

Respondent Response to Fact-Finding Questions

Employee Relations Investigation File

Employee Name: Tarek Salaway

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Position: EVP, CEO Health

Department: Hospital Administration

Investigator: Genevieve Krietemeyer

Witness: Angie Sklenka

Statement Date/Time: March 12, 2026 – 7:30 p.m.

Location: Virtual, Teams

Number of Interviews: One

A) Opening, Scope, and Ground Rules

Process & Expectations

- “Today’s meeting is a formal fact-finding interview. I’ll ask about several events and communications. We looking to get to truth and facts. At any point in time if you need a break, please let us know.
- First, I want to express a thank you for your continued professionalism at a time that is particularly challenging.
- At this time, I also want to stress that I value our working relationship currently and on an ongoing basis. My questions today may seem cold, please know that I am trying to remain objective throughout this process so the questions are designed to be generic and to provoke thought – so that we can come away from this meeting with facts.
- Where possible, I will be leaving names of individuals out so as to provide some level of anonymity through this process.
- “Just as a quick confirmation, since we last reviewed confidentiality expectations, have you had any follow-up conversations with others about these topics?” – No

B) Entry Questions

Question: For the record, what is your role at OHSU?

Response: The role of CEO of OHSU health and my primary responsibility around the quality, safety and delivery of care across the OHSU health system That includes the provision of services and quality of care delivered to patients and families/ loved ones. Working with faculty, School of Medicine and hospital staff on improving quality, patient experience, financial performance and patient flow / patient access. It also includes working with university leadership on health system fundamental links to the rest of the university.

Question: What are your first impressions of OHSU and the people?

Response: A lot of committed people, and front-line people. People are there for the right reasons. I see that there is a good esprit de corps on patient units within their teams. Huge opportunity to share information with multiple constituents. Faculty are incredibly talented and commitment. The relationship between health system and faculty in the SoM – needs a lot of developing, and I have demonstrated my commitment to that. Faculty, physicians play such a huge role in the organization. Understanding their needs, roles and priorities – fundamental building blocks of partnership to help move the organization forward. I feel like I have done a good job building those relationships thus far – such as with the chairs of departments and with Nate, the Dean of the SoM. Real important building block to work with faculty leaders to build trust and shared understanding of strategic priorities, as fundamental to my role. In addition, I recognize in the short time period that there is a history of distrust and even animosity among leaders in the hospital leadership team. This has been evidenced by a lot of criticism I am hearing is happening against one person in particular – Brooke Baldwin. And also concerningly, the denigrative and discriminatory remarks towards Donn Spight – unfair and unwarranted.

Renee desires to have the role she used to have – external facing vs internally facing addressing quality. She feels unheard if she doesn't get to dedicate more time to external facing and broad externally constituents across the university, instead of focusing deeply on patient safety, quality and risk prevention (something she was counseled on frequently by my predecessor). I am still evaluating this as I go forward.

Brooke L has been a great contributor to the organization, she has been committed to her team. I respect her passion, especially ambulatory. I was very sad when she told me she was leaving. I had asked her to step up to take on a leadership role to run Hospital Admin meeting – for a 6 month, which is something new our team hasn't done before. This was a means to establish greater connectivity of the CEO Exec team weekly huddles (focused on Quality/Safety, Care Experience, Finance and Pt Access/ Pt Flow) to the broader hospital admin team with Brooke L. playing a leadership role for 6 months; to great greater organizational alignment and voice of the front line leaders in hosp admin group in shaping our priorities. We had a conversation prior – leadership skills/coaching needed to be a well-rounded leader, including development to be a well rounded COO. Since then, the announcement of her departure, there has been a lot of whirlwind. I am not sure what it's going to take collectively for the culture that is fraught with the lack of trust. After Brooke L's announcement of her planned departure, I asked Brooke B. to take the same responsibility for the Hosp admin team meeting for 6 months (as mentioned above).; however, in

response, I am receiving (un?) warranted complaints that Brooke B is “expanding her scope” across OHSU health.

I am learning there is disproportionate resistance to certain people, with certain potentially concerning undertones I am picking up on and will elaborate further in subsequent sections below. That is why I have been having a lot of conversations with HR executives and others executives on those topics, related to trust and change management.

C) Alleged Threatening Language or Gestures

Question: You expressed yesterday that you do not recall ever using the word “cut” or making gestures related to slitting of a throat. Can you share some context as to how this perception may have come about?

Response: I have thought through this in a deliberate manner. I have provided a detailed summary in my written documentation (submitted on 3/12/26) as follows:

On 3/10/26

I had returned to my office from a well done joint strategic planning retreat I had helped to co lead. CMH- OHSU Strategic Retreat” at approximately 11:15 am.

Tionna was out for the past 10 days on PTO, so when I saw her I said with excitement:

“Tionna, Tionna, Tionna. So good to see you!”

“Do you want to connect? Great.”

She came into my office and I shared with her important updates.

(For background context, as Exec Assistant to the CEO, over the last 2.5 months, she has provided me tremendous insight on team dynamics, individual leaders, past experience of prior CEO’s with individual leaders, in her objective to give me wider context and history that I otherwise don’t have. In her role she is expected to handle sensitive matters and related personnel information or documents. In addition, when I tried to retain Tionna and reclass her position with professional growth in a domain of hospital business as a project manager, she shared her insights (some unfavorable) on individual leaders on the team, whom I had recommended as leaders related to this potential new position I would create for her career path).

I shared with her. “So much has gone on. I’m so concerned because as a whole the team is swirling and I didn’t realize how bad the lack of trust factor is amongst each other. But it’s bad. And also now I realize how much is being stirred up as Brooke L has announced her departure. None of this I would have expected.”

I continued, “I’m getting non stop critique of Brooke B, which feels like an agenda, with no sense of patient safety focus as a framework to consider. I even experienced dismissiveness of Anthony M. and Brooke L. trying to force me to put Brad in situation that looks bad, where Brooke L is trying force me to take Brad away from Respiratory, rather than her willingness to have Brad work in partnership with Anthony, who is an established clinical leader at OHSU. When it doesn’t need to be an ‘either or’ situation at all, in my opinion.”

