because the world is so tumultuous, and the subjective element is just that, subjective—what is most likely to happen? Do we really think we're going to fall off a financial cliff in January? Because if we do, it's going to look like one way and if we don't, it's going to look like something else. So because of the uncertainty in the world—or in the United States in particular—on a number of fronts, the model just can't be as accurate. It's still, I think, very

useful. It gives us a kind of ranges, if you will, but with less certainty. So that makes it—living in an uncertain world makes the experience factor that much more valuable.

Tacey Ann Rosolowski, PhD
00:28:29
When did you begin using this forecasting model?

Leon Leach, MBA, PhD
00:28:32
The year after I got here.

Tacey Ann Rosolowski, PhD
00:28:33
Oh, okay. Who was it that selected this model? Did you go out and search for some kind of forecasting model that was around?

Leon Leach, MBA, PhD
00:28:43
No, it was homegrown. It was an Excel spreadsheet. It was based on—you know—I talked about the primary, secondary, and tertiary. It was made up of primarily the primaries. We're just getting it into the secondary drivers. It took us a number of years to get it to the point where it is today. I mean, we've moved it off—I think we were on an Excel spreadsheet for probably five years or so, and we moved it off of that to a more sophisticated software base. What we use today compared to what we did in the first few years is night and day. It was the first time MD Anderson really had any kind of organized intellectual rigor around a budget. It was the first time we actually ever looked at a model that predicted out into the future. They always did budgets, but it was a different type of mindset. It was more how to break even. And we were more future oriented. How's this going to look over the next five years or six years?

Tacey Ann Rosolowski, PhD
00:30:08
Now did you have a big hand in developing this forecasting model? Is it your child?

Leon Leach, MBA, PhD
00:30:15
It was my baby.

Tacey Ann Rosolowski, PhD
00:30:16

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How neat, yeah. And was that something that you brought with you? Had you innovated that elsewhere?

Leon Leach, MBA, PhD
00:30:24
It's something that—yes. I didn't bring one with me that was the size and scope of MD Anderson's, but I had used that type of tool as a CFO in other places. But they were custom made. It was designed around that business to model that business, but the principles are the same. What you're modeling— What we started modeling was just the financials—balance sheet, income statement, cash flow statement. They all look similar for Joe's Body Shop and MD Anderson as far as money in and money out, so it was capturing that. But the level of sophistication and degree of sophistication was appreciably different at an academic medical center and more comprehensive cancer center like MD Anderson because it was just so complex.

Tacey Ann Rosolowski, PhD
00:31:16
So it was really a strategic planning tool, a really important strategic planning tool.

Leon Leach, MBA, PhD
00:31:20
Uh-huh (affirmative).

Segment 10
B: Building the Institution
Growth Initiatives: Capital Campaigns, Global Oncology
Story Codes
A: The Administrator
A: Contributions
A: Overview
B: Institutional Processes
C: Professional Practice
C: The Professional at Work
D: Fiscal Realities in Healthcare
B: Philanthropy, Fundraising, Donations, Volunteers
B: Beyond the Institution
B: Institutional Mission and Values
B: MD Anderson Culture

Commented [T10]: Dr. Leach begins this segment by explaining that funds from the Capital Campaigns are all factored into the Economic Forecasting Model. He briefly mentions his role in keeping the Board of Visitors aware of what his office is doing to develop the institution. He then moves to the Global Oncology initiative, which was started because of data that indicated that the institution was paid more for patients who came from out of state. He then talks about the international sister institutions and MD Anderson Banner. He explains that the goal is not necessarily to bring these institutions to the level of care offered at MD Anderson, but to raise the level of care as high as it can go. In addition, quality of care at these other institutions is the primary considering; spreading the MD Anderson brand and increasing name recognition is a secondary consideration.

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Tacey Ann Rosolowski, PhD
00:31:27
Can you tell me about—because obviously when you came in, there was a huge capital campaign that was in progress, and then there were a number of capital campaigns that were initiated under John Mendelsohn. And I'm curious about how the Office of Business Affairs and you were involved with all of that. I know that you go and speak with the Board of Visitors every year, probably more than once a year, and bring them information. So could you tell me about your role with capital campaigns and with the Board of Visitors?

Leon Leach, MBA, PhD
00:32:02
Yeah, well John as the president made the final decisions, but what we would do would be economic modeling, and the forecasting model was factoring that in. If we raised "x" million—First of all, the way the accounting works with gifts is when development says, "Oh, we raised 200 million last year." Well, they might not have gotten 200 million in cash—what they got was the commitment for 200 million dollars. The cash on that may take ten years to come in or longer. It could be an estate gift that will only pay when there's an estate. So you've got to kind of figure out what the cash flow is going to likely be from these promises that are out there. And our cash flow—we have an amazingly good record of people honoring their promises. So what we would do is just come model it out as to if we raise this in a certain amount of time, we would do that in conjunction with people in development and what their thoughts were. It would all come together as far as the sources and uses—where we're getting the money from and how we're using it. It would all come together in the Economic Forecasting Model, which then the executive team—that would be John and the three EVTs—would bless, and that's what we would strive to achieve. That's what we would manage to that. So if we came up short on the philanthropy, we would have to do something somewhere else to recognize that we don't have that money to spend. If we came up over, well that was good news. Maybe next year or the coming year, we could spend a little bit more aggressively in some other area. The main thing I did with the Board of Visitors, or that I do with the Board of Visitors, is just keep them aware of our financial position. The presentations I make to them are largely the same as what I would make to our faculty leadership. It's more, here's how we're doing it, and just keeping them apprised of it. And through that lens, they can see how important their role is in helping us with philanthropy.

Tacey Ann Rosolowski, PhD
00:34:46
And I suppose you provide some hard numbers which, of course, help them very much in their promoting and communicating what the needs of the institution are.

Leon Leach, MBA, PhD
00:34:58
Absolutely.

Tacey Ann Rosolowski, PhD
00:34:59
Is there a back and forth between the Board of Visitors? I know that Dr. Mendelsohn said that he had some very useful conversations with the business leaders who were on the Board of Visitors, who obviously brought expertise he didn't have. Do you find that you have conversations with them as well?

Leon Leach, MBA, PhD
00:35:23
Absolutely, we've got formal committees of the Board of Visitors—one is MD Anderson as a business—that help us in certain areas. The thing is, it's a Board of Visitors; it's not a fiduciary board. The governing board is the Board of Regents. That's who we have formal presentations to, and they approve or disapprove our budget. The Board of Visitors doesn't have that power, but you have brilliant businessmen and businesswomen on that board that can really help us in different aspects of running MD Anderson as a business. So we will use that resource. It's like free consulting, if you will.

Tacey Ann Rosolowski, PhD
00:36:08
What are some instances in which you have found that resource to be very, very helpful?

Leon Leach, MBA, PhD
00:36:12
What were some issues?

Tacey Ann Rosolowski, PhD
00:36:13
What are some instances?

Leon Leach, MBA, PhD
00:36:14
Well, I found them to be very helpful back in 2008 and 2009 when we had to make certain difficult changes, because they understood why we had to do this and were confirming, "Yeah, you need to do this because things don't look good." They're an excellent sounding board.

They're very innovative. They're very much for MD Anderson, and they're very supportive. And we do work closely with them more as an advisory team, and we would be idiots not to. There is so much wonderful experience there. Now, we may not always do what they suggest because there may be other extenuating circumstances that we have to consider, because ultimately we're the ones responsible, and we're responsible to the Board of Regents, so we have to follow their directions and their lead. But the Board of Visitors has been very helpful in helping us think through and thinking through with us different business challenges that we're facing and what the options are and what the next steps might be.

Tacey Ann Rosolowski, PhD
00:37:39
Another—well I have a little brain jam right now because I really wanted to ask you about the Moon Shots obviously. But before we get to the now and the future, I kind of wanted to ask you about strategic planning in the past because I know that another set of projects that you undertook to help secure MD Anderson financially were the remote locations, MD Anderson España, and all of the pieces of global oncology. So I wonder if you could tell me about that a bit, what the rationale was and what you brought to that.

Leon Leach, MBA, PhD
00:38:25
Well, again it's a team sport. Nobody has a monopoly on good ideas. But in just studying their data, it was pretty clear that there was a relationship between how well we were paid and the distance the patients came.

Tacey Ann Rosolowski, PhD
00:38:45
What do you mean—more the farther they came?

Leon Leach, MBA, PhD
00:38:49
Yeah, we would get paid more for people who came from further away, and there's a whole bunch of reasons for that. Typically Medicaid doesn't travel for services, so they're here, so that's going to be lower paying. Medicare is lower paying. Managed care companies pay better. If you have large volumes of—like—the Texas Blue Cross Blue Shield, they're our biggest provider of managed care patients, and they drive the sharpest contracts, but if you have somebody in the Pacific Northwest who we don't have a contract with, they will call you up and try to do what we call a *one of*, and we will do a contract for that patient. Well, they don't have quite the same bargaining power as Texas Blue Cross Blue Shield because they're delivering an occasional patient where Texas Blue Cross Blue Shield is delivering tons of patients. So we do

better on a per-patient basis with those that are from out of state. We were cognizant of that, and we tried to attract more of that business. I don't know what the numbers are today. I looked at them a few years ago, and then we had over 600 *one ofs*, and I imagine the number is closer to 1000 now. These are folks who are coming here for a specific cancer trial or whatever. Oftentimes they've used the computer to find us, or it's been their daughter or son or someone who is more up on how MD Anderson ranks in healthcare who would say, "Oh, you've got to go to MD Anderson." In those situations, the managed care companies will generally pay more because they don't have the ability to demand less.

So going to regional networks, I think that's been a very positive thing. Internationally we've— I think our international centers and our sister institutions, that's worked well. That's been largely research and educational based. It hasn't been a whole lot about patient care, and it hasn't been financially driven. MD Anderson España is producing nicely now. They went through their ups and downs as they—and even now with the economy what it is in Spain, we're doing okay. The owners of that center—actually they're doing okay, too. It's the hospital chain that we partner with there, and they're doing okay also, but it's tougher times because you've got a lot more unemployed in Spain now. But overall, it's been a very worthwhile strategy—with the Banner relationship. These are things that help bring out quality of care—our level and excellence of care—into communities that may not have that level of excellence.

Tacey Ann Rosolowski, PhD
00:42:13
I know that Dr. Mendelsohn said that there were some real challenges when MD Anderson first started working with MD Anderson España and that there were some bumps with raising the level of care. What is your philosophy about that? He told me what his philosophy is about coming into a new environment and raising the level of care, but how do you see that relationship? If MD Anderson goes to a region where they're not capable really of delivering the level of care that one would find in Houston, what's that?

Leon Leach, MBA, PhD
00:42:52
Well, I think the goal here is to raise the bar, and if we can't raise the bar, then why would we want to be there? We certainly don't want to dilute the value of what we do. If it's not going to be appreciated or if it's not going to be implemented, we don't have any reason to be there. So to me, while it may not be easy and it may be a challenge, will you ever get them to the status of 1515 Holcombe? Probably not. That's not really the goal. The goal is to raise the level of the bar to improve the services and give access to, when things that are really difficult, 1515 Holcombe Boulevard. If folks were to look at what we do internationally and think that we're somehow going to recreate what we do here in Madrid—no. But we can certainly move the bar up, and we

can certainly give them access to what we do here. And I think that's occurred, but I think John was right. It was a rough road getting there. But it has occurred—and that's the only reason in my mind for us to be doing this. We had four rules that I made up at the time. I can't recite them now, but John probably could because he would remember them. And one of them, the fourth rule, was we're going to make a profit off of it. We're going to make money off of this. But the first rule was to deliver quality of care—improve the quality of care. It's all predicated upon that, but again we can't be a charitable institution for the rest of the world. We have to be able to cover our costs and return some profit to MD Anderson for doing this. Profit is not the right word—we use the word operating margin. It has to be a positive operating margin because profit in a nonprofit organization is shunned. But we need to do this on a basis that increases our net surplus.

Tacey Ann Rosolowski, PhD
00:45:25
And to what extent do you feel those regional centers and international sister institutions have worked strategically to brand MD Anderson and to create name recognition? How has that all worked?

Leon Leach, MBA, PhD
00:45:45
Well, that's secondary to delivering quality care also. In my mind, there is more importance in delivering quality of care. If you do that, then yes, your brand value goes up. People perceive that they would rather go to MD Anderson España than the local alternative. So I think that has had a positive impact, but it's a positive impact because of the quality of care.

Segment 11
B: MDACC in the Future
Financing the Moon Shots Program; Coming Changes to MD Anderson Structure

Story Codes
A: The Administrator
B: Building/Transforming the Institution
B: Multi-disciplinary Approaches
D: Business of Research
C: Healing, Hope, and the Promise of Research
D: On Research and Researchers

Commented [T11]: Dr. Leach begins with general comments on Dr. Ronald DePinho's Moon Shots Program –a speculative and expensive initiative, he says, designed to move the bar. He notes his belief that the most exciting developments in cancer will be coming in the next four to five years.

Dr. Leach then explains that, with the complexity of research today, a new framework is needed to think about conflict of interest. He then notes that the Moon Shots will reorganize all of MD Anderson, moving the institution to more efficient structures that free faculty members' time so they focus on what they do best.

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B: Building/Transforming the Institution
B: Philanthropy, Fundraising, Donations, Volunteers
C: Understanding the Institution
B: Ethics

Tacey Ann Rosolowski, PhD
00:46:21
Tell me a bit now about the Moon Shots and how that whole balance of research and funding is going to work with these huge initiatives.

Leon Leach, MBA, PhD
00:46:33
Well, I think we're in the process of modeling it out now, so anything I tell you at this point is more speculation than it is history. So I just want to be clear about that. The history of this is Ron [Ronald DePinho, MD] getting together our scientists and saying, "If we focus our efforts, where could we truly move the bar getting us back to moving the bar and making that difference? And we identified several opportunities where we thought—or the MD Anderson scientists think—that there is enough in place that with enough focus, we could reduce a disease to something that is manageable over a reasonable amount of time. So if we put the money into doing that—focus translates into dollars—and it could be pretty expensive to do that. We're talking 3 billion dollars over I think a ten-year period, or a six-year period—I think it was a six-year period. But part of it is, if we commit to Moon Shots in various disease areas, as the world starts learning about what we're doing, we're going to have more and more people with those diseases that want to come here, because if we're making that effort to push this disease into the manageable category and you've got that disease, what better place would there be to go to?

Tacey Ann Rosolowski, PhD
00:48:27
Right.

Leon Leach, MBA, PhD
00:48:30
So I think some of the funding will come from people coming here from not only Texas but the nation and the world, and I think that will help with some of the funding. But I think the initial funding is going to come from philanthropy, people who are excited about what we're doing, and different grants and contracts we may be able to obtain with industry, and I think some of it will be from our own reserves just to get it up and kick-started, but I think it will over time. And like I said, we are in the process of modeling that out now, what does that look like? But over time, I

think it will be self-sustaining as more people come in for care for those particular types of cancers where we've made progress.

Tacey Ann Rosolowski, PhD
00:49:32
Let me just read them for the record—acute myeloid leukemia, myelodysplastic syndrome, chronic lymphocytic leukemia, melanoma, lung cancer, prostate cancer, the type of breast cancer known as triple negative, and ovarian cancer. So that's quite the list. In terms of the modeling, what can you tell me about what that looks like in terms of needs for new faculty, buildings—what is it looking like? Is there more growth that we're looking at?

