EDITORIAL

Innovation in Our Nation's Public Hospitals: Three-Year Follow-Up Interview with Five CEOs and Medical Directors—Part 2

Tom Janisse, MD

This is Part 2 of a two-part conversation with leaders (Table 1) from four hospitals and systems who participated and attended the 2010 annual meeting of the National Association of Public Hospitals in Boston, MA. Part 1 appeared in the Winter 2011 issue of *The Permanente Journal*.

Tom Janisse (TJ): Welcome. It's good we can talk together again. In Part 1 you discussed: community interventions, community clinics and the hospital, system integration, and integration of people in the system. In this second part we will talk about innovations in quality improvement (QI), resident training and QI, how you improve a patient's experience, and your approach to health care reform. To begin, let's discuss about innovations in QI. This is a growing area and becoming more credible as it is recognized that the delivery system offers a critically important way to advance medicine.

LaRay Brown (LB): Just getting everybody involved is a major advance. Traditionally, it's been primarily the quality control people and the nurses, but the physicians weren't involved much. Now our physicians are involved as part of a quality objective and they are actually doing peer reviews. We're seeing a tremendous difference in how they perform.

Table 1. The 2010 participants

John W Bluford, III: President and CEO, Truman Medical Centers, Kansas City, Missouri; Chairman of the American Hospital Association Board of Trustees
Susan Currin, RN, MSN: CEO, San Francisco General Hospital and Trauma Center, San Francisco, California
Sandral Hullet, MD: CEO, Cooper Green Mercy Hospital, Birmingham, Alabama
Claire Horton, MD: Associate Medical Director, San Francisco General Hospital and Trauma Center, San Francisco, California
LaRay Brown: Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations, New York City Health and Hospitals Corporation, New York, New York

Sandral Hullett (SH): They didn't like being involved at first, but now they see the results. They're doing things correctly and they make no mistakes, and when they see the results of the hard-core data it just makes them more involved.

LB: I agree. You talked about the multidisciplinary team, which is essential to QI and successful outcomes: everyone involved in achieving their identified area of improvement. Another example, at Kings County Hospital, was achieving an award for zero ventilator-associated infections in the Emergency Department, and the surgeon who stood up there and accepted the award was very clear that it wasn't just the surgeon. It was, of course, the quality person, the data analyst—the entire team must work together to achieve this. There's a myriad of examples of work throughout the New York City Health and Hospitals Corporation (HHC) that demonstrates that QI has become embedded in the organization. The quality assurance committee of our governing body meets weekly for two to three hours to hear from each facility, which on a quarterly basis reports on what has happened—what's great that has happened, and what's bad that happened. Most important, they report on their QI efforts with outcomes data. These are good improvement stories with good data.

TJ: Dr Horton, you wanted to talk about training residents and QI, specifically in the safety net.

Claire Horton (CH): We recently had the first of what hopefully will be a recurring set of conferences focused on residents and QI, funded and coordinated by the Safety Net Institute, which is part of the California Association of Public Hospitals (CAPH). It grew out of a work group, launched by the Safety Net Institute, of faculty at public hospitals in California that are training residents. One of the outcomes of the conference was more networking for residents learning about QI. Ten years ago that training was rudimentary, now many more people are interested and many more residents look toward QI as a career path. We would like them

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to consider a career not only in QI, but QI in the safety net. That's why this collaboration between the Safety Net Institute and our training sites was so important. There were QI seminars and conferences where we could send residents, but there wasn't a forum for them to showcase their own great work in QI, nor for the faculty who teach QI in the safety-net network to compare teaching methodology and curricula. Last June, we had the first conference for academic CAPH hospitals. Seven institutions participated and many residents gave oral presentations. The Safety Net Institute selected one resident for a scholarship to the Institute for Healthcare Improvement National Forum on Quality Improvement in Health Care. The whole endeavor represents a great new collaboration.

TJ: Could you mention a couple of specific QI activities that residents do now that they never did before?

CH: When you look at published papers about how to teach QI to medical residents, it is apparent that it's critical to have experiential components. This allows them to be integrated into and to work closely with the staff of the clinic or hospital. What wasn't obvious to everyone was that the residents really know the system better than anybody else. They're absolutely on the front line. There are several examples of what residents presented at this conference. One focused on improving cervical cancer rates. Two clinics had different systems to reduce the Papanicolaou smear rates; two residents formed teams at both of those sites, learned what sources of data were used at the hospital, and taught staff the guidelines for who should get a pap smear, which resulted in significant rate improvements at both clinics. Another project was conducted by a resident who coordinated with clinic schedulers to ensure that patients were scheduled with a follow-up appointment when they left the clinic. The resident learned a lot, but the project was also critical for us because so many of our patients get lost to follow-up, in part because the residents' clinic schedules are notoriously difficult to predict because of the demands of the inpatient service. The percentage of patients who never received a follow-up visit declined from 18% to 11%. Another great project integrated postpartum depression screening into a pediatric residency clinic. There were many well-done projects presented.