I further continued “And then, worst of all how quick she was to denigrate and belittle Donn (Dr. Donn Spight) and his role. I was so upset about this. Pt experience does not even report to Brooke L and she is telling me “What business does Donn have overseeing care experience. I mean really Donn???” I was so shocked. And you want to know what also upsets me about this, besides the flagrant dismissive and belittling of Donn? Is the fact that there is a lack of executive function if someone misses one fundamental link: the essence of health equity is patient dignity. (health equity is what Donn is known for; and comments like this show me they want to keep him in that narrow box, let alone acknowledge its core connection to our mission and patient experience)¹. Pt dignity and Pt experience are one in the same and go hand in hand. Plus, she wasn’t the only one to do this to Donn. Renee was willfully or blatantly ignorant to see the link or merits between Health Equity and Pt Experience, when she was simply lobbying it to go back to her, without any credit or leadership recognition of its value directly linked under Donn: Health equity and patient experience.^{1,2} And now she’s trying to rush me into making rapid personnel changes for her team (promotions to VP) before she goes, only for me to learn later what potentially massive impact it would have on The SOM, all the DA’s and everyone under Elaine. And if I do that, it could seriously harm our working relationship with Nate and the entire SOM. Thus, more people swirling across those under Brooke and then all the folks under Elaine once they get wind of this”

I said “many have asked me if it’s better if she’s out sooner (Brooke L)? To avoid all this collateral damage”. I further stated that where I am now is I’m thinking we just hold a few weeks and do nothing, no changes, until she is out after her last day, before we make any changes.

In this conversation the only hand gesture I could have possibly made is the one similar to baseball umpire gesture when they take their hand with thumbs up from their side to above their shoulder, as in, “strike three you’re out.”



As in:

At which point Tionna said to me, “do they not realize your role? You can make any org change you want.” To which I said, I know, but it’s all about the approach we go with.

¹ By tacitly and verbally belittling Donn and questioning his qualifications and abilities to lead care experience (or to even ignore them) is a racist trope that implies he is here as a “token”, focusing only on health of communities of color. This widely recognized racial microaggression is harmful and perpetuates systemic inequalities with lasting negative psychological and professional impacts on the recipient, in this case: Dr. Donn Spight.

² Given the unsolicited disparaging remarks about Donn I had heard from Brooke L. (on 3/5/26 at approximately 6:54pm telephone call re. Org changes for ambulatory), I had given it thought, and reach out to Angie S. and Angela F. (with Angie’s recommendation). We connected on 3/8/26 at approximately 2:19pm, where I shared what was said about Donn by Brooke L. and how concerned I was about the dismissiveness and belittling from Brooke L., as well as the willful ignorance by Renee, related to Donn and his care experience duties. I can provide more details of this escalation of concern conversation with Angie S and Angela F as needed.

I then said "So that's what's been going! How are you? How is your family? I know you just went on your trip. I hope your family is doing a lot better than this one" (referring to our exec team).

Tionna replied "OMG, did I tell you about my daughter? The older one is really giving me a run for the money now that she's been living home". Tionna went on to tell me how she's been frustrated with her daughter and really wanting her to take responsibility. She went on to tell me how she had gone out to dinner with Julie just the other night and when she got home, her daughter mockingly asked her. "OMG, WHAT are you wearing???" as if to mock her. At that point Tionna expressed her frustration and said to her daughter, "OK, that's it. You're gonna go out and learn how to make some money! You're going to go Door dashing for the next 3- 4 hours. I don't care how long it takes to get a customer order, but you're doing to do it". She went on to tell me that her daughter said she didn't want to go out alone so she was going to wait for her boyfriend to come to town to ride with her. (her boyfriend lives a few hours away). Tionna went on to share how ironically funny it turned out to be. She got a call from her daughter while door dashing who said she's been waiting for a few hours and finally got an order for a pick up from 7- Eleven. The order was for a slurpee. Not knowing fully how door dash works, she shared that her daughter went in to 7 Eleven and actually paid for and bought the slurpee with her own money and then delivered it. So with her small driver payment from doordash, less the expense of (mistakenly) paying cash for the slurpee when she was supposed to pick it up from 7 Eleven, less gas, she ended up losing way more money from the whole experience. Tionna was in a jovial mood laughing as she was trying to make light of a stressful situation. So I smiled as she told the whole story and then grinned and said OMG, you're kidding?!"

Knowing I had to go to our next meeting, she said "Oh I want to show you the map. She said with excitement ". (referring to the Map of Oregon I had requested). There was a large frame box sitting against the wall in my office. I said, cool, I saw the box earlier and I was excited. We pulled the cover off the frame and she was showing me the type of frame and grid the framer used and she said "I think you're going to really like this". To which I said upon us pulling the cover off of the frame, "oh I see, it's the gridlines, that's actually is pretty cool! I like it!". She then asked me if I wanted her to put it up, to which I said while holding the frame and saying "it's pretty heavy, it's not a small picture frame; I think you would need a stud finder to hold it properly and securely on the wall and balance it given the weight, and so, It's probably better for the guys to do it, the facilities team."

I then added as I was leaving, "Hey, are you sure you won't reconsider and stay????? What if it is a role like Tim Kreiger?" to which she smiled and then said "let's talk later". As I headed out for the 11:30 am meeting.