Leon Leach, MBA, PhD
00:50:11
Well, there is certainly going to be more growth. You can't do this without growing. We're using the Economic Forecasting Model that I just described. It's flexible enough that we can plug in different components, if you will, different modules for the different Moon Shots. I could only speculate at this point. We haven't presented it to the Executive Committee. I have seen it. It is very much a work in progress, and I'd rather not speculate. But I can tell you that it does need more growth—that's clear.

Tacey Ann Rosolowski, PhD
00:50:51
Does that just jazz you?

Leon Leach, MBA, PhD
00:50:54
Well yeah, and there's a lot of things that have me jazzed because, in the years I've worked in healthcare, the most exciting years are going to be the next probably four or five because of what's happening environmentally. We've got incredible pressures and changes that are happening environmentally. Then because of our strategy, the Moon Shots, we've got a chance to cure—cure is a big word—but we've got a chance to reduce some cancers to a lesser stage of disease to something that is manageable. We're probably the only folks on the face of the planet that can bring all those things together to make that happen. And we can't do it singularly. We're going to have to enlist others in this crusade. So it's a very exciting time. I don't see in my crystal ball anything more exciting or a more exciting place to be. But it's going to be exciting, and it's going to be a bit tumultuous because we are going to have to deal with the external environment while we're trying to cure cancer here in a bubble.

Tacey Ann Rosolowski, PhD

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00:52:22
Are there some internal challenges that you foresee as well instituting—

Leon Leach, MBA, PhD
00:52:27
Oh absolutely. It gets back to academic medical centers are not, by their nature, nimble creatures. Forgetting about the Moon Shots and just looking at the external pressures, that's going to force us to be much more nimble, and that's not a natural thing in academic medical centers. Add in the Moon Shots where we're going to have to be much more decisive about what science works, what science doesn't work, get it in the right orders, and move ahead and drop those that aren't getting us there, that's a real challenge in itself, too, because that's not—again, the nature of academia isn't to move through these things. What Ron brings to the party is that he's done this at Dana-Farber. He's gotten cures out there in the forms of companies. All the rhetoric that you read in the paper about the conflict of interest, that's because he's on the board of companies he started with his science to cure cancer. So we're looking at progress through an archaic lens. We've got to have a different framework for looking at progress and accepting progress and managing the conflicts. There is a general assumption that conflict is conflict and you can't manage it. Well, that's not necessarily true.

Tacey Ann Rosolowski, PhD
00:54:08
What would that new system look like? What would that new framework look like from your perspective?

Leon Leach, MBA, PhD
00:54:15
I think it's going to be much more nimble. It'll be more overtly data driven. The facts are going to be important, and there will be more clarity around the facts. It'll be harder to argue the numbers, and I think there will be more real-time data. Information systems and information technologies will play a big role in that. It's going to be well informed and better informed on a more timely basis—the decisions that will be made. A lot of that will be because of the power of the computer, but what we have to rely on is the power of mankind to respond to it, and that means stepping away from the old and stepping into the new and our willingness to do that on a fairly responsive and fairly quick basis.

Tacey Ann Rosolowski, PhD
00:55:25
To what extent do you think these Moon Shot initiatives will reorganize MD Anderson? Do you think that it's coming, that it will take a different structure?

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Leon Leach, MBA, PhD
00:55:37
Yeah, I think first of all, organizations aren't a static thing—they're constantly changing. You've got the formal organization, and you've got the informal organization. The formal organization is what you see on a piece of paper. The informal organization is how it really works. Oftentimes if you try to diagram out how it really works, it's not worth putting it on paper because it's based on interpersonal relationships, trust, years of working together, and a whole bunch of other factors. So yes, organizations are living, breathing, dynamic things. They are going to change. I think part of what you're going to see at MD Anderson is a move towards more efficient organizational structures that basically free up people's time to do what they do best. If we have that physician scientist who really is better at being the scientist than the doctor, hopefully we can free up his time to follow what he's best at, or her time to follow what she's best at. I think that's the optimum. The same thing can be said on the business side. We've got business people embedded in clinical operations because they have business functions there. At times they may report directly to the clinical function. They may not have as much of an appreciation for what the business needs are or may have greater appreciation for the needs are. They are first stymied by a bureaucracy that is not responsive to them. So we've got to create more responsive structures, and I'll think you'll see changes in that regard.

Segment 12

A: View on Career and Accomplishments

Bringing Structure to MD Anderson's Finances; Developing Spiritual Strength

Story Codes
A: The Administrator
A: Contributions
B: Institutional Mission and Values
C: The MD Anderson Ethos
D: On the Nature of Institutions
D: Fiscal Realities in Healthcare
B: Building/Transforming the Institution
B: Growth and/or Change
A: Career and Accomplishments
A: Character, Values, Beliefs, Talents
A: Personal Background
C: Faith, Values, Beliefs

Commented [T12]: In this segment, Dr. Leach summarizes his contributions to MD Anderson and the growth his work on higher degrees has offered him. He first stresses that MD Anderson has undergone exponential growth and moved to a more businesslike structure, and he underscores that an institution must be self-sufficient so it is free to reinvent itself.

Dr. Leach then says he has been pleased to have a role guiding the finances and structure for the institution's accomplishments, which have come through the efforts of fantastic doctors, scientists, and research support.

Dr. Leach then talks about the degrees he earned while serving as Executive Vice President: his Ph.D. in Public Health and his M.A. in Christian Education and what they contributed to his abilities to perform in his role for MD Anderson. The M.A., he explains, helped him develop patience, a quality that takes spiritual strength. He needed patience to deal with complex challenges in strategic positioning, as institutions tend to hold onto the old rather than moving ahead into change.

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C: Evolution of Career

Tacey Ann Rosolowski, PhD
00:57:43
How would you say the institution has changed since you arrived?

Leon Leach, MBA, PhD
00:57:49
Well, just the numbers alone— There were 7,000 people when I got here, and now there are 18,300. The square footage, I forget the numbers. I can't rattle them off, but it's like a threefold increase in square footage. The revenue numbers, oh gosh, I think it was around 700 million the year before I got here, and now we'll be 3.6 billion this year. So that's about a fivefold increase roughly—

Tacey Ann Rosolowski, PhD
00:58:22
A fivefold increase in philanthropy—

Leon Leach, MBA, PhD
00:58:25
So I think that just in size, it's been exponential, but I think more importantly the way we conduct ourselves. We have—what I'm fond of telling people is we've moved to a more businesslike structure, not to be confused with a businesslike structure. We've moved in that direction. We are more businesslike in what we do, but we're not a business per se. We are in many, many ways, but the way we're run—we're still an academic entity at heart, which is the way I think it should be. I think if you were to run this as MD Anderson, Inc., you would lose a lot of what's important to making MD Anderson MD Anderson. It's not all about the bottom line, but the bottom line has to be sufficient enough to let you reinvest in yourself, and we've been able to do that over my years here. That is going to become more challenging. That's going to be—this is where the external factors—the government and managed care companies—are going to perhaps have more control and influence. If our funds are reduced, then we could be in a more difficult position as far as reinvesting in our own success.

Tacey Ann Rosolowski, PhD
01:00:03
As you look back over the time that you've spent here, what have you been most pleased to have participated in—? What have you been most pleased to have participated in? What have you been gratified to have worked on and pushed forward?

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Leon Leach, MBA, PhD
01:00:21
Just to be able to be in a position where I could help guide what we've done with the place in fifteen or sixteen years—guide the financial and the structure for that, the business infrastructure for that—to be able to support that. We have just fantastic doctors and scientists, world class, and I think we have world-class business support and financial support for them, and I think that's important. Just being involved in that process in a position where I could help guide that process has been the capstone of my career.

Tacey Ann Rosolowski, PhD
01:01:18
What if you—? It seems sort of trite to say what have you learned? But how have you—? You came here with enormous experience, but how did this institution help you to continue to grow and become more sophisticated?

Leon Leach, MBA, PhD
01:01:32
Well, it has helped me in several ways. Since I've been here, I've completed a PhD. I've also completed a master of arts in Christian education. I guess in short it's developed the humanistic side of me. When I came in, I was a businessman, you know. I'm still very much a businessman, but I'm probably a lot more rounded than what I was, or at least I like to think that I'm a lot more rounded. People would probably disabuse me of that pretty quick, but I think I'm a kinder, gentler version of the person that came here. I think what I've learned is— I was very used to the command and control model of the business world, and here you have to get a lot more things done by moral suasion. So it's the weight of your argument and the weight of your ideas that carry the day, not because I said so.

Tacey Ann Rosolowski, PhD
01:02:41
I was curious—why did you do the MA in Christian education? What drew you to that?

Leon Leach, MBA, PhD
01:02:51
Well, I went to Southwestern Baptist Theological Seminary, and I've always had strong religious beliefs. I just really didn't have a plan to use that degree, so to speak. It was more the curiosity. I already had a masters degree, an MBA—that's what I do every day. And that was more of an intellectual curiosity thing. Now the PhD was a little bit different. The PhD was one part intellectual curiosity and something that I use. Because what I wrote on—I think we—

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Tacey Ann Rosolowski, PhD
01:03:40
Yeah, yeah, Uh-hunh (affirmative).

Leon Leach, MBA, PhD
01:03:41
—those studies we did at Baylor and MD Anderson. When you asked me about the one decision point, well there were fifty-some—I think it was fifty-three—different presentations given to different committees and faculty leadership in that eighteen-month period that we were trying to convince folks they had to change—fifty-three . Now what I've learned is to not let my blood pressure go up quite so much when that happens because the world that I came out of, you would not do fifty-three. You would get fired for doing fifty-three presentations in eighteen months to try to convince people to change. You would just issue an edict and away you go. The chief financial officer was truly the chief financial officer. Here you've got to bring people along with you. You've got to convince them of your ideas, and you've got to do it in a fashion that is timely so you don't burn through the resources. Baylor didn't do that—they burned through their resources.

Tacey Ann Rosolowski, PhD
01:04:52
This was with their hospital project.

Leon Leach, MBA, PhD
01:04:57
Yeah, with their hospital project they burned through their resources. We had to make the changes, and we really should have made them sooner than what we did, but we just—as it was told to me by one of the folks that I interviewed for the PhD, you really didn't have a burning platform. You were still making money. Well, we were essentially breaking even. We had a little bit of an operating margin, so he was right. We were still making money. But you know, the world I came out of, if your bridge catches on fire, you get fired. Your job is to keep the bridge from burning. So it's two different mindsets. Here, I didn't have a burning bridge, so therefore I shouldn't have made the changes. We made them too soon. Part of it was suggested that we did too much too soon. And my religious studies taught me that only one person has gotten it right in 2000 years, so I'm either going to be too much too soon or too little too late. Guess which one I'm going to pick—too much too soon. I didn't want my tombstone to say, "Leon Leach, he did too little too late," because that would not make a good tombstone. I want one that says, "Leon Leach, he did too much too soon." I can live or die with that.

Tacey Ann Rosolowski, PhD

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01:06:36
That's funny. I've any number of interviews where people have mentioned what they would or would not want to have on their tombstones.

Leon Leach, MBA, PhD
01:06:44
Yeah, "He did too little too late" really bothers me.

Tacey Ann Rosolowski, PhD
01:06:50
Is there anything from your MA or your time at the theological seminary that you feel you draw on?

Leon Leach, MBA, PhD
01:06:57
Yeah, I draw— I mean, it needs a lot of spiritual strength to have the patience to— One of the things my wife said to me—you know—I had this kind of fantasy about being a pastor in a West Texas church somewhere, and she said, "You might as well give that up. You don't have the patience to do that. The next time Bubba comes in with a drinking problem, you're going to tell him to get a life. You don't have the patience." And she's right, I don't. But I had to develop a lot more patience in dealing with things here, and I'm still probably viewed as being somewhat impatient because I want the changes to happen tomorrow. I view it as more of a sense of urgency than impatience, but there's a thin line between the two. Academic medical centers—if you're in the clinics, there is distinct sense of urgency—if you're in surgery or something like that.

Segment 13
B: MDACC in the Future
A Prescription for Fiscal Health: Be Pro-Active

Story Codes
A: Overview
A: The Administrator
A: Contributions
B: Institutional Mission and Values
C: The MD Anderson Ethos
D: On the Nature of Institutions

Commented [T13]: Dr. Leach begins with segment by explaining that institutions tend to hold onto the old rather than moving ahead into change. He then talks about activities that will enable MD Anderson behave pro-actively in the current and future economic context. He notes the importance of commercializing technology, of moving science to the bedside, and establishing relationships with other institutions. MD Anderson, he says, does well with managed care companies, as they recognize value, though he is not certain that the federal government will do the same. He says that health care is a current target of the federal government as health care represents 20% of the economy. He expects that the institution will create savings from a more streamlined organizational chart and continued strategic positioning. He discusses his roles with the state government in Austin.

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D: Fiscal Realities in Healthcare
B: Building/Transforming the Institution
B: Growth and/or Change
B: Beyond the Institution
B: MD Anderson and Government

Leon Leach, MBA, PhD
01:06:57+
From the strategic positioning, there's a tendency to hang on to the traditional, hang on to the old, and I think there is value in that. I don't think you should throw out your traditions, but you can't become a dinosaur either. You can't be making buggy whips in this market. You've got to be progressive. You've got to react to your environment. What I preach is a proactive environment. Another line I've used a lot in presentations and stuff and in the paper—I quoted all these great writers on strategy and strategic positioning and all of that, but the best explanation of strategy I've heard—Gordie Howe claims to have said this, and Wayne Gretzky claims to have said this—but it's skating to where the puck is going to be. That's what we need to do—we need to skate to where the puck is going to be. So that means strategically repositioning yourself before you have to. You need to get to where that puck is going to be, not to where it is or to where it was. So we need to be thinking ahead about what's going to happen with these external pressures, take our best guess, and get there before anything happens.

Tacey Ann Rosolowski, PhD
01:09:37
What are some ways in which MD Anderson could be doing that now?

Leon Leach, MBA, PhD
01:09:42
Well, we are. Remember the things we've talked about—the regional centers, what we're trying to do with commercializing our technology. One of the main reasons why Ron was so attractive to the Board of Regents is he's got experience in moving science to the bedside, literally in commercializing it—the Banner-type relationships and some of the things we're looking at certainly with the Moon Shots. And if you do those things, the business will come. If we can move the bar significantly on those eight cancers that you just read, the business will come. Now whether or not it's business that you can handle on a profitable basis having that surplus, that's going to be more determined by the federal government and by managed care companies and how you can fare with them in negotiations. I think we can do reasonably well with managed care companies, because I think they do perceive that value and will pay for value. The federal government—I'm a lot less comfortable with them in this environment because we basically

have a huge financial problem that we have to solve. We can't keep spending more money than we have year after year and run up a huge federal deficit without there being some repercussions.

When you take up twenty percent of the economy, which is what healthcare does—just rounding off slightly, I think it's like 18.7 or something like that—when you're one out of every five dollars that is spent in this country, you're going to be a target. You've got to fix something about healthcare if you're going to fix the economy. So you're going to be a target, and whether or not society lets us grow to the point where we can continue to reinvest and continue to move forward trying to cure cancer, that's a decision that we don't control. That's a decision that is going to be made more on society's terms, but we're going to have to live with whatever comes out of that. So we've got to skate to where the puck is going to be and figure out what is most likely to happen and where do we need to be delivering the services that will help support what we need to do longer term in order to stay at the very cutting edge of cancer care, and that means investing in research. So how do we do that?