TJ: Let's continue with your thoughts and activities to improve the patient's experience. Is there something particular you want to mention?

John Bluford (JB): The industry and particularly safety-net hospitals are really getting engaged and involved in improving patients' experiences. We have a concierge service at our hospital that is not any different from what you would see at a hotel in terms of meeting patient needs. We have a very strong initiative right now to balance our workforce to better match the patient base that we serve. As a particular challenge in our community, the birthrate of Hispanics is exploding: 20% to 25% of all of our babies delivered. Our Hispanic patient growth is new for us (as in the West Coast, Florida, Texas, and Kansas City), and we have nowhere near that percentage of Hispanic employees. So we're working to improve that inequity.

TJ: Remember the last time we talked, John, you mentioned that you didn't want your hospital or health system to be for one purpose—for poor people. You wanted it to be for everyone in the community.

JB: That's right, and the concierge service is a model for this. It starts at the front door with the baby grand piano, and the ambiance of a hotel lobby, and follows through to the art gallery that we're producing—changes that are good for everyone.

Susan Currin (SC): As far as improving the patient care experience, our initial approach has been to focus on patient safety. For example, to examine and improve our culture, we're participating in an Agency for Healthcare Research and Quality culture-of-safety survey. It dovetails with what Dr Horton is doing with the residents in QI. Another example is a new system of "rounding with a purpose" where staff make frequent rounds on the medical-surgical units. Through this program, we've decreased the number of falls as well as the number of hospital-acquired pressure ulcers. Also, we are looking at the patient satisfaction data related to noise on inpatient units and are developing several initiatives to decrease noise during certain hours of the day.

Patient safety and satisfaction really come together in our care for the elderly. We have two acute care for the elders (ACE) units—one that's a general medical unit; the other focuses on cardiac patients. We have attendings specializing in the geriatric patient population, who lead a multidisciplinary team of nurses, many with national certifications in geriatric care, nutritionists, rehabilitation staff, and social workers. This group starts discharge planning early in the hospitalization and develops treatment plans focused on improving the functional status of patients. We're excited about this program's success in returning patients home after discharge, as well as reducing their readmission rates. It is a great experience for the patient and delivers quality, team care.

CH: I'd like to talk about the ACE unit that Sue Currin just mentioned because it's so fantastic. When I first saw the San Francisco General ACE unit, when anyone sees the ACE unit, you think why on earth haven't we been doing this all along. The geriatric patients on that unit have meals together in a communal room at the end of the hall. And people actually get to sleep through the night at the hospital, if you can imagine that—because the staff minimizes nighttime wake-ups for vital signs, etc. There is a huge emphasis on function as opposed to the normal parameters of getting better from a medical standpoint. Physical therapists and nurses work intimately together for patients. Our patients are always very happy when they are transferred to the ACE unit.

Besides the ACE unit, another new service we have is palliative care, which is incredibly important for patients facing the end of life; and in the hospital, it has made a tremendous difference in many, many patient's lives to have a specially trained multidisciplinary palliative care team available to consult with any patient who is at the end of their life.

SC: We're hoping to expand this program to the ambulatory care area. That's really where we need palliative care: in the outpatient setting. Although there are some who believed they provided really good care and did not need a palliative care service, the number of projected consult requests doubled after six months.

CH: We didn't know how much better we could be.

SH: We had a great problem with patient satisfaction because in our community the public hospital has the image of being not the best place in the world, even though we have the same quality physicians as most of the hospitals—most of our physicians are from the university. But still, people don't really want to go there. We did a lot of facility renovation—cleaning it up—and addressed staff behavior, teaching them customer service. That has been difficult because people worry about potentially losing their jobs. I work for the county, and people just get callous after a while when you put them in the same spot; you don't move them around, you don't do anything special for them to make them feel good about who they are and what they do. And we just started doing that. There's a new program within the hospital where staff contribute their ideas of the best ways to improve both staff relationship and patient satisfaction. They suggest very simple things but they make a world of difference for both the patients and the staff. We acknowledge the staff by listening to what they have to say. And then for our patients, they now feel much more comfortable. Instead of complaints every day—we never get them now—we get many compliments because people feel wanted. And that's what we want them to feel. For three years in a row, we have had one of the highest Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores in the nation. But it dropped last year. It's still high, highest in the state, even though we dropped from a score of 95 to 90—I think we got a score of 89 in 2009. The lower scores were related to multiple issues during the time of the survey; such as the changing economy and the financial shortfalls of the county. Cooper Green suffered loss of staffing and reduced staff working hours, and other significant changes, which caused decreased staff morale. The staff wasn't happy and that unhappiness was observed by the patients and I think this was the reason for the lower scores.

LB: From our perspective, the patients' experiences are important because we are in a very competitive environment. We have some of what are called the boutique, internationally renowned hospitals.