I do not use "cut" language nor would I ever express the concept of cutting anyone or anything for that matter. That is not in my repertoire, nor my spirit of how I work or think. I reiterate that I do Not have violent thoughts or any type of violent or "cutting" feelings toward anyone at all, including Brooke Lippincott, as she is someone I have thought highly of, have been having direct conversations about her development with her and steps for readiness to be COO. If this was somehow misperceived, I will apologize profoundly, as that is not my style intent or being. Just a few weeks ago, I even asked her to take on a key leadership role for a dedicated 6 month period leading our whole hospital admin team meeting (every 2 weeks) to link the Exec CEO Huddle focus area work (Quality/Safety, Care Experience, Finance, Patient Flow / Patient Access) to the hospital admin team structure as a coordinated working group. In addition, even after receiving notice from Brooke L, I have stated to her and in her team meetings, "if someone ever wants to change their mind, that always welcome, as life always has changes". There are several witnesses to these statements as well. (Notably, after I received notice from Brooke L., I asked Brooke B. to take on the 6 month leadership assignment for the hospital admin team meeting, since Brooke L is leaving, which then resulted in lots of allegedly negative comments about Brooke B. increasing her scope within OHSU health and that perception causing alleged consternation). For someone to characterize me as violent, when I am clearly

*expressing concerns about explicit bias and racism, is also a concern and speaks to a larger pattern of behavior. Similar to the history of the gross mischaracterization of the Provost*³

D) Alleged Violent Phrasing

Question: “Have you ever said, or joked, that you would physically harm a colleague (for example, by strangling or cutting), or used language that could be perceived that way? If yes, when and in what context?”

Response: Never ever in my career ever, or in my personal life. I don’t ever have thoughts of strangling. And the only cutting I have ever discussed is cutting fruits, chicken or meat for meal prep, or branches in landscaping projects.

E) Alleged Descriptions and Derogatory Terms

Question: “Have you ever used labels or profanity (e.g., ‘gaslighting,’ ‘asshole’) to describe a colleague or their impact on an organizational change? If yes, what words did you use, and in what setting?” If no, do you have any context that can shed light as to why this perception may have come about?

Response: In reference to gaslighting, I used this as a description of what Brooke L. was doing to Dr. Donn Spight in her conversation with me on 3/5/26 at approximately 6:54pm⁴. She shared with me, unsolicitedly, “What business does Donn have overseeing care experience? I mean really Donn???” reflecting her position on care experience and questioning why it was reporting to Donn. I escalated this concern with Angie S. and Angela F on 3/8/26 and used the word “gaslighting”. I shared that it was gaslighting of Donn – implying he was in over his head or had no business being involved in care experience. Gaslighting has been used in reference to how Donn has been treated. I go on to further explain the racist trope involved in this questioning of Donn⁵.

I have not used the word “asshole”. I could have asked the following question, “why would someone be an a-hole to Donn?; I can’t even comprehend this”. (again use of word “a hole” not

³ see page 10, Footnote 6.

⁴ My primary purpose in calling Brooke L. was to affirm her recommendations for ambulatory. That Angeline Hill would be her preference. I asked about Yen Pham for ambulatory (not just professional services). She reaffirmed Angeline for ambulatory (only); I asked if Angeline would be the best person to keep the momentum of the amb. Care team and the leader they are seeking to follow, to which Brooke L. affirmed.

⁵ see page 4, Footnote 1.

“asshole”). This would be a question reflecting my shock and chagrin about treating an esteemed colleague and surgeon I admired, Dr. Donn Spight, in such a way.

F) Allegation regarding Motive Attributions

Question: “Have you stated or implied that a departing colleague was leaving because they are fishing for a higher role? If no, do you have any context that can shed light as to why this perception may have come about?”

Response: Out of the blue she (Brooke Lippincott) asked me if I was going to post the COO role. This was about 4 days before I received notification from her about her planned departure. She said: “I was being groomed to be a COO”. I thought that was weird, and did not realize she was going to give me notice, nor did I expect someone to ask me about the COO position so soon. I told her, first we want to recruit for our CFO so we know what skills they have. So that we know what skillsets we need. Have to get clear on what COO, CFO works on. No, I am not ready – think it is going to take some time. After I got notice from her – many leaders asked me, why do you think she is leaving. I responded with: “looks like it is a big attractive job at Peace Health over several states” Comments made are that Peace Health is so messed up, why would she go there? I know she wants to be a COO, she expressed strong interest and I think she can be developed for that, but we want to recruit our CFO first.. Numerous people wanted to get into this question, and if I didn’t share what I actually thought they would think I am hiding something. Regardless, I made serious attempt to retain Brooke L. with strong assistance from Angie and Abby C., presenting a serious financial package retention proposal for Brooke L., which she ended up declining.

G) Allegation re: Professionalism in Meetings: Public Comments in Group Settings

Question: “In a group meeting where a participant asked a basic operational question, was there conversation/ remark made about taking their KP pass away? and did you laugh? What was your intent, and how might others have perceived it?”

Response: I know exactly when this happened – in our newly reformatted executive huddles, first quality presentation, talking about the A3 format. Clea was mentioning tools you use when you work with Lean A3 process improvement. She mentioned Kcards (referring to [Kamishibai card](#)) as part of Lean methodology people have used and she referenced K cards in this discussion. It is a visual method, how you show evidence-based performance to show it is tracking. I shared that I am familiar with those, as it was all over KP (Kaiser Permanente) extensively. Brooke L. turned and said: “I don’t know what Kcards is”. That’s when I thought, is she being serious? I said, “oh my gosh, this has been so KP (Kaiser Permanente) for so long, I know you know what it is. Given how much you know and share from your extensive KP experience to colleagues”

I was trying to lighten the mood I when I said smiling (not laughing), “should you turn in your KP (kaiser permanente) card”?, as it was such a KP thing. And she had several years at KP that she made us all aware of. The next day, she told me in a 1:1 and gave that she was upset about the kcard comment. Tarek apologized immediately and said he was trying to make light and lighten up the comfort level in our team. Tarek told Brooke: “Please accept my sincere apologies, never meant anything to be disparaging.” He explained that he was making an attempt to bring light into our meeting with a sense warmth and closeness. By no means was this intended as an insult. I apologized and thanked her profusely for coming forward. This occurred in her office. Sitting down face to face. “Brooke, please know I care about you, think the world of you. You have huge upside potential and a huge career ahead of you” I said it a very sobering and sincere tone, I am so mortified that you would think I think that about you. I was very clear with her that I was trying to make light of K cards being pervasively in KP. You are a Very important leader on this team.