Tacey Ann Rosolowski, PhD
01:12:26
What are some projects that you are going to be taking on in the immediate future?

Leon Leach, MBA, PhD
01:12:37
Well, I think the administers say things could come from a cleaner organizational chart—simpler organizational chart. I think that's one that I'll be involved with closely over the next couple of years. I think the continued strategic repositioning of MD Anderson to keep us in front of the curve, in front of the wave, so to speak—skating to where the puck is going to be—I'll be very much involved in that. The planning for those things—the Economic Forecasting Model that ties it all together, and the governmental relationships in Austin and DC—I think I'll be involved in those quite a bit.

Tacey Ann Rosolowski, PhD
01:13:36
What about those governmental relationships? How will you be involved with that?

Leon Leach, MBA, PhD
01:13:42
Well, I already sit on the Executive Committee of the Alliance of Dedicated Cancer Centers. That's a group of the twelve comprehensive exempt cancer centers exempt from the DRGs. They have been very involved in financial and legislative issues in Washington and Austin—I'm going there Thursday. There's always—I sit on the Health and Human Services Counsel. I was

appointed by Governor Perry several years ago. This is my—I'm in my second term now, near the end of my second term actually. It's those types of things. Dr. DePinho will be very much involved in those, too. He's the face of MD Anderson obviously. But when it comes to the business and financial and how decisions that are made in Austin or Washington can affect our ability to operate, then that falls a lot to me.

Segment 14

B: Key MD Anderson Figures

MD Anderson Presidents, Values, and Teams

Story Codes
A: Character, Values, Beliefs
B: Institutional Mission and Values
C: The MD Anderson Ethos
C: Portraits
C: Giving Recognition

Tacey Ann Rosolowski, PhD
01:14:54
Just a couple of more questions. One of them is, you obviously worked very, very closely with Dr. Mendelsohn, and you're establishing a close working relationship with Dr. DePinho, and I'm wondering if you could talk about those two individuals as leaders and how you would characterize them with their similarities and differences as leaders.

Leon Leach, MBA, PhD
01:15:18
I think they were both the right person and the right leader for MD Anderson for the time that they were here. I think John—his record of growth in what was a relatively stable time where we could look at the trends and say it's probably going to go like that—John had the courage when he came in here to invest, and frankly there were a lot of reasons to be concerned about that because managed care was still an unknown. They actually had a consultant come in who suggested laying off a number of people, a consultant from northern California where managed care really got a lot of traction. It didn't get the same kind of traction in Texas. The other thing is MD Anderson—there are a few exceptions to the managed care rule where you can leave somebody out of the program and not be hurt. Anderson in Texas is probably one of those few exceptions. I think both of them had great visions for the time. If Ron came in when John came in, with his vision, it wouldn't work. It would have been viewed as Buck Rogers and Star Wars

Commented [T14]: Dr. Leach begins this segment with the observation that John Mendelsohn and Ronald DePinho were the right leaders for their times. Dr. Mendelsohn had the courage to invest, he says, and turned MD Anderson into one of the few exceptions to the managed care rule. Now Ronald DePinho is building on John Mendelsohn's work. He talks about "moral suasion" and the importance of communicating.

Dr. Leach then talks about MD Anderson's values and the moral responsibility that the institution has to deliver on their promise.

At the end of this segment Dr. Leach names important members of his staff and says that the secret to success is hiring well so one can benefit from the strength created by building a team.

stuff. The base that has been built by John propels that next—the Moon Shots—it gets you to the point where the Moon Shots are a credible strategy. It's still very visionary and very futuristic, but it's within the realm of reason. It's doable—we can get there. It's challenging, and it's invigorating. And Ron has done this in his personal career. So I think there were two different eras that called for two different leaders, and I think the Board of Regents has done a superb job in both eras, picking the right person to get MD Anderson to the next level. When John came in, you probably couldn't even define what we needed fifteen years later or sixteen years later as we can't define today what the next leader at MD Anderson will need to deal with, but I think they were both the right people for their time.

Tacey Ann Rosolowski, PhD
01:17:55
Is there anything else that you would like to add about your role in institution financial health?

Leon Leach, MBA, PhD
01:18:03
Well, it's just—there are several hats I wear, but I think the bottom line is making sure we're vibrant—financially vibrant. And I can't do that alone. I need the cooperation of tons of people, and the moral suasion comes in. You've got to bring people along.

Tacey Ann Rosolowski, PhD
01:18:26
You've used that term a number of times—moral suasion—and I haven't heard that before. Where does it come from?

Leon Leach, MBA, PhD
01:18:31
Well let's Google it and see.

Tacey Ann Rosolowski, PhD
01:18:35
I was wondering if it was your own.

Leon Leach, MBA, PhD
01:18:41
Well, I'm sure somebody used it before I did, but to me it's descriptive of the environment where you have to build consensus, whereas I use command and control when I talk about the business world. Now there are a number of business leaders out there that have much more input and do

things more in a—based on a consensus fashion, but that's not really the norm. But they've done well.

Well, we'll go to the ultimate authority, *Wikipedia*. "Moral suasion (a phrase from the Latin words *moral* and *suasio* which denote respectively conduct or character that is right and virtuous and to present in a pleasing manner, sometimes known as jawboning), is defined in the economic sphere as the attempt to coerce private economic activity via governmental exhortation in directions not already defined or dictated by existing statute law. The moral aspect comes from the pressure for moral responsibility to operate in a way that is consistent with furthering the good of the economy."

Tacey Ann Rosolowski, PhD
01:20:22
So you're kind of putting your own spin on that.

Leon Leach, MBA, PhD
01:20:25
Well, I think it's just relevant to here, and I would say— I'm not sure about the—if I go through and read it again, "a phrase from the Latin words *moral* and *suasio* which denote respectively conduct or character that is right and virtuous." So I think that it's what I'm talking about. I don't know—and it says, "and to present in a pleasing manner." I don't know how pleasing my manner is. I won't comment on that. "Sometimes known as jawboning." Well, I would view jawboning as something else, something different. It's defined in the economic sphere as the attempt to coerce private and economic—that doesn't really fit. "The moral aspect comes from pressure from moral responsibility operating where there is consistent with furthering the good of the economy." I think that's very consistent as it pertains to MD Anderson.

Tacey Ann Rosolowski, PhD
01:21:18
Absolutely, and then also I guess that I was assuming that added on to that would be the assumption that there would be a responsibility to act in a way that was also consistent with the values and mission of the institution.

Leon Leach, MBA, PhD
01:21:36
Well yeah, I think that is implicit if not explicit. When you talk about moral suasion, our values are well known—caring, discovery, and integrity. If we're going to continue, we have a responsibility to deliver—I'll use business terms to deliver a product to a world that needs it. And in some cases, we're the only ones that can deliver it. So if we have to do certain things to

enable us to do that, then I think there's a certain moral responsibility that we do. I think the way I'm using it—it is in contrast with what I would call control and command—you know, command and control where you can do things by fiat or you can do things by moral suasion where you're asking people to do what would become later recognized as the right thing. I don't know when I started using the term, probably back when I was—this is probably a latent influence from them of arts in Christian education, but it's a term I had heard before, and it's a term, as this says, that comes from the Latin.

Tacey Ann Rosolowski, PhD
01:23:18
It makes sense. Is there anything else that you would like to add?

Leon Leach, MBA, PhD
01:23:25
I think you've pretty much covered it all. One of the things that I've been blessed with is an excellent staff. Sometimes I'm asked—well, I'm asked a couple of different questions. One is what do you do—what does an executive vice president do? And I've been asked that by my sons, and I tell them I go to meetings, which is largely what I do. If you follow me around, that's what I do—I go to meetings. It's what I do at the meetings that hopefully makes a difference. But the reason I can do these things—I can go to Austin and I can go to Washington—is I have a tremendous staff and have had for years. Dan Fontaine and I have worked together my whole career. He preceded me by about six months. Dwain Morris, I think all but four years, the first four years or maybe three to four years, of my career—he wasn't here. I hired Ben Melson, who is now the CFO of Texas Children's, to be the CFO when I took over responsibilities about three years in or three and a half years in to my career here. Ben brought Dwain with him, and Dwain has risen through the ranks to be the CFO now. So I've got very capable people. Chris (inaudible) (???) **1:24:50** basically runs my office, so I don't have to worry. There are a lot of things I don't have to worry about that frees my time to worry about the really important stuff or think about the more important stuff. There are so many people that I see in executive positions that don't have that luxury. The secret to success in my mind is hiring well, hiring good people. And I could go on. I just gave you a few examples.

We've had some tremendous people and facilities. We've had huge demands upon—there's no other healthcare institution that I know of that has built what we have. Bill Daigneau did a lot of that, and I never had to worry that much about it. Bill was a consummate professional. Spencer Moore, who we now have, worked for Bill and got a promotion to go to the University of Houston, and we were fortunate enough to hire him back to take Bill's—he's of the same caliber, the same ilk. Gerard Colman—he doesn't work for me, but a lot of the things that we need to get done through the clinical side, he carries the torch. Tom Burke and Tom Buchholz—I've always

had good partners with the executive committee level, and that's real important because you have to have certain trust and confidence that your partner at that level is going to be there for you when you need them. So we've been fortunate in that regard.

Tacey Ann Rosolowski, PhD
01:26:31
So excellence at every level and in every niche.

Leon Leach, MBA, PhD
01:26:35
Yeah, and we've got a strong bench. There are meetings that, if I can't go to, I'm comfortable if Dan, Chris, or Dwain goes to them. We're interchangeable parts in many ways, and that produces a synergy that is not always there in other organizations that I've worked at. So I think part of it is just the team that we've built. The things that we've talked about, I can't do alone. The changes that we're looking at and positioning the institution, I may the one who has more time to think about these things, but the execution belongs to others and a lot of others. I guess, you know, "It takes a village," to quote one of our former president's wives.

Tacey Ann Rosolowski, PhD
01:27:30
Is there anything else you would like to add at this point?

Leon Leach, MBA, PhD
01:27:35
No, I appreciate the time. I guess this is the kind of process where I'll get another look at it, and if there is anything that is unclear to you, feel free to call me.

Tacey Ann Rosolowski, PhD
01:27:49
Okay.

Leon Leach, MBA, PhD
01:27:50
Okay.

Tacey Ann Rosolowski, PhD
01:27:50
Well I'm turning off the recorder at 4:34.

Interview Session: 02
Interview Date: November 27, 2012

01:27:57 (End of Audio Session 2)

Leon Leach, PhD
Session 3—January 9, 2013

Segment 00C
Interview Identifier

Tacey Ann Rosolowski, PhD
0:00:01.5 We are live now, so I just want put an identifier real quickly. This is Tacey Ann Rosolowski. I am beginning my third session interviewing Dr. Leon Leach. Today is January 9, 2013. The time is 9 minutes after 3. So thanks again for agreeing to do this unexpected third session.

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Interview Session: 03
Interview Date: January 9, 2013

Segment 15

B: Building the Institution

Strategic Financial Initiatives: MD Anderson España

Story Codes
A: The Administrator
B: The Business of MD Anderson
B: Beyond the Institution
D: The Healthcare Industry
C: Professional Practice
D: Fiscal Realities in Healthcare
C: The Professional at Work
C: Critical Perspectives
C: Understanding the Institution
C: Professional Practice
C: The Professional at Work

Tacey Ann Rosolowski, PhD
0:00:27.9
And as I mentioned to you before I turned on the recorder, I realized that we hadn't really talked about—in depth about many of the strategic business opportunities that you have developed. I wanted to ask you first what the method to the madness was—I think it was your phrase—and why these were initiated.

Leon Leach, MBA, PhD
0:00:50.6
Well, we have known for some time that folks didn't want to pay. It has not been a secret that things are changing on the national front. Healthcare, the gross domestic product when I came here in 1997 was probably in the ten percent to twelve percent range that healthcare would take of the gross domestic product. Today it's pushing twenty—you know—fifteen years later. If you wind the clock back further, I can remember when I first got into the business it was six or seven percent. So it's taking up more and more of the national financial pie, if you will. Now some of it's very explainable. We do have an aging population, we do have baby boomers that are now—I think that this year is the first year technically the baby boomers are eligible for Medicare. And that's the more expensive years, it's the cancer-bearing years primarily. I mean, you do have cancer in younger people also, even children, but it's—the incidence is far less. So we know that our traditional reimbursements are going to come under pressure—money that we get paid from

Commented [T15]: In this segment, Dr. Leach explains that the increasing costs of health care signaled that traditional reimbursements for medical services were going to come under pressure, creating the necessity to look for other revenue streams. The sister institutions created such a possibility as well as satisfying the institutions mission to eradicate cancer globally.

Dr. Leach tells the story of starting his first day on the job in September of 1997, meeting with President Dr. John Mendelsohn and then immediately going cold into a meeting with Spanish representatives to talk about opening a cancer center from scratch in Madrid. Dr. Leach explains why the Madrid location was selected and describes some of the challenges met. He explains the main lesson learned: that MD Anderson is best suited to guiding institutions to create new cancer centers, rather than itself owning and operating new centers. The España project gave rise to a new department for consulting services, Global Global Business Development.

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Medicare, Medicaid, managed care companies. So we had been looking for opportunities to develop other revenue streams.

But more important than that, our mission is to eradicate cancer in Texas, the nation, and the world. We've got a strong presence here in Texas, but not so much the nation and the world—or at least that was the case in 1997 when we first came here. Even the presence in Texas was physically limited to 1515 Holcombe. So over the years we developed a number of strategies to more effectively address that mission of eradicating cancer in Texas, the nation, and the world but also speak to the diversity that's needed from our revenue side.

And you rattled off—you've got a list of projects, which we can just kind of take them and—we can either take them in random order— The first two that we actually did, if you want to take them in some form of time sequence—the first one was MD Anderson España, which is where we partnered with folks in Spain to do a cancer center there from scratch. And this is—this is kind of a fun story for me to tell, because my first day on the job in September of 1997—I got here at eight o'clock and went into the president's office and said hello to him. He was happy to see me, closed the door, we chatted for a while, and he said, "The first thing that I want you to do is there is a group sitting in the conference room—" which is literally right outside of his office, "that are here from Spain, and we've had talks with them to do a cancer center." In fact, the talks had been going on for probably a year or maybe longer. He was getting impatient and wanted to do a deal. So long story short, I walked into that meeting cold with a gentleman by the name of Hugh Wilfong, who was the—at the time he was the counsel for our—it was called then MD Anderson Outreach, which is now MD Anderson Services Corp. Mr. Wilfong went on to become the president of that. That became the entity which contracted with this group in Spain to do what is now known as MD Anderson España.

So we did open a cancer center literally from scratch. It was a real learning experience. It didn't go nearly as smoothly as we would have liked, and that's pretty typical with any new business venture like that. I mean—I think we made a couple of mistakes early on. One was we kind of used the same folks that were the venture capitalists, if you will—the people that kind of pull the deal together. The entrepreneur is a better word. It was the entrepreneurs that pulled the deal together in Spain. As we moved towards operations and moved towards actually building a cancer center, we were still using people to do so that were entrepreneurs and not kind of established business people in that realm—kind of classic to open a new business. Usually the person whose brainstorm it is at some point has to give it all to professional managers to do. So we had to go through that. We were also undercapitalized going into it. Anderson didn't put money into the deal. We brought our expertise to the table. The ones that we did the deal with brought capital, but not an adequate amount. It takes a huge amount of money to start a cancer center. And that was—you know—we figured we'd raise the money as needed.

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Tacey Ann Rosolowski, PhD
0:06:47.5
Can I ask you a question?

Leon Leach, MBA, PhD
0:06:47.6
Uh-hunh (affirmative).

Tacey Ann Rosolowski, PhD
0:06:47.8
Why was the Madrid location chosen specifically of all the many that I'm sure were on the table?

Leon Leach, MBA, PhD
0:06:55.7
Well, that's a very good question because we— When I came in the door in 1997, there really had not been a systematic study of the business opportunities— Do we want to be in Madrid or would we rather be in Beijing? There was no study of that nature that existed. The answer was we had some willing entrepreneurs who thought they could do this who had—were well connected in Spain with the investment community, with the governmental agencies. We actually did this in what was a former naval hospital in Madrid, and the government worked very closely with us. At our grand opening, the King of Spain was there. He's largely a figurehead these days. And various officials in the Spanish government, President Bush—H.W. Bush, 41, came over and helped us with those ceremonies. So it was an opportunity where we had willing partners.

Now we did go through a business evaluation—a business feasibility study of the Spanish market. It was going to be a challenge in any country, because in Europe where you look at socialized medicine because you do have to work with the government. But again, the group had very strong contacts with the government. In Spain there was about a ten percent, at the time, private market. And we were geared more towards that. But we also worked with the government insurance folks. Our payor mix was heavier on the private side, if you will.

So when we kind of analyzed it prospectively, it wasn't, do we do one here or in Bonn or in Paris or in Rome. It was, how does this market compare to others? And we did find out that it compared reasonably favorably to other European markets. There were factors there that had we done this from scratch, we would have been looking forward. So it was not a negative place to do it at all. In fact, we thought it was a good place to do it. When you get down to the success of anything like this, it's usually very predicated upon the people who actually do it. So we felt we

had a good group to do it with and at least get us started. As the project matured, so did the owners and managers. Today it's quite successful. The original investors in the projects sold out to a company that is very much like Hospital Corporation of America. They are a hospital management company, and they have operations. They do have one hospital here—I think it's in Florida. But they've got hospitals in the Caribbean. They've got hospitals in the Canary Islands and in Spain. So this company knows how to run hospitals.

Tacey Ann Rosolowski, PhD
00:09:56.8
I believe that Dr. Mendelsohn said that with the change in management, actually the center is better run.

Leon Leach, MBA, PhD
0:10:04.8
Yeah.

Tacey Ann Rosolowski, PhD
0:10:05.3
And is performing much better.

Leon Leach, MBA, PhD
0:10:06.4
Yeah, it's performing considerably better. So it is a learning curve. I think what we learned is we probably wouldn't—I know we wouldn't do it quite the same today if we had the opportunity. You know—this was a good experience for us to figure out how we wanted to do this.

Tacey Ann Rosolowski, PhD
0:10:23.5
And how would you—what would you do differently?

Leon Leach, MBA, PhD
0:10:25.7
Well actually you can see this in the relationship with Banner—you know—how we developed that relationship. It's much more of a joint venture. Doing a startup comprehensive cancer center is tough. We had the ability to do that, but if somebody wants to do that and wants to work with us, we have a whole consulting wing now that we would help them—you know—for a fee we would help plan the facility. But to do it for them, probably not. It's too much of a demand on our resources. We do have the ability to advise them on how to do it. But to actually manage it and own it, that's—you know—more than what we would want to do generally.

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Tacey Ann Rosolowski, PhD
0:11:05.8
Now are those consulting services something that arose because of the MD Anderson España initiative?

Leon Leach, MBA, PhD
0:11:13.1
That was the genesis. When you look at how that happened, we did get tons of opportunities. We wanted to get some experience in the international marketplace. We certainly have the experience on how to build a cancer center and how to manage and run and operate a cancer center. That's our strength. So when you look at it from a strategic standpoint, what's your strength, it's really the knowledge that we have of how to do this. When you try to do—to build a cancer center in a foreign country, one of the things you really have to understand is the culture and the business plan that they're—and there are people that live in that and know that. So we just think it makes more sense if we kind of stick to what we know—how to build cancer centers and how to run cancer centers and—but not necessarily try to own cancer centers in a foreign climate.

Tacey Ann Rosolowski, PhD
0:12:20.1
Right.

Leon Leach, MBA, PhD
0:12:20.6
So—you know—we have—we can help you with it. It's kind of—you know—do you want to—the old biblical parable about—I think it's biblical—about catching a fish. Do you want to catch a fish for somebody and give them the fish, or do you want to teach them how to fish? So we'd rather teach how to fish. And there's a lot less risk in it for that. Again, we never did put any money in Spain, but we did have our pride on the line, and we had a lot of investment of individuals' time. We were compensated for it, but we were very committed to that project being successful. And frankly there were times that we considered whether or not we wanted to continue with the project because there were things that local—the local owners had to sort out that we didn't think were being sorted out quickly enough.

Tacey Ann Rosolowski, PhD
0:13:17.6
Can you give me an example of one of those reevaluating moments?

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Leon Leach, MBA, PhD
0:13:22.4
Well, there were probably three different times that management changed there. That is part of the natural growth of a company from an idea and the entrepreneurs that pull that together to make it happen to a functioning business. But never was this smooth, and most of the time it's not smooth. So it was just being involved from afar and being focused on—primarily on patient care. We did have some scientific research links to our friends in Madrid. That became a bit of a distraction as management changed. It would be—we build a number of safeguards into the model that we now use. And it's—for international opportunities, it's more of a consulting model. For national opportunities, it's more of a partnership with an established player where we can be instrumental in raising the bar.

Tacey Ann Rosolowski, PhD
0:14:36.6
What is the name—? Is there a specific department that takes care of those consulting services for—?

Leon Leach, MBA, PhD
0:14:42.7
Yes.

Tacey Ann Rosolowski, PhD
0:14:43.3
And what is the name of that department?

Leon Leach, MBA, PhD
0:14:44.9
It's run by Amy Hay. We refer to it internally as Business Development.

Tacey Ann Rosolowski, PhD
0:14:55.0
Oh, okay.

Leon Leach, MBA, PhD
0:14:56.3
There may be a more official name—in fact, I'm sure there is a more official name, but off the top of head, I can't think of it. So that was one example.

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Segment 16

B: Building the Institution

Strategic Financial Initiatives: The Story of the Proton Therapy Center

Story Codes
A: The Administrator
B: MD Anderson History
B: The Business of MD Anderson
B: Beyond the Institution
B: Industry Partnerships
D: The Healthcare Industry
C: Professional Practice
D: Fiscal Realities in Healthcare
C: The Professional at Work
C: Critical Perspectives
C: Understanding the Institution
C: Professional Practice
C: The Professional at Work

Leon Leach, MBA, PhD
0:15:05.9
Another example was the proton center. I know you talked with Dr. Cox. This was his brainchild. He met with me and kind of educated me on what proton beams were. I had no idea what they were and why they were advantageous to cancer patients and cancer treatment. Most of what they were seeing back then—in fact, there were only a couple in the United States at the time. There was one in Loma Linda, California, that did largely prostate cancer, and there was one in Mass General in Boston. It was more for research, but they did see some patients. And there were some other interesting pediatric cases or ocular tumors that would wrap around the ocular nerve where if you went in and operated, chances are the patient may not have vision afterwards. It might knick the nerve or something like that because it's such a delicate operation. The proton beam was so accurate that you could radiate that and not damage the nerve.

So—and he really built a good case about how this was the next step in many types of cancer. At the time it was being—proton centers were being looked at a little bit by a hospital company in California that has its roots back here in Texas, a company called Tenet—Tenet—T-E-N-E-T. They were looking at building maybe as many as twenty proton centers throughout the country. They had actually contacted the University of Texas Southwestern Medical School and did some

Commented [T16]: In this segment Dr. Leach explains the rationale for building MD Anderson's Proton Therapy Center and describes the unusual financial partnerships that enabled it to be funded. He begins by noting that only a few proton centers existed with only one providing patient care –and that one, in Loma Linda, California, only treated prostate cancer. Dr. James Cox [Interview # 32] made the case that proton therapy was a next step in cancer care. He notes that he ran feasibility studies that confirmed that MD Anderson had the patient volume to support a Proton Therapy Center offering treatment for many different cancers. Dr. Leach then describes a first attempt to finance a center in partnership with Tenet Healthcare Corporation and why that failed. He explains the feasibility studies done regarding patient availability and the possibility for reimbursement, and other financial concerns at the time. (23:00) He then talks about the consortium that responded to the call for proposals: The Styles Company (a healthcare development company) and the Sanders Morris Harris Group (investment banking firm), both Houston based. He goes on to explains what these companies brought to the project, who eventually invested, and (25:00) sketches the innovative dimensions of the consortium/partnership between a government supported academic institution (not usually business friendly) and private investment. Next Dr. Leach explains why some technological challenges made it necessary for the Proton Therapy Center to open with only one of its four gantries in operation and outlines the financial implications this had on Hitachi, the company providing that technology. The delay opened the possibility that investors could return their shares to Hitachi, receiving back their money plus a percentage of their investment. The Center ran for a year with only one gantry. (Continued, Segment 21)
[Cuts off abruptly at 29:17.]

studies there. But these were quite expensive. We did ours for about $128 million. Today you're looking at $200 million for one that would be the same size and scope as ours—if not more.

Tacey Ann Rosolowski, PhD
0:17:32.5
Wow, and that's only—that's less than ten years.

Leon Leach, MBA, PhD
0:17:34.8
Yeah.

Tacey Ann Rosolowski, PhD
0:17:35.1
Wow.

Leon Leach, MBA, PhD
0:17:35.9
Yeah. So it became pretty clear pretty quick that Southwestern didn't really have the volume with cancer patients that justify that. We were asked if we would be interested in talking with Tenet, and we did. And we were progressing nicely towards what could have been a deal, but a couple of things happened. There was an earthquake in California. I think it was the Northridge earthquake—no, I think it was after Northridge. But there was a major earthquake in California that did a fair amount of structural damage to hospitals that were owned by Tenet. But all hospitals—there were some laws passed in California about how they had to earthquake proof hospitals. So Tenet was a major player out there. It had to spend a lot of capital on that. It made it difficult to fund the proton vision. And they also got into some trouble with the Medicare and Medicaid folks—or Medicare folks—federal government on some of their Medicare billing. I think they got a pretty huge fine, and that kind of dampened their appetite a little bit, too. So that deal—that deal fell through. But by now we had done enough research that we were pretty convinced this is a good thing to do.

Tacey Ann Rosolowski, PhD
0:19:08.5
Now what was the research you were doing? What piece were you bringing to that table?

Leon Leach, MBA, PhD
0:19:13.2
Really the business side. I mean, the research I was referring to when I said, "This is the right thing to do," was more medicalized as far as this is something that—the science that we need to

have here at MD Anderson. And Dr. Cox was convinced of that before the rest of us, and he had to kind of get the rest of us there.

Tacey Ann Rosolowski, PhD
0:19:38.4
Now did you start doing feasibility studies or running—

Leon Leach, MBA, PhD
0:19:42.6
Yes.

Tacey Ann Rosolowski, PhD
0:19:42.8
Okay. And what—what was coming out of those?

Leon Leach, MBA, PhD
0:19:45.7
Well we—we did a very sophisticated feasibility study that basically showed we did have the patient volume to support something like this. So we had built the model, and we knew what we wanted to do. We also knew that we were in the expansion phase; we were building lots of buildings. The University of Texas Board of Regents had been very generous with us as far as supporting our financial needs and letting us have access to the money that we needed for those facilities. We felt that this might be a step too far for the University of Texas because it was still very experimental. And the one concern we had at the time was the payers' willingness to pay for something that's deemed experimental. Now Medicare was already paying for it. So that was huge in our decision-making process, because we used the Medicare numbers as kind of the can we make this work on Medicare. And also the fact that Medicaid was paying for it we thought was a good argument with the managed care companies as to yes, this is—it's leading the realm of experimental. It's standard of care.

Tacey Ann Rosolowski, PhD
0:21:08.1
Can I ask—it seems like pretty early in the game you must have been thinking about how a proton center could—I mean, obviously generate more revenue, but then also support whole new areas of research and then enhance patient care. So those—you know—

Leon Leach, MBA, PhD
0:21:28.3

Right. All the pieces came together. I mean, this was new—well, it's not really new to technology. Proton centers have been around since the fifties. The Russians looked at them more as a possible weapon, but they were around. There were twenty-something of them at the time in Europe and places in Asia. But they weren't being used extensively for patient care. Loma Linda was the only one in the United States that was really using it extensively for patient care, and that was primarily for prostate cancer. So that was part of—that was all part of the due diligence that we did. Is this usable technology? Is it cost effective? You know—the cost for treatment is considerably more than your normal radiation. We understood that going in, because you have this incredible expense in the facility that you have to recoup over time. And the question really became, do we have enough patient flow and will the payor levels be there to recoup that over time? And that's where Southwestern kind of bowed out because they didn't think they had patient flow. We had a big enough patient base that we thought it would work.

Tacey Ann Rosolowski, PhD
0:22:46.0
Uh-hunh (affirmative). So what happened when Tenet backed away?

Leon Leach, MBA, PhD
0:22:50.2
Well, when Tenet backed away, we had already done all the research, and we decided to go out and issue an RFP to see if there was another partner out there that wanted to do this with us. And we got some responses. Long story short, the successful responders were a combination of the Styles Company and Sanders Morris Harris. The Styles Company is a Houston-based hospital management company—very small, kind of family owned. And Sanders Morris Harris is an investment bank based here in Houston. But they were the winners in the RFP process, if you would. Sanders Morris Harris, what they brought to it was the ability to raise the capital that was needed. And the Styles brought outside hospital management in the experience that they could use it in managing the institute for us. We thought about going to the Board of Regents for their money, but we had been to the well quite a bit, and we thought it would be better if we could demonstrate that this is something—this is an idea that the private sector is willing to invest in.

Tacey Ann Rosolowski, PhD
0:24:09.4
Now I read that that was really unusual.

Leon Leach, MBA, PhD
0:24:12:7
It was extremely rare to put together the kind of deal that we did because it was not only Sanders Morris Harris from the private sector, but folks that put money into the deal included the Harris

County Police Department pension fund, the Harris County Police Department—Fireman's Fund, Hitachi put a fair amount of money into it in a couple of forms. One was just taking back the debt for the machinery that we bought—from the proton machinery that we bought from them. And then there was a consortium of investors that Sanders Morris Harris had raised. So it was—

Tacey Ann Rosolowski, PhD
0:24:55.4
Why—I'm sorry, but why is it so unusual for an academic institution to embark on a project of that kind using private money?

Leon Leach, MBA, PhD
0:25:05.3
You know, that's a good question, and I'm not sure I know the answer. I know it doesn't happen all that much. I suspect having been on the outside of academic medical centers, I had never thought about doing that kind of joint venture with them when I was in the other world. But I know from my days in the HMO business that trying to just arrange and negotiate services with them is difficult because they tend to be very high-priced and pretty rigid in what they will and won't negotiate. So they're not really—my experience—my personal experience has been they're not really that business friendly, and I think we were. This is what I did for a living in the other world. And Dan Fontaine was very instrumental in bringing this off, and he had kind of a similar ilk. So we were looking for ways to make it happen, not ways to keep it from happening.