H) Filtering and Judgement for Executive Level Leader

Question: “It’s alleged by a Traveling nurse that you discussed potential legal matters or investigations involving clinicians with them? If yes, what was shared and why?”

Answer: That is not true or accurate. There is a cath lab tech (not a nurse) that lives in the same building as me. I take my dog out often so when I encountered him in early January, he introduced himself. He went out of his way to introduce himself. He shared with me that the landlady told him about my role at OHSU. He was trying to be nice and warm. I also talked to another nursing Traveler in the hospital around the same time. I know some of these roles are very specialized and hard to fill, and as a CEO I am always interested in speaking with travelers to see what drew them here and what we can do to convince them to stay, particularly in our highly specialized departments.

I asked as I would usually – tell me about your department; what’s the esprit de corps?. I know Cath lab techs are specialized, hard to recruit. This guy’s home is in Arizona, he shared, and working here 7-days a week. This moment that I ran into him, it was not even 1 month into the job for me. Usually, when talking with OR or Cath/Interventional staff you ask about the dynamic between physicians and staff, as a normal question when rounding in the unit, as that is the environment of team they work in day to day. It is a regular question I ask, even when rounding. He begins to tell me about the work environment, the high skillsets of the team and the close working relationships in the Cath lab with the doctors. He stated:

- “This team does a lot of strong work. They are dedicated. There are also interesting dynamics going on. Some things that are said there that shouldn’t be discussed.”
- Feeling a sense of potential concern, I was wondering in my head if he was suggesting something that may need HR or similar. He replied with: “well there are some things that are said there that should not be said”. I told him (Traveler),

that he should be able to share his concerns with his supervisor, “and if unable to I can point you in the right direction if escalation is needed.”

About a month and half later, I later learned in my conversation with Angela Fleischer, she shared that there was an allegation that I specifically asked the cath lab personnel person living in my building about Dr. Cigarroa (specifically) being in the cath lab and calling his attorney. I shared with Angela that I was just 2-3 weeks into the job – that I would even know this physician’s name? I did not even know who Dr Cigarroa was, let alone ask his name or any questions about phone calls. No. And it isn’t even logical.

On night shift rounds in one of the K units, I met another Traveler. He tells me – he was a traveler and just converted. I asked: “Okay, tell me – what makes you pick our hospital over others. My conversation was very similar in spirit and intent as the other traveler. When I concluded that conversation with the cath Lab tech – what would it take to make you stay? It was the same way I asked the nursing traveler, what made him stay.

I) Characterization of Strategy

Question: “In a 1:1 meeting in the month of December, did you describe your approach to business negotiation with a colleague using ‘get gangster’

Response: I do recall nor have I ever used that language “gangster” being used toward or in reference to any individual or colleague at all. Regarding business negotiations I have the concept of “gangster move”. I have heard others use the word “gangster” when describing one of our esteemed leaders at OHSU (explained in detail below).

For example related to business negotiations, I have had conversations with Maulin and the expression “play gangster” relative to our payer negotiations with him. What does that mean?. It means and is a synonym for playing hard ball – you are ready to pull business triggers that are like decisive chess maneuvers that have (often immediate) implications for one party, in order to advance a decision or progress in negotiations. For example, if we pull out of Regence blue shield payer negotiations because of an inability to meet our financial terms, they lose network adequacy. – they can’t sell their health plans in the state. In order for them to sell their health plan, they have to have a quaternary health system like OHSU in their plan. This forces their hand, such as in playing hard ball, in order to move to the next level of negotiations. Additionally, I have used this language, such as “gangster move” when in a small meeting with EVP’s, such as Dean Selden, we were discussing the state of our heart transplant program and the history of Providence St Vincent taking decisive moves to build a heart transplant program, including their most recent poaching in the last 60 days of a prominent senior heart failure faculty member from OHSU cardiology/ heart failure program. I used the expression “gangster move” when describing one of the biggest business and clinical events in the world of transplant, namely heart transplant. That event was approximately 12 years ago, and I saw it first hand while working as an executive in the LA market, and it had impact of seismic proportions:

For decades UCLA Health had been home to the most prominent heart transplant program in the country, performing close to 120 heart transplants/ year. (as reference, OHSU performs approximately 15-20 heart transplants). The “gangster move” I described in this meeting was when UCLA’s fiercest competitor, Cedars Sinai, successfully recruited away the Kobashigawa group heart failure faculty, in entirety from UCLA to Cedars Sinai. This resulted in the massive shift of one of the most prominent heart transplant programs in the country from UCLA -- where it has grown and lived for decades as a highly reputable program – to Cedars Sinai, who now for the past decade has had the largest heart failure program in the USA, performing approximately 140 heart transplants.

Importantly, and extremely concerning, I have heard the use of term “gangster” in a concerning derogatory and even potentially racist way by a member of my team in their description of Provost Marie Chisolm-Burns. Our provost is one of the most prominent leaders in higher education in the country, serving as Provost leading the development and academic advancement of such fundamental core schools and programs at OHSU. She is also a highly respected Black female clinical leader serving in this role. My concern stems from a member of my team, Tionna, in a meeting in my office, stating “Marie reminds me of a gangster; you know her style and mannerisms. I like her very much but that what she reminds me of.” To my horror, I responded and said, “you cannot say that! That is so wrong. There are implications and racist undertones in that reference”. She said “oh I don’t mean any harm, I actually really like her”. I documented the reference to the provost as “gangster”⁶, as a racist term being used towards a prominent female who has a contralto level voice and who uses some hand gestures as part of her communication. I struggled with what to do in this situation. I documented it in my notes so that I could bring it up in her evaluation, while I determine what other escalation I needed to take. I also pondered if I should say anything to the Provost. I was also cautious because (1) I didn’t know if this was an isolated incident and (2) I know Tionna could trace any reporting of this to me, and yet she had the ability to make my life difficult as I was still learning so much of OHSU thru her and dependent on her. So thus, I opted to save it for formal discussion and documentation in her annual review in the upcoming months, while I make assessment and determination, especially in my 1.5 month tenure at the time, if this is even a safe environment to speak up about what happened to the provost and where I go with it, also recognizing some consequence to Provost and to me. This incident occurred on 1/29/26 when the topic of conversation related to when Marie had kindly extended a warm invitation to me to her leadership meeting on 2/6/26 at the same time I was out of town visiting my parents

Question: “Did you use a comparison suggesting that providing funds to one program would result in ‘starving children’ at DCH? What did you intend to communicate, and how do you think that language may have been received?” –

⁶ Illustrative of culture of tacit racism towards leaders of color, and in particular those of Black and African descent. To reference our Black female Provost as “reminding me of a gangster” is a harmful, enduring racist stereotype that equates Blackness with criminality, violence and danger. The stereotype is embedded in the history of American policing and institutional racism (incl. at OHSU) designed to demonize Black people.