Tacey Ann Rosolowski, PhD
0:26:09.0
Uh-hunh (affirmative).

Leon Leach, MBA, PhD
0:26:10.9
So we wound up with a great government private sector and academic medical center type of consortium that put this together with people from Japan as the provider or the builder of the equipment and services. So we built it, and we opened it. We opened it with a single gantry. There are four gantries down there, and we got a single one up and running.

But at the time, Hitachi had developed some new technology called—the shortcut description was paintbrush technology. And what they did, instead of just zapping the tumor, they kind of painted in the beam so it was even more precise than zapping it with the beam. And we kind of switched strategies at the request of Hitachi and the agreement of our faculty members that were into this who thought the beam could be more precisely delivered. And we were assured that this

technology was ready to go. Well, as we got into it, we found that the technology was pretty much ready to go. There were just some bugs and just some things.

In the meantime, Hitachi had agreed to certain completion dates. And if by no fault of ours, if they were at fault for not missing the completion dates, then the investors had an option to put the investments back to Hitachi in return for what I believe was they would basically give the investors back their money plus—I think it was something like eight percent interest a year. For purposes of the paper, we probably ought to say X because I don't remember—you know—X%.

So what happened was we were—we opened and for about a year ran it with just one gantry. We actually opened on schedule, on budget, but it was one gantry. We didn't open the whole facility. The rest of the facility—what was available got held up because of the paintbrush technology. And dates were missed, and Hitachi was now at risk at having the shares put back to them. But the project was coming along well, and everyone kind of believed in the project. There was no real danger of doing that. The investors had some kind of—they had a window. They could put it back for maybe a year or something like that. And I think Hitachi—my recollection is that they actually extended the window while they were fixing the problems.

Tacey Ann Rosolowski, PhD
0:29:10.3
Can I ask you to just pause one sec. Okay, I'm good now.

Leon Leach, MBA, PhD
0:29:16.0
Okay.
Tacey Ann Rosolowski, PhD
0:29:16.4
I'm sorry I interrupted you.

00:29:17.3 (End of Audio Session 3)

[**Interviewer's Note**: The recording cuts off abruptly at this point because of an equipment failure discovered only later. An additional session was scheduled to recapture lost material. Notes on the lost material are included below.]

> LOST MATERIAL:
> This became significant, Dr. Leach explains, with the economic meltdown of 2008, when many investors exercised this option. Hitachi did not want to run a proton therapy center, and MD Anderson, Harris, and Styles were able to purchase the center for pennies on the

dollar. Dr. Leach then explains the legal and economic status of the Proton Therapy Center vis a vis MD Anderson and sketches what it represents financially to the institution.

Dr. Leach describes the lessons learned through the Proton Therapy Center: become more involved in varied aspects of health care deliver to control your destiny; MD Anderson should do what it is good at to further its; and remember, "no margin, no mission."

Dr. Leach sketches the partnership established with Banner Healthcare in Gilbert Arizona, leading to the opening of MD Anderson Banner in 2011, the first fully autonomous center carrying the MD Anderson name. He also talks about the satellite care centers around Houston. Dr. Leach begins by noting that such initiatives can only be successfully undertaken when there is a "meeting of minds" on how cancer services must be delivered.

Dr. Leach explains it is important that MD Anderson's partners share a vision –for example a vision of multi-disciplinary care as a key to successful cancer treatment. He explains the "employee model" that guarantees that all MD Anderson faculty adhere to the same standards of care and contrasts this with systems outside of the institution.

Dr. Leach notes that Banner is a like-minded institution and explains what MD Anderson and Banner each brought to the partnership. He also says that MD Anderson will be developing more autonomous centers, probably in the west and south. President Ronald DePinho supports this long-range vision and under his direction McKinsey & Company was hired to do a growth analysis. Next Dr. Leach talks about the rationale for opening the satellite care centers around Houston.

Dr. Leach quips that the Texas Medical Complex is 'complex' and daunting for many patients –one element of the rationale for situating care centers so patients have local access to MD Anderson care.

The local care centers, he notes, created a cultural change for faculty.

Dr. Leach imagines a patient who lives in the suburbs driving in to Houston for an eight A.M. appointment.

Dr. Leach observes that it is cheaper for MD Anderson to build facilities outside the city and notes that the institution has just purchased property near Katy. He briefly talks

about why the Woodlands will be the next location for a care center. He then touches on the importance of personalized care.

Dr. Leach describes what personalized care will offer to patients.

Dr. Leach explains that President Ronald DePinho's Moon Shots Program will generate many financial opportunities that have not yet been imagined. He sees MD Anderson evolving into an institution where patients will come for specialized treatment or for specific cancers.

Dr. Leach explains how he describes the value of MD Anderson care to the people who live in the town near his ranch. "If your pickup truck breaks down," he says, "you don't take it to the shop that only repairs one or two pickups a month. You take it to the shop that repairs hundreds of them."

Finally, Dr. Leach summarizes that MD Anderson will have to be more accessible in order to secure its financial health. He notes that very few of the faculty are clinicians only. While not advocating any change of the research-based culture, Dr. Leach explains that there must be a discussion about encouraging some faculty to serve only as clinicians and also for the institution to "open portals" to see a wider spectrum of cancers.

Leon Leach, PhD
Session 4—April 29, 2013

Segment 00D
Interview Identifier

Tacey Ann Rosolowski, PhD
0:00:04.6
Right your story. Okay, so I'm Tacey Ann Rosolowski, and today is April 29, 2013, and I am in Pickens Tower at the MD Anderson main campus. Today I am interviewing Dr. Leon Leach for a supplementary session. The time is about four minutes after three. So thanks very much for agreeing to do this—

Leon Leach, MBA, PhD
0:00:29.0
Thank you.

Tacey Ann Rosolowski, PhD
0:00:29.2
—and helping us recapture some material.

THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

Interview Session: 04
Interview Date: April 29, 2013

Segment 17

B: MD Anderson and Other Institution

MD Anderson Banner and Satellite Care Centers

Story Codes
B: Institutional Mission and Values
B: Multi-disciplinarity, Teams, and Collaborations
B: The MD Anderson Brand, Reputation
B: Multi-disciplinary Approaches
B: Growth and/or Change
B: Obstacles, Challenges
C: Understanding the Institution
A: Overview
B: The Business of MD Anderson
B: Beyond the Institution

Tacey Ann Rosolowski, PhD
0:00:31.5
So as I mentioned, I need to ask you a couple of questions about some of the strategic initiatives that expanded MD Anderson care beyond the boundaries of Holcombe. So I wonder if you could take me through the process of the development of MD Anderson about—you know—why was it that the institution decided to establish a care center there, and why Banner?

Leon Leach, MBA, PhD
0:00:59.6
Okay, well why we are outside the halls of 1515 Holcombe—?

Tacey Ann Rosolowski, PhD
0:01:04.6
Uh-hunh (affirmative).

Leon Leach, MBA, PhD
0:01:04.6
—is a good place to start. Our mission is to eliminate cancer in Texas, the nation, and the world. So we didn't feel that because we're a Texas institute, we're necessarily limited to 1515 Holcombe Boulevard, or Texas, or the nation, for that matter. Banner really was linked to a strategy to understand how we could take what we do—our processes and procedures—and make them more universally available. One of the ways to do that would be seek out partners

Commented [T17]: In this segment, Dr. Leach sketches the partnership established with Banner Healthcare in Gilbert Arizona, leading to the opening of MD Anderson Banner in 2011, the first fully autonomous center carrying the MD Anderson name. Dr. Leach explaining that the motive to expand beyond 1515 Holcombe comes from the MD Anderson mission –to cure cancer in Texas, the U.S. and the world. The center at Banner came about as MD Anderson experimented with a process of adapting MD Anderson care procedures to make them more universal. He notes that MD Anderson seeks out institutions with which there is a "meeting of minds" on how cancer services must be delivered.

Dr. Leach describes MD Anderson's multi-disciplinary approach to treating patients, giving the example of the wide range of options that teams consider for prostate cancer.

Dr. Leach explains that MD Anderson is open to establishing partnerships with institutions that embrace a multi-disciplinary approach. MD Anderson does not need to seek out partners, as institutions approach MD Anderson. Dr. Leach next talks about the many lessons learned by establishing partnerships. He mentions MD Anderson Orlando, Florida, which he says eventually morphed into a Banner-like situation. He explains some of the financial challenges setting up MD Anderson Espana, an initiative that also became more like Banner. Through these experiments, "We now know what a good partner looks like." Dr. Leach then discusses the regional care centers, explaining that they were created to offer patients more access to services.

Dr. Leach explains how MD Anderson insures the quality of care at satellite centers, giving an example of MD Anderson physicians in Houston confer via teleconference with colleagues at MD Anderson Espana.

Dr. Leach notes that all of the satellite centers have a business plan.

that were looking for the kind of expertise that we offer. So we did some preliminary planning about what that would look like, how we would do that, and there are several key thoughts. The partners need to be of like mind. And probably on the first point there is multidisciplinary care. We have a certain way of practicing medicine here—cancer medicine—and it deals with doing what's right for the patient. Just because you walk into the surgeon's door doesn't mean you get surgery. Just because you walk in Cancer Medicine or Radiation Oncology doesn't mean that we're going to radiate you. There will be a team that looks at your situation, and there will be discussions with you as the patient as to what the options are. I often use prostate cancer because there is an array of options there ranging from radium implants to radiation therapy that's traditional to the proton therapy which is a much newer way of treating several different types of cancers—prostate is one of them—to what they call watchful waiting, which is just if it's not that aggressive and you're probably not going to die from it, let's just wait and see what it does. So you have all kinds of ways that you can treat that, and we'll evaluate the patient and have a discussion with him based on what's best—you know—what's best for that individual patient.

So what we look for in a partner is that same kind of mindset and a willingness to kind of follow what we do in treating cancer. We look to be able to have an impact, to be able to raise the bar in an area, and we look for people that are really looking for us. We want partners that are seeking out the kind of medicine that we practice, the way we go about doing things—tracking our quality and our outcomes—

Tacey Ann Rosolowski, PhD
0:04:16.3
Did Banner get in touch with MD Anderson? How was that connection established?

Leon Leach, MBA, PhD
0:04:21.9
My recollection is probably vague on that. I can't say—my recollection is they contacted us. We're not really out there marketing our services per se. We know the kind of partner that we want. We have lots of discussions that usually don't go anywhere because the other party just wants the MD name on their building. We won't do that. If the MD Anderson name goes on the building, so do our guidelines, so do our pathways. And another thing that we're looking for in this world is alignment with the hospital and the doctors. In the case of MD Anderson, they work for the same entity. Anderson owns the hospital, and the doctors are part of our faculty and they are employees, so to speak. So we look for a similar type of entities that have that kind of arrangement or are willing to move to that, and we look for the opportunity to have an impact on the area as far as raising the bar for the level of care.

So with Banner, they pretty much all those criteria. And again, I have likened it before—if people didn't want to do business with us, it's like, wow, fishing and the fish are jumping in the boats—in the boat—and you get to pick which one you want to keep and you throw the ones back that aren't as much of a prize, so to speak. That's probably a crude analogy when it comes to medicine and healthcare and cancer, but Banner was very much of like mind, and that's what we—that's very important to us.

So that's how that arrangement came about. Most of these arrangements will take a year's quick, because there are so many discussions that you have to have about not only the business details but more so on the medical side—the clinical side—as far as who we are, what we're about, and how do we go about interfacing on medical issues. And we're looking for a few more partners, kind of like—what is it?—the Marines looking for a few good men. We're looking for a few good regional partners. We're not out there beating the bushes, so to speak. It's kind of, you'll know 'em when you see 'em. And we prefer that they come to us, because that's more of an expression of self interest—their self interest—than us going to them. But it's—we view it more as a mission thing and the fact that our mission goes back to eradicating cancer in Texas, the nation, and the world. That's kind of how Banner came about.

Tacey Ann Rosolowski, PhD
0:07:19.8
What were some lessons learned over the course of establishing that relationship?

Leon Leach, MBA, PhD
0:07:25.2
Well, we did learn several lessons. I mean—we did a couple of bites of the apple, one with MD Anderson Orlando, and that one worked out very well, but it morphed into a very much Banner-like relationship over time. We didn't go into it knowing what it would look like. We had a similar experience on the international front with MD Anderson España where we pretty much started as a cancer center from the ground up using an old Navy hospital with some folks who were really venture capitalists. And it turned out the early efforts were undercapitalized. We were able to recruit a quality staff, but it was tenuous at best going through that process when you're not properly capitalized. Long story short, that evolved to a Banner-like model too with a hospital management company that's really an international company that has—they have operations in Spain, but they're also in the Caribbean and I believe they have one or two hospitals here in the United States. I know they have one. So—you know—they stepped up and basically bought the venture capitalists out. We didn't have financial support—direct financial support—from the Spanish government, but they were very helpful in helping that entity integrate into their healthcare delivery system in Spain. They were very helpful in their willingness to help us with facility arrangements. There was a naval hospital that we converted.

So a lot of it has to be the chemistry of the partners and things coming together and knowing what you want. We now know what a good partner looks like. But we went through a period where we kind of developed that to the point where we now understand it better.

Tacey Ann Rosolowski, PhD
0:09:30.0
So it's clear to me what MD Anderson can do for these institutions that are requesting partnership. What does MD Anderson get back?

Leon Leach, MBA, PhD
0:09:41.1
Well, the arrangements vary, but basically the theme is that we take a fee off the top. There may be something based on results, outcomes, and there may be some patient flow, because there are things—a stem cell transplant, that kind of thing—where patients may want to come here versus having it done locally.

Tacey Ann Rosolowski, PhD
0:10:08.4
How much revenue does Banner, for example, represent to MD Anderson?

Leon Leach, MBA, PhD
0:10:13.9
Uh, I don't have that statistic off the top of my head. I mean, right now our—these relationships are relatively small, but we do have the original relationships where MD Anderson has developed regional centers that basically ring the Houston area—The Woodlands and Katy and the Clear Lake area—and they're done oftentimes in conjunction with another healthcare facility where we use their facilities and we have our doctors there, and the doctors are in our employ. And you know, that's—we have a nice financial return all through those efforts.

Tacey Ann Rosolowski, PhD
0:10:53.8
What was the reason for establishing the regional care centers?

Leon Leach, MBA, PhD
0:10:57.2
Basically the same principle—basically it's curing cancer in Texas. Uh, 1515 Holcombe is maybe not as convenient of a spot. You come here, you know the parking, you know the challenges. A lot of people that wind up in our regional centers come here first for their diagnosis, and if it's, let's say, rad onc, radiation oncology, and they can get those services out in

the satellite offices, more people are going there now first with a diagnosis, but it works the same way as the mother ship. You know, you have the team, and you have the evaluation of the patient, and it's done in a multidisciplinary fashion. We do have some capacity to do surgeries out in the regional areas, but about thirty percent of the patients get sent in here for their surgery. So it's a matter of trying to make yourself more accessible.

Tacey Ann Rosolowski, PhD
0:12:08.5
And how does quality control work—you know—with Banner, with all the satellite centers?