Response: Here is what I have said, not starving children at DCH. I have shared that the clinical leaders of DCH, such as Dr. Braner and Dr. Krishnaswami have stated that DCH has been “starved for capital” for years. The verbiage of ‘starvation’ was not my original use of the term, but rather me sharing the DCH physician leadership expression of “starvation” around capital.

What I have said in other settings is that in leading a large complex organization with multiple departments, supporting resource investment across is similar to having a family: all the children need to eat; otherwise, it’s perceived as unfair. I reiterate, that in my seat I have heard leaders from DCH say at multiple settings: “we have been starved from capital for years”.

J) Email Responsiveness

Question: “Several of your direct reports describe sending you detailed historical information and data without response. What’s your take on this, and how do you typically ensure timely responses?”

Answer: One I have heard that from – Atif relative to [REDACTED].. In situations like that, where I have responded to her prior emails. I feel like she is choosing when to pick on me. There are times when I have responded: I have the fiduciary responsibility, you are asking me to respond with millions at stake for OHSU, in a situation with governing rights, where I am putting OHSU’s capital resources, which are extremely tight, at risk. I have been trained to be highly cognizant of fiduciary responsibility, especially when being responsible for organization wide capital. I shared with her that it would require a deeper dive into governing rights and fiduciary responsibility. Being new in my role, I was especially cautious about making a major commitment of several million dollars to [REDACTED] with these foundational risks at stake. Please see attached email.

She has sent me several emails essentially asking for the same thing, money for capital spend, and I shared with her, both by email and in our monthly meetings that this a bigger issue that goes deeper. I was hoping that as a [REDACTED] she would understand as I layed it out clearly. Rather than keeping a paper trail of me saying No, that she could send to her board or attorneys, I did not respond. I went to Alice, asking for her help that we have to get it straightened out with the foundational underpinnings of the contract that puts OHSU at risk.. Alice acknowledged the contract was not well written (it predated Alice’s tenure at OHSU), and we have been setting up discussions internally for this matter

Others may have sent me data, I may reference it in my 1:1 – I usually unpack it together in that meeting, and moreso, in our exec team huddle. An example is that the finance team sends a lot of financial information as we are working on regions. Let’s get the data so I can tell you what KP’s game plan is - they want to pay us less. If it is a medicare patient – they will only pay medicare DRG – so they let them sit at our hospital. When it is a commercial patient (which generates more revenue for us); KP will often move the patient within hours. I do it in a way to inform them of how you make a better decision. I am also careful not to put said concerns regarding KP playing the system in their favor in an email that could potentially be subject to

subpoena. So thus, I have been trained particularly when I have questions, to be cautious in what I write in email, as it serves as a paper trail (subpoena risk), and also I also realized that when I ask too many questions in response by email, people will be quick to assume and label me as being critical, (or worse, accuse me of going “out of my lane”⁷). So thus, I rather address the data in our exec team meetings or 1:1’s where deeper explanation, questions and the why can be explored.

Productivity data is data that is sent out to leaders including myself routinely – how I have handled it is rather than taking action by email response from me, we have evolved and implemented formal productivity council every two weeks. Based on performance functions – FTE counts, premium pay use and productivity/ efficacy relative to volume. We also highlight the orange folks – heads up, though they are not required at the council meetings. This is not meant to be punitive and let me be very clear, it’s meant to be assistive and productive. I have shouted out Erin and Tara from finance for recognition, who work hard to produce these reports, to thank them for their meaningful engagement doing all the hard work behind the scenes for productivity council and lifted up this work for recognition in our leadership team meetings.

No individual leader is picked on or chosen as an individual to come to productivity council. It is 100% about the numbers as basis for these meetings. Given the magnitude of spend, FTE’s and productivity levels Nursing could almost always be in the top 10, so thus, we have explored either bringing them to the same productivity council or having one just for nursing, given the expense they carry. When speaking of the what and the why at the Exec team huddle, Brooke B. even joked about it, “Tarek is saying that I am the most expensive department”.

K) Communication Style Shift

Question: “Several witnesses and leaders describe initial conversations as cordial but later interactions as more interruptive or even condescending. When you hear that, what comes to mind?”

Response: I would not describe my approach as condescending or interruptive; but rather as probing and direct to find facts and drivers of issues. Two things – especially as I hear from physician leaders – honeymoon is over, want action. If people feel I am more pointed, trying to ask more pointed questions. Keep in mind, I am serving as CEO, while also covering for the roles of hospital COO and CFO (positions we do not have currently), I am unpacking details with more pointed questions in the goal of problem solving/ action, which I hear as a clear call from faculty leaders I particular. In my career tenure, this depth of questioning and problem solving analysis is most often done by COO and CFO, and thus, without said roles at this time, I am covering that function, and doing so with particular questions. Because of my tenured experience in hospitals, (and without these filled roles), I have been trying now to trouble shoot, new information gathering and asking pointed questions. Our performance as a health system, including KPI’s reported to the board, illustrate lackluster or mediocre performance for a long

⁷ see page 18-19 Dofor more depth of explanation.

period of time in many fundamental areas, such as quality, patient safety, finance, care experience, patient flow/ LOS. My hope is that with a full team in the future, I would be able to lean into more A3 thinking and approach to collective programmatic problem solving (as we do in the CEO Exec team huddles), with other members of the team, such as COO, CFO, CMO doing the more probing fact finding of issues. In addition, for me my hope is that as a leadership a team – we build trust over time with facts, information, and issue identification and resolution. I would rather describe my direct and probing questions that people experience is a reflection of my sense of urgency, esp when it comes to patient safety/ quality/ access to beds/ pt flow and experience. I sense people have either been used to mediocre performance or complacent with lackluster results, rather than a sense of urgency when poor quality/safety and care experience mean patients are actually being harmed or cared for sub-optimally every day with high risk. In the context of deteriorating financial performance without urgent, time sensitive resolutions, it puts the organization at deeper risk.

When I reflect on these matters, I recognize I have walked in on a culture of mistrust, and with a tremendous amount of resistance to change. There is so much work we need to do, because what I'm seeing, even on a day to day basis, is that the patient is lost from the center (and doing best for them is lost) with our inability to trust as well as this frozen response to the need for change. When the patient is lost from the center that's when we see ongoing deteriorating performance, meaning direct harm to patients, suboptimal care experience and harm to our brand. Thus, I also question here, is this resistance being lobbed onto the messenger (ie, me)? Regardless, the culture of mistrust is crippling, as I have shared with my team, and is definitely a major focus going forward for our team collectively.

L) Bias and Disparate Treatment: Comparative Language

Question: “Have you ever made statements suggesting a colleague would be viewed differently ‘if they were a man,’ or similar comparative remarks tied to gender? If such language was used, what was your intent?” If no, please share any reason why and how this allegation was made?

Response: Couple of complaints I got about Brooke Baldwin were about the very same incident. It was about a document that went wide – it had communication in it about repurposing a union job to a management level job. Maybe the presenters did not know that specific implication, but leaders closer to that work area and dept, knew what it meant (replacing a union position with non union role). When Brooke Baldwin learned of it, she set very clear and direct information – pull it back from any audience or sharing with immediacy. The array of people who received it may not understand the why, they took her assertive remarks as harsh critique – “why is she being so critical of us?”

I have said to Brooke Baldwin I was being told she was being “hard and forceful”, and I did have thoughtful conversation with her. I shared with her that people are speaking of your communication and directness. I understand what you are doing, why you need to pull it back. But it is the How. She went into a description of the leadership challenges to implement change in her tenure at OHSU – “if you are not assertive, people won’t get it. They accept complacency and status quo”. I reflected and said that I also recognize there may be double standards for you

as a woman. “I’ve seen situations where if it comes from a man, like me or Tim Goldfarb, people may barely flinch or question / and may not be perceived that way”. When I brought this concern to Angela F., it was shared with me that people in OR may be very reactive to direct assertiveness from women leaders. “Oregon can be a cold place for women who are assertive.” She stated.

M) Consistency Across Audiences

Question: “Several accounts suggest your demeanor differs by audience (e.g., board meetings versus 1:1s; some leaders versus others). How do you ensure consistency of tone and respect across settings?”

Response: When in different environments, my role and line of inquiry will vary based on 1) clinical/business need, 2) sense of urgency to determine patient harm risk and 3) financial and fiduciary risk immediacy. In a board meeting I may be fielding questions from Board members about issues of high relevancy for the board. When faced with organizational deteriorating or lackluster performance (also requiring explanation to the board on a regular basis), I may approach my 1:1’s with more spirited and direct inquiry. How do we know the patient harm risk has been addressed? What patients today are likely to face the same immediate risk of harm? Rapid fire questions may occur with the sense of me trying to understand how big the problem is, where the weakpoints are and with what immediacy things need to be addressed, whether it’s immediate safety or fast changing financial landscape. In a board meeting, I may demonstrate more deference, because they serve as the overseers. In my 1:1’s I may demonstrate more direct inquiry as I try to determine where “holes in the swiss cheese” may **line up**⁸, with immediacy, referencing patient safety science. Hundreds of patients are in our care every day, and thus, the safe provision of care, access to care to ensure their most urgent needs are met, ensuring care standards are not seeing continuing sub optimal performance are all elements that impact patients every day, with my accountability legally and criminally to CMS to keep them safe. My tone of directness in different 1:1 meetings may well be viewed differently than, for example, my approach with members of the board.

Another example is Donn Spight, someone I am accused of showing favoritism. I ask the same directive questions to him. Maybe as a surgeon, this type of questioning is not foreign. I am not different with him even on one of recent exec team meeting on 3/3/26, I was very directive towards him. I looked at him and said: “You know: the surgeon has ample opportunity to tell the patient what their length of stay is”. He replied with: “Ooh you are getting pointed”.

The work I do in the 1:1’s is often that of troubleshooting, and I am an N of 1, covering multiple based including that of COO and CFO which are not roles that we have in our medical center. My predecessor’s stated primary responsibility, understandably, was financial performance turn around

⁸ The Swiss Cheese Model in patient safety science illustrates that harm events occur when multiple, imperfect defenses (slices) fail, allowing hazards / harm to pass through aligned or a series of weaknesses, ultimately impacting the patient.

(he shared openly that this was clearly the case, and that he did not focus on other aspects with the same intensity or focus). I have been asked to address all domains of performance at the same time: Financial, quality/patient safety, care experience, patient access and patient flow in the hospital.

I would like to reaffirm: When I reflect on these matters, I recognize I have walked in on a culture of mistrust, and with a tremendous amount of resistance to change. There is so much work we need to do, because what I'm seeing, even on a day to day basis, is that the patient is lost from the center (and doing best for them is lost) with our inability to trust as well as this frozen response to the need for change. When the patient is lost from the center that's when we see ongoing deteriorating performance, meaning direct harm to patients, suboptimal care experience and harm to our brand. Thus, I also question here, is this resistance being lobbed onto the messenger (ie, me)? Regardless, the culture of mistrust is crippling, as I have shared with my team, and is definitely a major focus going forward for our team collectively.

Additional questions brought up in interview:

Angie shared the following in the same interview. She shared that there is perceived Favoritism by me: Accusation that I have demonstrated favoritism to Dr. Donn Spight and Brooke B.