Leon Leach, MBA, PhD
0:12:15.6
Well, I'm not going to pretend to be an expert on the clinical side. But there is a lot of involvement of medical directors at MD Anderson for your employee and a lot of coaching from the mother ship. You know, in Spain it's interesting because we use teleconferencing there where the doctors will get together on a live video network that's bouncing off a satellite and talk about particular cases for that week. Or one particular case, they may bring in a specialist in that area right here so that they don't have to make the trip from Spain to reap the benefit from our expertise. So in today's world, we're very much linked electronically to our other sites.

Segment 18
B: Overview
Tools for Economic Modeling and the Budget at MD Anderson

Story Codes
B: The Business of MD Anderson
C: Understanding the Institution
C: The Institution and Finances
A: Overview
A: Definitions, Explanations, Translations
C: Professional Practice
C: The Professional at Work

Tacey Ann Rosolowski, PhD
0:13:11.5

Commented [T18]: In this segment, Dr. Leach explains how economic modeling and budgeting works for the entire institution, using a "current year plus six years" plan. This long view helps his team accommodate building plans, anticipating the financial effects of expansion. He explains several cost-saving measures that have been taken to bring the budget under control. He is also proud to report that administrative costs for the institution have dropped 4% (from 15% to 11%) since 2008 and there are 200 fewer employees in Business Affairs. Dr. Leach describes how financially-focused employees are imbedded throughout the institution, influencing the complexity of bringing these costs under control.

Interview Session: 04
Interview Date: April 29, 2013

Now, in one of our earlier sessions together, we talked about the economic modeling process that you worked through. Did you send—did you use that kind of modeling to anticipate what the risks were or possible benefits for these satellite centers—?

Leon Leach, MBA, PhD
0:13:33.1
Yeah, all the satellites have a business plan. Virtually anything that we do, that commits new funds, would be connected to a business plan. And business may not be the right word. I use that because I'm a business man, but basically what we want to understand is, what is it we're going to need to do, and what are the deliverables, and what are the cash flows? What are we putting in? What can we reasonably expect to get out? Time frames, staffing, any facilities costs, that kind of thing. So while people may find the term business plan uncomfortable, that's essentially what it is. It has the ingredients of it.

But the modeling that I was talking about, I believe, was more what we do for the institution as a whole, and we have an annual cycle that we go through. Today is what? April 29th today, something like that—

Tacey Ann Rosolowski, PhD
0:14:32.9
Uh-hunh (affirmative).

Leon Leach, MBA, PhD
0:14:33.0
—and we have our Rgent's budget is due by June 6, so that's put together through discussions at the executive committee. And there are probably about 200 variables now in that, but there's probably about twenty that are really the key drivers. And from that you can probably get down to a half a dozen that are really in conflict. So those key drivers—those ones that are most impactful—they are discussed at the executive committee level and then factored into the model, and we'll do some trend analysis for the others—this is what's been trending—and we'll adjust the trend analysis based on what we know is going to happen. For instance, this year we know there's going to be a two percent Medicare sequestration to start April 1, so that's a no-brainer. We know that managed care is probably not going to be paying as much next year as they are this year, so we factor something in for that, and we produce a one-year budge that is signed off by the executive committee, filed with the University of Texas, and approved ultimately by the Board of Regents usually at their August 4 meeting for the next fiscal year that starts September 1. Once that's approved and once we have the year numbers—you know, which typically the year end is August 31—and we'll have final accounting by usually the third week in September. Then we will take that one-year budget and roll it into what would be a seven-year

plan—this one-year budget plus six years. But we already have that plan. That model exists, and it already is populated with last year's numbers, but we also look at it quarterly, and I would say half the time we look at it quarterly and scratch our chin and say, "Oh, that's nice." And we don't adjust it because it's tracking according to the plan. If we see that there is some issue that's not tracking according to the plan, we'll address that and then we'll order the projections accordingly.

So we look at it quarterly. Oftentimes we will order it mid-year, and that will just filter through the whole modeling scheme for the seven years. And the magic behind seven years, one is that it's what the UT system asked us to do—the current plus six. But there is some logic to it because we've grown tremendously since I came here in 1997, and you can't grow if you don't have buildings and places to put people. So you've got to go out past three years. The first three years are usually, we've been highly accurate. You get out further, and it—you know—then your crystal ball gets a little foggier. But what you want to do is, it may take you three or four years to build a hospital as we did. So you start anticipating that and you start modeling it in well before you really need it so you can anticipate the financial effect and you can have the monies there when you need them.

And as part of that plan, there is something called the long-term capital plan, which is the funds that we use for facilities and major IS investments and that kind of thing, so that's all part of it. And then that's not to be confused with actually managing the budget, because once you set the budget, the idea is to manage to the budget and not let the budget just kind of happen to you, you know? (laughs) So all those go together to form kind of our financial planning system. The—you had asked if there was anything I wanted to mention. I guess a couple of kind of bragging rights type of things when it comes to the administrative side. In 1997 when I came here, the administrative cost that were—the business and regulatory affairs—took about fifteen percent of the total. And today's it's down to eleven percent, and we hope to get it under ten. Things like Resource One that are in the process of—it's been installed—in the process of getting it right.

Tacey Ann Rosolowski, PhD
0:19:18.6
And what is Resource One?

Leon Leach, MBA, PhD
0:19:20.6
It's a—basically a management information system that is fairly broad based. It deals with budgets, expenditures, human resources, that type of thing. As that gets implemented, that will help us get the cost down. It more standardizes what we're doing. You know, we've gone from—it's a matter of continuous process improvement where in 1997 it was fifteen percent of

the total. Today's it's eleven percent. A more interesting statistic—I mean, you can see the shrinkage here, but more interestingly—from August 31, 2008, to today, we actually have 200 fewer people in Business Affairs than we had in August 2008. So we've been able to manage that side pretty economically. And there's still more to do. I mean, I still—to me it's bothersome that we still take more than ten percent. I think we should get under that, and that's what our goal is.

Tacey Ann Rosolowski, PhD
0:20:28.0
So how did you identify the areas that needed to be cut in order to accomplish that?

Leon Leach, MBA, PhD
0:20:33.2
It's not so much areas that needed to be cut. It's areas that need to grow slower than what the institution is growing as a whole. There are several opportunities still. We have a very decentralized finance function where we have people that are part of the central finance area, and then we have folks who are embedded doing financial work in different areas, and maybe we could get better at standardizing that. We've had a number of innovations in facilities management. We've had a lot of innovations in energy management. Just how we go about buying energy these days is much more sophisticated than it was in 1997. So we're able to control costs on a variety of fronts. Purchasing—there are still opportunities there. We've done a lot of centralizing purchase functions where if you don't have a dozen pairs of—this is an example of where we haven't done quite as good—but if you have a dozen different brands of surgical gloves, and if you can get it down to a couple, you have more leverage with those couple of suppliers.

So we've done things along that line. There are areas where we haven't been as good because we haven't been as willing to standardize. So there's still—we could still get it lower. Some of our IS systems, because we did a custom IS system station. We were bearing the total brunt of the development costs moving towards a commercial product. Nothing is cheap in IS. They are expensive, but it's not to the same extent as doing it yourself or writing the code yourself. So that helps us in lowering that cost. Those are several opportunities that we're still pursuing.

Segment 19
B: The Finances and Business of MD Anderson
A New Economic Reality will Drive MD Anderson's Fiscal Future

Commented [T19]:
In this segment, Dr. Leach explains that the Affordable Care Act will drive systemic economic changes that will have a dramatic impact on MD Anderson's finances. He anticipates that the sister institutions and regional care centers will help bring in patients and that it will be necessary to continue to seek out cost-saving measures. Dr. Leach also states that the Moon Shots will eventually generate technologies that the institution can commercialize: the Moon Shots have already created interest from donors and philanthropy has increased. He explains that unlike previous financial fluctuations, the current economic situation represents a "sea change" in which the country is now saying "We won't pay so much for health care." MD Anderson's financial health is connected to the nation's limited resources, and Dr. Leach explains that the institution must continue to be "a good steward" to be successful.

Dr. Leach explains that, with the new financial realities, MD Anderson will become more patient-centered. He then explains that that the MD Anderson mission to cure cancer will carry the institution through. He anticipates that the institution will become a leader in looking at patient outcomes, noting that the world already has confidence in MD Anderson and that "we have what it takes to thrive."

Dr. Leach acknowledges that academic institutions are slow to change and speaks about anticipated faculty responses to the need to change. He then describes the shift in thinking that everyone at MD Anderson has to embrace in order for the institution to move forward. He explains the paradox of getting individuals to accept that "We're number one and you want us to change."

THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

Interview Session: 04
Interview Date: April 29, 2013

Story Codes
Story Codes
B: Overview
D: The History of Health Care, Patient Care
D: Fiscal Realities in Healthcare
D: The Healthcare Industry
D: Politics and Cancer/Science/Care
C: Healing, Hope, and the Promise of Research
B: Philanthropy, Fundraising, Donations, Volunteers

Tacey Ann Rosolowski, PhD
0:22:39.5
Maybe this is a good time to ask you about the Affordable Care Act and how you foresee that having an impact on finances.

Leon Leach, MBA, PhD
0:22:47.8
Well I—the—I doubt very much that it's going to get cheaper, and I doubt very much that people are going to be paying us more. There's nobody out there talking about paying us more, yet the regulations—the regulatory compliance that we have to comply with gets expensive. New patients coming into the system can be a real plus because these folks oftentimes have been coming in through the wrong portal. They don't have insurance, so they wait until they get sick and come to the emergency room which is incredibly expensive compared to going to the doctor's office. It doesn't impact cancer quite as much because then tend to come in through the doctor's office. But from the standpoint of the act itself, I think there are some opportunities for savings, but also Medicare really doesn't cover our costs. It pays about ninety cents on the dollar of our actual costs. So to the extent that we have more people that are covered but we don't get our full cost, that becomes a challenge. There is a phenomenon known as cost shifting where basically you bill managed care more to make up for what the government is not willing to pay, and managed care figured that out a long time ago. And that's the world that I came out of, and I knew that was true in 1997. I didn't realize the extent to which that actually happened, and I think managed are companies are going to get more aggressive in wanting Medicare-like pricing. Well, that's going to put more pressure on everybody. And it touches all aspects of MD Anderson, because we actually invest about $250 million a year in our own research. Well, if you're not able to generate that money out of the clinical side, you're not able to spend it. It's not just on research. It's on any capital items that we need. That's the way that we pay for it, so it can't—if you're not allowed to build that capital up, it's going to be a challenge to pay for those types of investments going forward.

So I think that it's going to—first of all, I think it is real. Here in Texas we like to pretend that it's not, but I can tell you it's real, and it's a matter of time. And it's going to drive change, and it's going to put a premium on being more efficient, and we've got to continue finding ways to do that if we're going to remain competitive force.

Tacey Ann Rosolowski, PhD
0:25:36.0
So what are some responses that you see coming to deal with that situation?

Leon Leach, MBA, PhD
0:25:41.2
Well, I see many of the things that we just discussed as far as regional centers, more of a national presence. I think that will bring more patient flow, hopefully more managed care patient flow too that would still be covering its expenses and maybe even a little bit more so that we can continue to grow and continue to build. I think you're going to see increased efficiencies. I think IS is an opportunity for that—changing to an off-the-shelf system. The clinical station did a lot of things that were designed specifically for MD Anderson. We won't have those developmental costs. Money will get spent in a different fashion because it will get spent to buy and install the system, but over the long haul that would be more reasonable than what we're doing now to try to save money.

I think there are opportunities in purchasing still where we have to get more agreement on certain items and drive better deals and perhaps not have quite the same latitude when it comes to choice. I think with the Moon Shots, there are apt to be technologies that come out of that that we can commercialize. Now this gets speculative, because I'm pretty sure there will be technologies that come out of that that we can commercialize. I don't think anyone is going to a physician and saying this, that, and the other thing right now. You know, there are still discoveries to be discovered and taken advantage of as far as being able to accomplish them and get them into the commercial market—which you want to do, because that's how you get it to the patient. That's the link to the patient. So I think there are opportunities there.

We had an incredible amount of support on the donor side. Former President [Herbert Walker] Bush—H.W. Bush—was very dedicated to this institution and really helped us in many ways. And Dr. [Ronald A.] DePinho [MD] has made that a priority. There are a lot of people that have been willing to help out. So I think that helps too.

Tacey Ann Rosolowski, PhD
0:28:05.0

Are you saying that there has been kind of a surge in donations and philanthropy as a result of the Moon Shots?

Leon Leach, MBA, PhD
0:28:11.8
Yes.

Tacey Ann Rosolowski, PhD
0:28:13.2
Um, okay.

Leon Leach, MBA, PhD
0:28:13.5
There's—I think it's a strategy that people are embracing. There are still a lot of—again, there are a lot of questions to be answered and research to be done, and it's not a—you know, you don't put a man on the moon tomorrow. That type of thing.

Tacey Ann Rosolowski, PhD
0:28:29.8
Right.

Leon Leach, MBA, PhD
0:28:30.7
But it has the potential to break through on these different types of cancers that we're looking at in that regard. So I think there are several opportunities that we have to ease the pressure. It's not going to relieve the pressure. I mean, the pressure is going to continue to be there. In 2008 and 2009 when we made some changes, that was more of a reaction to events at that point in time where today it's more of a sea change. Basically you can look at the Affordable Care Act as the country telling healthcare that we're not going to spend twenty cents out of every dollar to buy your product. You've got to come up with a way to do it more reasonably. And when you look at this nation versus any other nation out there—I mean the nations that have more developed economies spend somewhere in the twelve-percent range. We're spending almost double that. We're not quite at twenty, but we're not far under twenty. Rounding it to twenty is very reasonable at this point. So that curve needs to be met, and I think everyone recognizes that. It will be, in my estimation, a challenge for MD Anderson to bend that curve, because there is so much we want to do in the way of discovering a cure for cancer. And we don't have unlimited resources. We do have limitations on resources. And the country is in a similar situation—you know—the debt that we have and how much are we going to be allowed to finance innovative

things and accommodate the tougher world to live in. So that needs to work its way out. Anderson is well positioned, but we have to be good stewards.

Tacey Ann Rosolowski, PhD
0:30:51.4
What changes do you foresee coming to the institution culturally as a result of some of these larger responses to the financial situation realities?

Leon Leach, MBA, PhD
0:31:03.5
Well, I think that the world is going to want more of what I would call patient-centered care. And I think there is an argument to be made that a lot of what exists out there—and this is not just at MD Anderson, but it's been more what I would call provider-centric. And I think that the world is—or the United States is looking to change that. And I think when that—just the way we go about our multidisciplinary care is very patient focused. It's very patient oriented. So it's not that we're not doing things in that regard, but I think there is going to be more of a demand for that, more of a push for that. And I think those who are going to be successful will be providing that.

Tacey Ann Rosolowski, PhD
0:31:56.7
Do you see that connected up with the movement to develop more personalized care?

Leon Leach, MBA, PhD
0:32:02.8
I think it's all related. I think as we move to an era where you're looking at the genomics of a person and making decisions based on scientific evidence and we move away from some of the treatments that are—you know, chemotherapy was based on mustard gas. And we've taken that to such a precise degree, but what's the next wave? What's the next wave? I think there's going to be more of a focus on that next wave, because—being broadly described as personalized care. Now again, you're getting to the edge of my knowledge, because that doctor thing is not an MD. (laughs) So I don't want to get too clinical in my observations, because I'm not really equipped to do that.