Firstly, I would like to say that I do not have favorites. If I did, I would expect some to accuse me of favoritism towards Yen Pham first and foremost. Why? Because approximately 4=5 weeks ago, I began exploring with her and senior EVP's the potential expansion of her leadership responsibility to include Clinical Lab and Pathology. (which is currently under Brooke L.). This was prior to any announcement from Brooke L. regarding her departure. This was executive thought I was exploring based on the size, scope and business function related to laboratory / pathology, its growth potential, revenue potential and the OP provision of service pt facing parallels to pharmacy. This me demonstrating a potential growth area for Yen and her leadership. I see this has not yet been mentioned as a favorite, though I have been concerned that people would only see it that way, as I have shared with HR leadership.

Related to my working and mentoring rapport with Dr. Donn Spight. He is a leader whose input and leadership potential I value highly (no more highly than anyone else's). He is our most recent SVP promotion, yet he has come to me to share that others still may not think of him that way. He is also the only other exec leader on my team that is of Black / African descent besides myself. With the history of racism at OHSU and the initiative where OHSU must remain a racism free environment, I am particularly sensitive to this experience for Donn (and others, including but not limited to myself). I am also cognizant of other forms of anti black/ anti African racism I have seen in my short tenure at OHSU particularly towards other executives/ EVP's, including comments about our esteemed Provost. Dr. Marie Chisholm Burns (see footnote #). In addition, we operate in a larger political environment where basics of DEI (Diversity/ Equity/ Inclusion) are being forcibly suppressed, and Donn carries the responsibility of

our health equity mission (along with myself in capacity as CEO) in this kind of environment. Maintaining a close working rapport with Donn as a leader and colleague has been a leadership goal of mine in an environment where health equity is under national political attack and where he and I are the only executives of Black/ African descent on the hospital exec team. As OHSU, we remain steadfast in our commitment to health equity.

After recent events where other members of the executive team, such as Brooke L. and Renee, have been dismissive and suggesting he is unworthy of leading care experience, I have been particularly incensed by the level of disregard expressed towards him. Whether in statements like “What business does Donn have overseeing care experience. I mean really Donn???” (Brooke L.) or in lobbying to pull care experience away from him, a fundamental lack of recognition of his leadership, value, let alone core strategic and human connections between health equity, patient dignity and patient experience. These direct comments and summary dismissals (whether willful or not), are illustrative of a potentially hostile or tacitly racist environment for leaders of color at OHSU⁹. For this reason, if I am perceived to spend focused time with Donn, the explanation above speaks clearly for my rationale.

As far as Brooke B. goes, I do not play favorites with her either. She leads the largest segment of our clinical workforce in the hospitals, our nurses. Hospital performance (quality, safety, experience, financial, etc) has a direct link and interdependence with nursing performance. I have not been shy at all in sharing coaching and criticism with Brooke B in an effort to build her resiliency as a leader. In these sessions she has opened up to me about the challenges she faces as a leader for which I respect. In addition, I have been assessing some potential unfair criticism directed at her for her statements of an assertive nature that might not otherwise be put on a male executive, in my experience. Lastly, Brooke B. is the only other member of the LGBTQ plus community on my executive team (besides myself), so thus enabling a working relationship where she can be a successful visible leader is of high importance to me. Personally, for me, as a leader who is LGBTQ+, Muslim and of Black/ African descent, it is completely familiar to me how difficult it can be to lead where all or some aspects of your core identity may not be welcome or where you may feel unwelcome, or purposefully need not even mention, whether in sum or parts. The experiences I have seen in short order at OHSU¹⁰ give reason to be increasingly concerned. Having some (not disproportionate) attention on leaders such as Donn and Brooke B. from my part have some clear rationale, relative to our mission.

Angie also shared that there is an issue with me recognizing the importance of MD – RN Dyad partners, particularly Peds/DCH, and recognizing the importance of the physician role in the dyad, esp in Peds/ DCH. Accusation that I do not recognize the MD partners nor do I value them.

⁹ See Page 4 -Footnote 1

¹⁰ See Page 4 - Footnote 1, Page 10 - footnote 6, Page 19 - Foot note 11.

In response to this concern, I would like to share the following. Firstly, I have been developing my rapport with individual faculty chairs of departments. This has been important to establish rapport, alignment and respect for the health care delivery, research and academic missions of OHSU. I have started by meeting individually with chairs and DA's of department in a shared review of strategic priorities. Some of this has led to superb chair interest in quality initiatives, particularly where we have been performing poorly, such as Terri Hough's (Chair, Dept of Medicine) interest and involvement with Sepsis. I am still learning the dyad relationships at the hospital department level in my early tenure, while still building core relationships with chairs of departments. I would like to call out one dyad physician leader in particular. I have spent focused time with one of our senior physician DCH dyad leaders, Dr. Amy Hermesh, faculty leader and physician medical director for our women's and children's program. I have so valued my rapport and discussions with her, that I have shared with others on my team that my meetings and discussions with her have been some of the best medical director physician dyad leader meetings for me while at OHSU. She came prepared with quality, market, population and financial information (all at her own discretion and determination, not mine) to allow us to have a substantive (and exciting) dialogue on building our future. It was quite positive and energizing and I have shared that with some of my colleagues.

One other area of Dyad focus for me has been at Mission control. This is an area of core turn around and focus need across and within the nursing and physician dyad structure. In addition, in my limited tenure, I have received 5 escalations from department chair leaders requesting rapid change in how the physician dyad is working, with concerns about how they are not enabling access for some of our most critical tertiary services that the faculty leaders are trying to bring in (thru hospital to hospital transfer or thru admission). Problems at mission control accepting patients has been called out as part of the reason for some very recent high profile surgeon departures from OHSU. This led to analysis of our entire admit and dc processes both of whom are fraught with significant opportunities for improvement. The work of this dyad was part of a recent CEO exec team huddle (Pt flow on 03/03/26). This was a team recognized at the huddle for taking on big and challenging initiatives for which I remained and demonstrated active commitment to help them. Without their prior knowledge (because I was assessing resource capacity) subsequent to the meeting, I reached out to Clea to ask respectfully for part time P.I. support from her area to that same patient flow dyad team that presented at exec team huddle on 03/03/26. Clea was kindly responsive and then I scheduled a brief call with the operational leaders from the dyad and Clea to share our commitment of the PI support from Stacia. The response in the first moments were one of "wait what does this mean?" to (a few seconds later) "wow, this is awesome support, we are so grateful and appreciative". The only ask I made of the team is to respect Clea's stipulation of time commitment (x hours per week) for Stacia's time (PI consultant) given her other duties.

Importantly, within this domain of mission control there is substantive reengineering involved in Nursing process flow (within nursing stakeholders unit to unit; ED to unit nurse communication); this matter is one that Brooke B is very involved in. The gaps on the physician side of Mission control and also called out in the PI work is the discharge process; the dyad coordinated relationship between Case Management and physician leaders. I and many other leaders (physician leaders included) identified this as a shared need with tremendous development focus needs across all parts (nursing and physicians). With much work in this domain ahead of us.

I remain open to meeting with other dyad leader partners, many of whom, I have yet to know and discover, given my short tenure. However, and importantly, I have established and am committed to the executive and faculty leadership dyad partnership I have been developing, for example, with Dr. Dana Braner, Pauline Ott, and Dr. Jay Krishnaswami from DCH. And of course, I have prioritized my dyad relationship with Dean Selden while developing rapport with faculty dept chairs as mentioned.

Angie also shared an accusation of me getting involved in areas that are not reporting to me, and I should not; that I have no business inquiring about. Namely, Supply and Logistics: that by asking questions, I am creating concerns for the team leaders.

To this concern, I would like to share the following. Namely, there are only 2 times I have been asking questions all in the spirit of care and concern for the front line staff in supply chain and logistics. I clearly recognize that throughout my career as a medical center CEO if I am not supporting essential front line teams that work tirelessly to keep our hospital operations running (such as supply chain/logistics), clean and safe (such as EVS), I would be missing our fundamentals, our people on the front line. The 2 times I inquired about supply chain were both thru my finance leader partner Maulin Patel.

- 1) When there was significant tear gas exposure impacting our warehouse and the team members in it, at the time of the large scale ICE protests on the waterfront. I reached out to inquire on the safety and well being of the supply chain and logistics team, their safety (including environmental respiratory safety from the tear gas), and ensuring they have safe passage if needed when leaving the warehouse. In addition, I have given recognition to the front line supervisor (David Newell) in Supply and Logistics for working to keep the staff safe during the HEAT leadership call related to the tear gas incident on 1/31/26.
- 2) In the past week, I reached out to Maulin related to the well being of the staff in Supplies and Logistics, after I was asked to review and approve (yes, I was being asked to review and approve at the Position Control meeting (Monday March xx) as leadership has asked me, since my start at OHSU, to weigh in on all positions presented at position control, and since the meeting is sent from my calendar to all leaders across the university. When presented with a very large number of positions to approve due to turn over and or FMLA from supply and logistics, I reached out privately to Maulin to inquire if morale was OK and if recurrent FMLA meant either (a) safety concerns in the dept. or (b) opportunity to more plan for the supply/logistics budget for an average FMLA rate of absenteeism.

While I am not privy to how it may have been communicated from Maulin to supply and logistics, my approach was entirely one of well being for the team members, so that we aren't just solving to post requisitions, but rather approach it from an injury free well being of the department on the front lines.

To hear this criticism of me as a CEO inquiring about the well being of the supply / logistics team appears belittling me (and my role) and rendering me and/or my role as diminutive, reflecting the "boy, stay in your lane" attitude with racist undertones to a leader of color. Even when my line of inquiry is about the safety / well being of the staff. This is particularly concerning when 85-90% of the supply/logistics team workload directly involves medical supplies and equipment in caring for patients whether in hospital or clinic, that I am ultimately responsible for. An expense of hundreds of millions of dollars per year that I am directly accountable for. The criticism of my inquiry (even when at the core of it is the safety of our

staff in supply/logistics) sends the message to me that I should butt out, and not show any care, which is deeply concerning¹¹.

Angie also mentioned a potential fear of retaliation by the supply/logistics team. Again, what grounds have I even given with any aspect of my involvement with the supply and logistics team that my efforts are retaliatory, when in fact, and as evidenced by the nature of all of my questions for supply/logistics team have all been in the context of safety for the staff as well as their well being that may be reflected in the very high volume of FMLA's on their team.

While I think about the entirety of the situations, I recognize it is not only a culture that has no history of trust (affirmed by many leaders), it is also a culture where people automatically assume the worst of each other. Not the best of intentions from their peers. I have brought this up in several 1:1's when colleagues on my team bring up concerns about fellow colleagues and initiatives they may be pursuing, and automatically think it is about a selfish rationale on the part of their peer. When in fact it may be entirely a logical business or clinical reason internal to their individual scope. The declarative issues around a culture of no trust amongst the health system leaders means the worst of intentions are automatically thought of, for one another. Then, only increasing the ire of suspicion toward a colleague. The lack of trust results in suboptimal and inadequate collective focus on the patient, resulting in direct harm, which for me as a leader is a matter of high urgency. I recognize the transformational work for this type of position is not easy, but it is also not really unexpected by me. I recognize it and am committed to a transformational journey to excellence for OHSU health. Thank you.

Respondent Signature: _____ *Tarek Salaway* _____

Date: __3/15/26_____

Investigator Signature: _____

Date: _____

¹¹ This "stay in your lane" approach is often used as a form of racial microgression or covert bias, designed to belittle individuals, particularly people of color (in this case me as a leader), by limiting explicitly or implicitly their professional or personal pursuits (including my own leadership responsibility). It functions as a form of subtle discrimination or microinvalidation, questioning a person's belonging in certain spaces. It is especially troubling when directed at the OHSU Health CEO, who is a well accomplished leader of color.