Tacey Ann Rosolowski, PhD
0:32:56.9
Uh-hunh (affirmative). Sure. But I'm just—you know, I'm just wondering because a lot of the shrinking of resources, the way that roles within the institution are going to have to change, the way that some processes are going to have to change. That will translate into cultural change within the institution, and I'm just trying to visualize what that might look like in say five years'

time and seven years' time as the institution responds. How is it going to be different than it was ten years ago?

Leon Leach, MBA, PhD
0:33:31.2
Well, I think the commonality that hopefully will carry us through that period would be our mission and our core values. The mission again is to cure cancer. The mission isn't really to do research. It's to take the research that we do and cure cancer. We do have research-based clinical care. But that's kind of the minimum. You know—you've got to have that, and you've got to be able to apply it and look at the outcomes and be a leader when looking at the outcomes. There will be more and more of that and more care as they find what are reasonable outcomes. I'm confident that we're there for our faculty, and the world is confident in MD Anderson. You can see how highly thought of we are in the *US News and World Report* rankings—that we've got what it takes to be a survivor in, and more than a survivor, but to thrive. But it is going to be a different culture, and it is going to be more outcomes driven, more value driven, and more responsive to patients individually, patient's needs. So we have got to change with the times. And oftentimes academic medical centers have been a bastion of tradition. So I think there is an inherent conflict with institutions that are thought of as a bastion of tradition. I think Anderson is unique though in that we also have been on the innovative edge of curing cancer. So there is an element of both, but I think it is going to shift more to how we interface with the patient and the patient's experience in addition to our wonderful, quality-level, high-quality faculty that provide great care. That all needs to be part of the patient experience.

Tacey Ann Rosolowski, PhD
0:35:55.8
Do you see that there's going to be a different role for faculty in the institution as some of these changes come about?

Leon Leach, MBA, PhD
0:36:03.5
Well again, that's not really something that a business guy would put a prime on, but I think that just looking at the forces at play, it's almost inescapable. So I think it's up to the faculty to kind of define how that works for them individually.

Tacey Ann Rosolowski, PhD
0:36:28.6
I want to make sure that we covered everything that we needed to cover about the satellite centers. I don't think we talked about how it was actually decided to start doing that. Wasn't the

first one in Bellaire in about 1997, 1998? I was talking to Dr. [James D.] Cox [MD] [Oral History Interview] recently—

Leon Leach, MBA, PhD
0:36:50.4
We had a rad-oc center in Bellaire, and I believe it was about that era, but it was—part of it was looking at the services that we rendered here and just, how big do you want to get in one spot and have our people to come in? Isn't there a better—? Is there a better way to reach the patient? Then we went through our usual— On the business side, we went through our usual cleaning process, but it was more driven by executive committee and needs to get our services in the outlying areas. So there was a shift in thinking. And then maybe the most traditionalist position was along the lines of, well, MD Anderson care can only be delivered at 1515 Holcombe. Well, in today's world we can deliver it in Madrid with telecommunications that we have, willing partners that are like-minded. So I think it's just one of the examples of adapting to a changing environment, and I think that skill—the skill to minimally adapt to a changing environment is what's going to be at a premium for MD Anderson going forward.

And when you get down to, what does that mean for the faculty? I think it's going to be up to the faculty to more figure that out than somebody like me suggesting what they should be doing. But the tea leaves are pretty clear. You don't have to be a chief business officer to pick up the paper and watch the news at night and see what's happening in healthcare. So the worst possible thought we could carry into that is, we're MD Anderson, we're different, we don't have to change. And part of it comes with being number one. You're asking us to change, and we're the number-one cancer center in the world? Why would we change? Well, the world's changing, and if you want to remain that— It's kind of like, why do you want me to expand out of the buggy whip business? (laughs)

Segment 20
B: Building the Institution
The Story of the Proton Therapy Center (continued from Segment 16)

Story Codes
A: The Administrator
B: MD Anderson History
B: The Business of MD Anderson
B: Beyond the Institution
B: Industry Partnerships

Commented [T20]: Dr. Leach explains that the 2008 financial meltdown resulted in a financial situation in which MD Anderson was able to purchase shares in the Proton Therapy Center previously held by other investors at a very good price. He lists the parties that came together to form the unique public/private partnership financing the Center and explains what the Center means to MD Anderson.

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D: Fiscal Realities in Healthcare
C: Understanding the Institution
C: Professional Practice
C: The Professional at Work

Tacey Ann Rosolowski, PhD
0:39:22.9
I wanted to follow up on our discussion about the Proton Therapy Center too. We had started a conversation about that, and then around the time when you were beginning to talk about the economic meltdown of 2008, the conversation was cut off. So maybe we could resume that. So, what was happening in 2008—the meltdown—and then what was the impact of that financial situation on the proton therapy center?

Leon Leach, MBA, PhD
0:39:57.6
Well, there were a few things that happened in 2008. One was local. It was Hurricane Ike. Another one was a financial meltdown throughout the world. There was no real effect of either immediately on the proton center. The effect on the proton center was kind of tangential, because in the spring of 2009, Hitachi held a strong position financially in the proton center. Directions came from Japan to sell off non-core assets, and at that point Hitachi's stock was basically bought by us and by The Styles Company, which were our partners in that at a very attractive price. So we were able to seemingly gain more control but they actually looked to us to run it.

Tacey Ann Rosolowski, PhD
0:41:12.7
So why was it seeming—seemingly—?

Leon Leach, MBA, PhD
0:41:15.7
Well, we had a lot of control to begin with, more so than what a minority stockholder would have because we were going to actually man—you know—manage and staff and run the facility. So Hitachi had a high degree of respect for us. So it's not the same kind of transaction that you see in the business world when you buy somebody's stock, because we already had on a contractual basis rights to make a lot of the decisions there. So that to me is—that wasn't a big story. You know, the story about 2008 and 2009 was earlier in 2008, we were seeing productivity drop off. And there was a lot of—

Tacey Ann Rosolowski, PhD
0:42:06.2

You mean productivity in the institution?

Leon Leach, MBA, PhD
0:42:07.8
Yes, as far as seeing the number of patients that you're seeing. And there are some logical reasons for it, because it wasn't that anyone was working any less hard. They may be working on different things. They may be spending more time in their lab, spending more time on the educational side. But the clinic side is not as—didn't have as much through-put as it was. It was dropping off a bit, and there were some warning signs there that didn't go unnoticed. They were brought out, but they weren't— It was a slow deterioration. It wasn't a rapid drop-off. But couple that with the Ike that put us out of business. We also got maybe about 3 weeks' worth of outpatient visits. That may be 2 weeks, 3 at the most. So that was a bit of a financial hit. It was nothing compared to what happened to UT Galveston Medical Branch.

But then also there was the economic—worldwide economic meltdown. So those things put pressure on us to do a lot of what we're struggling with today as far as becoming more efficient. But they weren't sea changes. They were a perfect storm type of thing where elements came together coincidentally that caused a problem that we would have to address. So we actually laid off about 500 people and the faculty scheduled less travel and saw more patients. So we turned a financial corner quickly. I mean, within 6 months, amazingly quickly.

But those problems were not systemic problems within the structure of the system. They were a hurricane, international meltdown, and a gradual deterioration of productivity. Today you have a fundamental change in your environment that isn't a passing thing. It's going to be a permanent thing. So you have to— I think we're under a lot more pressure today to change than we were in 2008 and 2009. What we demonstrated in 2008 and 2009 is that we can change, and we tend to change in a fairly rapid fashion. So what I'm hoping that we don't have to demonstrate in 2013 and 2014 is the rapid fashion. Hopefully we can change in a systematic way and produce lasting change that will be appropriate for the environment. Those that don't will then be faced with having to change in a reactionary fashion, and whenever that happens it's always not as smooth for the entity.

Tacey Ann Rosolowski, PhD
0:45:17.4
How did—just to continue the story with the proton therapy center— What was the effect of MD Anderson being able to acquire all those shares, and then what happened next in getting the center to the point where it could open and function?

Leon Leach, MBA, PhD

0:45:31.4
Well it was already— The Center was open and functioning.

Tacey Ann Rosolowski, PhD
0:45:34.3
Oh, okay. I didn't—okay.

Leon Leach, MBA, PhD
0:45:35.8
Yeah, when 2008 and 2009 happened. But that was a situation, and I think the story there is more the various elements that came together to make it happen. You had MD Anderson, the University of Texas, governmental entity, educational. You had Hitachi. You had the Houston Police Department. You had the Houston Fire Department. Some of their pension funds were invested. You had Sanders Morris Harris [Group, Inc.] which was a— I think they're the largest Texas-based investment bank in Houston, or were at the time. They brought investors in—people like Nolan Ryan invested in it. He is a baseball player—

Tacey Ann Rosolowski, PhD
0:46:31.6
Oh, okay.

Leon Leach, MBA, PhD
0:46:32.2
—famous baseball player. So you had an unusual group that came together to make this happen. And it went through some challenging times but not really traumatic times. And it wound up a little different at the end, but it was still very much successful. What happened was with the economic meltdown, folks that had invested more from a venture type of—you know—the Sanders Morris Harris type of investors. They had a—what's called a put—that they could put their stock back to Hitachi, and Hitachi agreed to buy it back but only if Hitachi didn't meet certain deadlines. And they were actually tracking on schedule, and then everyone agreed to put in a different—it's called paintbrush technology. That was the short name for it. It's how the bean gets distributed. It's a little bit more efficient.

Well that wasn't quite ready for prime time, so they didn't get the facility opened across the board in the time frame they had indicated. When the meltdown came, some of the investors—The contract said you get your money back plus eight percent annually—I think it was eight percent. So some of the investors saw that as a way to balance what was otherwise a pretty dismal performance year. So a number of them put the money back in Hitachi and put the stock back into Hitachi. So Hitachi never wanted to be in the business. They wanted to build the linear

accelerator for the proton therapy, and suddenly they found themselves in a business that they weren't really looking to be in. And then later that year in 2009, the edict from Japan about unloading non-core assets gave us an opportunity to buy it on a very reasonable basis and consolidate ownership. So it worked very well. It's an example of how strange bedfellows can come together. You know, entities that you don't think of as normally working together—ranging from private investment banks to the fireman's and the police pension funds to University of Texas to Hitachi international corporation based in Japan—work together for the common good. That's really the story there.

Tacey Ann Rosolowski, PhD
0:49:11.8
Is that kind of unusual partnership a model that could be repeated or would be worth repeating?

Leon Leach, MBA, PhD
0:49:18.4
I think the concept can be repeated. The model is so unique that you're not going to find too many circumstances under which it's repeatable, but the concept of a public entity—the University of Texas—working with other types of entities I think is an excellent one. And it came to be—it came together really for the common good, because it gave MD Anderson leading-edge technology to address the future needs of cancer patients. So I think it came together for the right reasons.

Tacey Ann Rosolowski, PhD
0:49:59.9
What else does the Proton Therapy Center represent for MD Anderson beyond that patient-care mission?

Leon Leach, MBA, PhD
0:50:07.8
Well there's— We do research there, and we do— It's staffed primarily— It's staffed exclusively by MD Anderson doctors, but there are certain types of cancers that are more common in children. So it was not uncommon for us to see patients from Texas Children's. We have a relationship with them where they will basically send their patients to MD Anderson docs for certain types of cancer services. So that's, you know—

Tacey Ann Rosolowski, PhD
0:50:46.4
Is that kind of collaboration something that you feel the institution should be interested in cultivating? This partnership with—?

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Leon Leach, MBA, PhD
0:50:55.7
Oh absolutely. I mean, and this one is just more— You don't need a proton center on every corner. So if you have it, you find ways to work with the folks that don't. It's just for the best of humankind. And if you have a situation where you need this for a particular child's cancer, then— you know, you've got Texas Children's Hospital right next door—you find a way to do that.

Segment 21
B: Institutional Change
Streamlining the System

Story Codes
B: Institutional Mission and Values
B: The MD Anderson Brand, Reputation
B: The Business of MD Anderson
B: MD Anderson in the Future
B: Critical Perspectives on MD Anderson

Tacey Ann Rosolowski, PhD
0:51:30.1
I wanted to ask you just a few more kind of general questions. There was the— I remember you had mentioned a—yes— There was an analysis that McKinsey & Company did for Dr. DePinho after he arrived. I wonder if you could tell me why that study was requested and how the findings are being used.

Leon Leach, MBA, PhD
0:52:00.5
This is the administrative—?

Tacey Ann Rosolowski, PhD
0:52:02.7
Uh-hunh (affirmative).

Leon Leach, MBA, PhD
0:52:04.8

Commented [T21]: Dr. Leach describes the review of administrative processes conducted in 2012, shortly after Dr. DePinho's took over as president of the institution. He gives background on the review and explains why Dr. DePinho requested that MD Anderson perform it earlier than required. He describes the constitution of the committee in charge of the review and their recommendations: reducing administrative overhead and staffing, reducing redundancy in staffing.

Dr. Leach asserts that, despite the economically challenging times, the institution needs to continually invest in research to preserve what MD Anderson's leading thinkers and doers in care. Research, he states, is the "driver for who we are."

Dr. Leach repeats, however, that the institution must learn to operate differently or risk not being as robust as it is currently.

That was actually an edict that came out from the UT system, and there's kind of a history behind it. When chancellor—Francisco [Gonzalez] Cigarroa [MD] became the chancellor, he formed a small committee to look at what the UT system did and how they did it—I think it was five people on that committee—and give him recommendations on how he could streamline the UT system. I was one of five people on the committee. He took our ideas and implemented them almost across the board. There were a couple of things that were timing issues, but he basically did everything we recommended. And we didn't use an outside consultant. He made one available, or he said, "You can go get one." He made the funds available, but for UT system we thought we had enough knowledge on that committee to really deal with it. And it's a completely different animal than MD Anderson. There's no healthcare delivery involved directly.

So after that worked, between him and the executive vice chancellor of business affairs, Dr. [Scott C.] Kelley [PhD, MBA], they decided it was a good idea for the healthcare components to go through that. And they suggested one per year, and I think they were also putting their—the academic components, I think they were doing two or three a year on that. But you were to do your own review, and they kind of had a page and a half—if it was that long—outline of how the review was to be structured. It was pretty broad, but it had certain committee members that were kind of mandated by it by category.

Tacey Ann Rosolowski, PhD
0:54:08.2
So what sort of guidelines were they offering?

Leon Leach, MBA, PhD
0:54:12.0
Well, they were very broad as far as just who you have participate on a committee. They wanted to have a president of another healthcare component. You need to have a business professor. It was just very broad categories and maybe four or five of them in all. It wasn't really big. And so we were not scheduled to do— We were towards the end of the schedule. And I talked to Dr. DePinho, and we thought it would be a good idea with him coming in to kind of do this—volunteer to do this up front. So we volunteered to do it up front, and that was accepted, and we basically went through a similar process—or they went through at UT system. Only we did use an outside consultant—that was McKinsey, and we— The person that we had chair the group was a guy by the name of Joe [Joseph V.] Simone [MD]. I half kiddingly tell people that Joe Simone's claim to fame in life is that he was John Mendelsohn's boss at [Memorial] Sloan-Kettering. (laughter) So he's well known, and he's written a couple of books, and he's an icon in the cancer world. And we had Kirk [A.] Calhoun [MD] who is in Tyler as the peer group president who participated. We had Ron [Ronald A.] Williams who is the chairman of the board at Aetna. Well he's the former chairman of the board. He stepped down about a year ago. He was

president, and then he became president and chairman of the board. So he brought the payer's perspective. We had Osama [I.] Mikhail [PhD] who was a business professor at the University of Texas School of Public Health in their Healthcare Policy and Business Program. I think it's called Policy and Management Program. We had a gentleman who was the vice chancellor of Health Affairs at the University of Texas. He was kind of a financial type that they wanted to have appointed. And I don't know if I've covered them all. No, there might have been another member or two, but that was essentially it.

And we pretty much followed the— They were pretty brief. I mean, there was room—by design, there was room to kind of customize it to what you wanted to do. McKinsey's role was more of staffing the committee, if you will. But even there, they worked very closely with Dwain Morris and some of our other resources here at MD Anderson just to kind of tee it up and give the committee an independent arm. They wouldn't be relying just on Dwain just to tell them. So the process was relatively short to do that. I think we had— I know we had three, we may have had four committee meetings. They were basically once a month. They went pretty quickly. A series of recommendations, most of which we're in the process of implementing on the business side, a number of which we were already in the process of implementing in the continuous process improvement thing. They went from fifteen percent to eleven percent. We were already well down that road having less people than we had in 2008.

But the major finding from my standpoint was the—and again, this wasn't an ah-ha. This was well known. We have a lot of redundancy in staffing. You have your CFO that has financial staff. Then you have financial people in the clinics, and you have financial people in the research areas. And that could be much tighter. It could be standardized. They could report in line to the CFO instead of taking direction from people that aren't financial experts. Same type of issue in IS, only we had dealt with centralizing a number of the IS functions. There still are areas that we haven't centralized. But that was met with more push back, if you will, because it's kind of, yeah, we need to save all that money, but you're not taking about my administrative perk, are you? (laughs) So you get into that a little bit. So it's been productive. We have saved money on it. There's still more that we can do.

Tacey Ann Rosolowski, PhD
0:59:21.8
So this was primarily on staffing issues then?

Leon Leach, MBA, PhD
0:59:24.7
Yeah.

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Tacey Ann Rosolowski, PhD
0:59:25.0
Okay.

Leon Leach, MBA, PhD
0:59:26.3
And as administrative staff, but— Well, people commonly think that, well that's the way I'm made. Well, I have maybe sixty percent of them. I do have the majority. But there are a bunch that are embedded—the IS and the financial people—in other areas, and they may or may not be getting the direction that they need on the technical—the finance and the IS. Also on the finance end particularly, we wind up having people in Dwain's area checking on what the people— You obviously have checkers checking on the checkers. So there are inefficiencies there that we need to get at as an organization. We haven't taken a big enough bite of that apple yet.

Tacey Ann Rosolowski, PhD
1:00:14.1
It sounds like a really slow process to unravel all of that.

Leon Leach, MBA, PhD
1:00:18.6
Well, it has grown and— It is. I mean, it's grown up out of kind of perceived needs, and frankly a lot of the IS got recentralized when it was perceived—this was before I got here—when it was perceived that central IS wasn't responsive. When I got here, we had a dozen e-mail systems—people putting in their own e-mail system. You know, wow, come on guys. You know? So we have driven up a lot of that. That's why it went from fifteen to eleven. There are a lot of things that we did do.

Tacey Ann Rosolowski, PhD
1:00:57.5
Well, I always say that people don't set out to be inefficient. There's usually a reason why.

Leon Leach, MBA, PhD
1:01:02.0
Yeah. It evolves into that oftentimes. And there's a lot of what we're being asked to do in compliance, that you may not have a system to do so you kind of string something together. And it's hard to justify. You want to be compliant, but my God, do we have to hire four people to do that—or whatever? So yeah, things evolve for a reason. So it was a good time, we thought, to take a look at it and try to put things together and tighten things up.

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Tacey Ann Rosolowski, PhD
1:01:41.4
I guess I just have a few more questions left. You've already talked about what you think will insure MD Anderson's health in the future in terms of being nimble and responsive to the environment and willing to do that work of changing. If MD Anderson is able to do all of that, what do you thing the MD Anderson's name will mean in seven years or ten year?

Leon Leach, MBA, PhD
1:02:18.6
One of the reasons we need to be nimble and we need to be efficient is so we do have the funds to continue to invest in Moon Shots or in technology that's going to drive the future. So I think there is a window through which we have to do all of this to keep the MD Anderson persona that we have today—who we are—and we're leading thinkers and doers in cancer. The world is changing. If we don't change, I would argue before it— We know the world is going to more efficiency. No one is talking about paying us more. A lot of people are talking about paying us less. We need to get ahead of that curve and be there so that at the end of the day we've got enough money going through to continue investing in our research, which really is the driver of who we are. Because that does get translated into care for the patient.

So I think it's possible for MD Anderson to continue being at the forefront, but we have to do things differently if we're going to do that. There is some risk that we can be—if we're not responsive—we could become pushed into an entity that is not as robust as we are today. As Cancer Centers of America and others, they might preclude certain patients from the ACO. It may preclude certain patients that we need for our research to keep that base large. So to the extent that we can be out in the suburbia or have regional operations, I think it enhances our ability to get the kind of patients that we need for the medical research that we do to move cancer ahead.

So it is about the mission. It is about being nimble. It is about reading— I've heard this quote attributed to Gordie Howe and Wayne Gretsky. Do you know those two names?

Tacey Ann Rosolowski, PhD
1:04:43.6
The names are familiar, but I'm not a sports person. (laughs)

Leon Leach, MBA, PhD
1:04:46.7
They are both hockey players.

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Tacey Ann Rosolowski, PhD
1:04:47.2
Oh, okay.

Leon Leach, MBA, PhD
1:04:47.6
They're both really good hockey players. And both of them claim that their strategy is to skate where the puck is going to be. If you stand around and see where the puck is, you're not going to be there any more, you know? (laughs) So I'm trying to get MD Anderson to skate where the puck's going to be. And you're not the first blank face that I've used that analogy with in Texas. (laughter) If I could only come up with something that had to do with longhorns. (laughter) It might work a lot better.

Tacey Ann Rosolowski, PhD
1:05:15.1
Or a lasso. (laughs)

Leon Leach, MBA, PhD
1:05:16.9
Yeah, exactly.

Tacey Ann Rosolowski, PhD
1:05:17.5
The lasso's got to be where the steer's head is going to be.

Leon Leach, MBA, PhD
1:05:19.7
Yeah, exactly. (laughter) You've got to kind of time things. You've got to care when a steer's going in. That's a good one. I like that. (laughter)

Tacey Ann Rosolowski, PhD
1:05:26.4
There you go. I helped you out. (laughter)

Leon Leach, MBA, PhD
1:05:29.0
Now if we could only find where Will Rogers or Gene Autry said something to that effect.

Tacey Ann Rosolowski, PhD

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1:05:32.4
There you go. I'm sure somebody has to say it. (laughter) Physics works in every field.

Leon Leach, MBA, PhD
1:05:38.6
Yeah.

Segment 22

A: The Administrator
Communicating the Need to Change

Commented [T22]: Dr. Leach talks about how he communicates with faculty and staff at MD Anderson about the need to change. He explains that he has been influenced by Harvard leadership specialist, John P. Cotter, who wrote a book called *A Sense of Urgency*. Dr. Leach explains some basic concepts from the book, then describes how he goes about talking to heads of departments and divisions to create buy in from leading faculty members who will disseminate the message.

Story Codes
A: The Administrator
A: Career and Accomplishments
A: Influences from People and Life Experiences
A: Contributions
C: Leadership
C: The Value of the Oral History Project
C: Professional Practice
C: The Professional at Work
A: Professional Values, Ethics, Purpose

Tacey Ann Rosolowski, PhD
1:05:38.9
Well I wanted to give you the opportunity to say anything additional that you may want to say. If there are any more bragging right things you want to add at the end or other comments you'd like to make about—

Leon Leach, MBA, PhD
1:05:50.2
Well, I just wanted to thank you for taking the time to do this. I think what we have experienced—the history of MD Anderson— There's a lot of things we did right. There are some things that maybe not so much. But all we did, we learned from, and we should learn from. And I think that will help us to avoid mistakes of the past. But I think it's a marvelous institution. I have enjoyed my sixteen years here and look forward to many more. But I think it's going to be a lot more challenging, because the world is changing, and it's hard when you're the best at what you do to see the need to change. And that's kind of my concern is that when you say being

nimble, and you're 20,000 people nearing $4 billion in budget, it's hard for something that big to be nimble. And yet it's our game to lose. We've got the resources to do this, and we just need the will.

Tacey Ann Rosolowski, PhD
1:07:11.7
Are there specific strategies that you're using right now to communicate the need for that nimbleness and the need for change?

Leon Leach, MBA, PhD
1:07:19.5
Yes, if you give me a second, I'll go up there and get it for you.

Tacey Ann Rosolowski, PhD
1:07:22.4
Sure. (laughter)

1:07:26.0 (End of Audio 1 Session 4)

0:00:00.0 (Start of Audio 2 Session 4)

Leon Leach, MBA, PhD
0:00:03.6
This book probably expresses it best. It's called *A Sense of Urgency* by John [P.] Kotter. John Kotter is probably the guru on leadership at Harvard University, well written, well read. The book is an easy read. It's an airplane flight. You can get most of it done on an airplane flight, and it's entitled *A Sense of Urgency*, but it's as much about frenzied urgency and the things that bracket a sense of urgency. On one hand, you have complacency. On the other, you have frenzied activity. The frenzied activity is, the rubber is not meeting the road. You're running around trying to get things done, and you don't have a plan, but this sounds like a good idea. Let's go do that. Complacency is, I've already got a full clinic, and I don't entertain anything new. I don't want to change anything. I want to keep doing what I'm doing. A true sense of urgency is somewhere between those two, recognizing the realities and moving in a prompt, nimble fashion to address them, and the book probably explains that better than any I've read. What I'm doing is, do I have a plan? My plan is to try to educate others to the need to change, because we're living in a world where—and he talks about this in here. When you're the biggest and the best, why would you change? I have a series of dinners where I'll take three faculty out to dinner. I won't bring the book with me, because it gives them something they have to carry, but I'll get the book to them afterwards, and I'll talk to them about what's going on, a lot of the stuff

that we talked about. Not so much the history—and some of the history of 2008 and 2009, because we have been through this before, or a version of this.

Tacey Ann Rosolowski, PhD
0:02:08.9
I was going to say, it's kind of interesting. As rotten as 2008 and 2009 was, it was sort of a testing ground.

Leon Leach, MBA, PhD
0:02:15.3
It was a testing ground, and when we came out of it we were so efficient that we topped off the Pickens fund, half a billion dollars in about three years. We can do it. We did it. It's scarier this time around because these are permanent changes that are happening in our healthcare, where back then it was a perfect storm.

Tacey Ann Rosolowski, PhD
0:02:41.9
Responsive to the situation.

Leon Leach, MBA, PhD
0:02:44.5
Yeah, three unique situations came together that caused that. It's a quick read. They get a free dinner out of it, and these are the leaders. These are the faculty leaders, because it has to be at that level that we drive change. I could stand up on the pulpit and preach all day long, and unless folks out there decide to embrace it and drive change, it's not going to happen.

Tacey Ann Rosolowski, PhD
0:03:15.2
Who were some of the individuals that you're speaking with that are going to take this down farther into the ranks?

Leon Leach, MBA, PhD
0:03:21.0
I can tell you who I'm having dinner with tomorrow night. It's basically division heads and department heads. Well, I can't tell you because I don't—my iPad or my iPhone is in the—but it's Paul [F.] Mansfield [MD]. It's generally department heads. It's the most influential thinkers among the faculty level, among the faculty leadership, and it's kind of randomly picked. I do specifically the four subdivision heads, some department heads and some people that are what I call rising stars. They're getting engaged and want to help change MD Anderson. Some people I

don't pick only because when Jack [D.] Stobo [MD], who tried to make changes at the Medical Branch—I interviewed him kind of like this for my PhD, and I asked him what he would have done differently, and he said he spent far too much time with people that didn't want to do this and were naysayers, and he was never going to convince them. He should have spent a lot more time with the people he was going to convince. It's not that I won't spend time, but if someone has got their mind made up, I'd rather spend time with somebody who doesn't that might see the logic, and this is not a soothsayer type thing. It's reality, and it's happening more and more. Not so much in Texas but—and you're seeing it happening here. St. Luke's decided to sell their hospital because of the changes that were coming. Catholic Health Initiatives out in Denver, they're a national player. They know how to do ACOs, and they know how to make things more efficient. You've got Memorial Hermann that's getting more and more into that business. Methodist is strong. They're a bastion. It's not clear to me—unfortunately they're moving in to that arena, but the change is going to happen. Even though it's not happening first in Texas, it doesn't mean we won't be immune to it.

Tacey Ann Rosolowski, PhD
0:05:43.8
What do you think the—what are the—how do I say it—resistance points among the faculty that you anticipate, and what are the things that they are more easily going to embrace?

Leon Leach, MBA, PhD
0:05:57.2
Some of them we already talked about. "It's fine but not my administrative part." I think some of them they will embrace, and this will be a variable. Some people, as we change to a new system—an off-the-shelf system—you're going to have some people that will embrace that. You're going to have some people who say, "You know, I really liked ClinicStation. I don't know why we ever moved away from it." You're going to have a variety of reactions to that. Some people just won't like the new because it's new, and they have to change. Probably the most common complaint out there, it's, "We're back to different compliance, and isn't there a better way? Isn't there a more streamlined way?" Well, the problem with compliance is you have to comply.

Tacey Ann Rosolowski, PhD
0:06:45.7
And compliance in what area? Because there must be a whole range of them.

Leon Leach, MBA, PhD
0:06:48.9
It's primarily regulations are in place upon us by governmental entities.

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Tacey Ann Rosolowski, PhD
0:06:56.8
And this isn't just institutional review boards and regulation of research but other things as well.

Leon Leach, MBA, PhD
0:07:01.9
It's part of that. It's part of that. There are some challenges with HIPAA as far as making sure you're in compliance, but you have to dot the i's and cross the t's. Can we more systematize that? Perhaps. But it's not going to go away, and it's not going to get to be a piece of cake. Compliance is compliance. You have to comply. But that's fairly common, and I wish we could wave a magic wand and make it go away, or we could at least wave a magic wand and make it very systematized. The concerns will be pretty much all over the place depending on what is that particular faculty's view. If they came from a place that used one of the systems where we were down to two systems—and I don't want to mention their names—but if they came from a place that happened to use one of those, whoever the winner is, they'll probably be fine. If they were just now getting used to ClinicStation after years and years of dictating medical records and doing it all manually and here is another change, they may not be fine.

Tacey Ann Rosolowski, PhD
0:08:27.3
They'll have to shift. Well, thanks for answering that.
Leon Leach, MBA, PhD
0:08:32.8
Thank you. That one is yours.

Tacey Ann Rosolowski, PhD
0:08:34.5
Thank you so much. Thank you, and thank you again for your time today. I know it was an extra session, so I appreciate it. I know how busy you are, especially with the budget due.

Leon Leach, MBA, PhD
0:08:44.3
I look forward to reading it over, or if you have any further questions, you know where I am, so don't hesitate.

Tacey Ann Rosolowski, PhD
0:08:51.7
Thanks Dr. Leach.

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Leon Leach, MBA, PhD
0:08:52.7
Thank you. Have a good day.

Tacey Ann Rosolowski, PhD
0:08:54.0
And I'm turning off the recorder at 19 minutes after 4:00.

0:08:57.4 (End of Audio 2 Session 4)

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