We do not aspire to be the hospital only for individuals who have no alternative. We aspire to be the hospital and health care system for all New Yorkers. And New Yorkers are persnickety. It's also an issue of when people feel wanted, they will come to you, and moreover, they will engage in a partnership for their health care. Therefore we invest in language-assist services not only because it's important to communicate with patients and make sure that you're getting as much information as possible to be effective in your service delivery, but it also indicates respect for patients. For many communities the availability of language services isn't as expansive as in HHC. People see that, and so they choose an HHC facility. We have people who look like them, and people who speak their language—both improve patient experience. We don't have Health Communities Access Program (HCAP) scores of 95—I wish. But our HCAP scores exceed other New York City hospitals on questions, such as "Would you refer this hospital to family and friends?" or "Would you come back?" Across the board, the HHC hospitals' scores exceed New York City scores and in some cases New York State scores, something that we're quite proud of, although we'd like to get to the national percentile level. New Yorkers are more critical than most folks. And, there remain many things that we can do better. We have invested a great deal in our capital program so we have new facilities, ambulatory care, including inpatient and ambulatory care centers. But it's not just the bricks and mortar, it's what you put in place in terms of patient flow. People won't be happy in a

beautiful place when they wait in a room or a waiting area for two hours before they see a physician. They're not happy if in the business office or the financial counseling office they're asked the same questions as before. We're also engaged with our workforce in performance improvement and we see increases in patient satisfaction and staff satisfaction.

TJ: With a new health care reform law, what particular adaptations or programs do you have in the works, in the context of your vision for the future of health care, to allow you to compete, or even excel?

LB: Creating an integrated delivery system will be more critical than ever in health care reform, particularly if the payment mechanism changes to bundle payments. With the emphasis on accountable care organizations—responsibility for the whole episode of care—then tightening up our current attributes will allow us to perform in that context. Our investments in care management will also provide us with foundational work required post health care reform. The year 2014, which is right around the corner, is also not a long way off when you're trying to balance your current budget confronted with hundreds of million dollars of cuts because of state budget problems.

SH: In a smaller area we still have the challenge of being competitive with other hospitals. However, we have 24,000 people we are already seeing, who fall in the uninsured group that would be eligible for this extended health care reform program. Our goal is to keep them. Once people get the insurance card, they're not obligated to choose us. They may have seen us as their last resort. Now they can go anywhere in town, or so they think. Some people actually do leave us; and when they come back, they say: "They don't treat me the same way you do," "I don't feel as comfortable there," "They treat me like a number," and "Everybody knew me here, so I wanted to come back." We want to keep them, so we maintain emphasis on personal customer service. On finances, we work to be sound. The county doesn't want to be responsible for us any longer, even though we get no funds from them. We have to get services like Medicaid, Medicare, and third-party to diversify the ways we generate revenue. For people that pay, we have the Geriatric Psychiatric (GeriPsych) unit now. We also have a contract with the state prison system for their less difficult patients and surgeries. The other hospitals don't want to see prisoners in their facility, but in Alabama, prisoners have Blue Cross/Blue Shield, which is the best insurance you can have. We work with a medical detoxification program, which requires seven days in-house. We're diverse in some other areas in the community. Our rehab facility is very large, and we have a contract with both the county and the city for disability. In fact, we are ready to lease a larger building to expand some of our services.

SC: With the advent of the Healthy San Francisco program, the Department of Public Health positioned ourselves to prepare for health care reform by reaching out to the community clinics to form a network of primary care medical homes that would provide access to health care and care coordination. It's been very successful. We have preliminary data that shows Emergency Department use by Healthy San Francisco members is down, as are hospitalization rates. Chronic care programs we have designed have been successful in this patient population. We enrolled 53,000 patients so far, going all the way up to 400% of the Federal poverty level. When health care reform funds the uninsured, we expect many of the patients currently in our system will want to stay.

TJ: Could you give us some specifics about both Healthy Choices and one of your Chronic Disease Programs?

CH: Healthy San Francisco, which is not a health insurance program, provides clinical care to uninsured patients, without distinguishing between documented or undocumented status. They get all of their inpatient health care at San Francisco General and they have to be assigned to a medical home within our safety net system. The San Francisco Health Plan (San Francisco's managed Medi-Cal plan) administers various aspects of Healthy San Francisco so that there is greater synergy among all leaders of the San Francisco safety net. It's just been fantastic so far.

SC: I think we had 80,000 uninsured patients and we got 50,000 of them into our system.

CH: The Healthy San Francisco program accomplishes many things that health care reform proposes. And under health care reform, many of these uninsured patients that San Francisco is now providing active care for will have Medicaid, so those dollars will flow into our system. The question is how to attract more medical students and residents into primary care, because health care reform supports primary care practice, and our Healthy San Francisco program needs primary care capacity. So what can we do to make them see the importance of primary care and make that an interesting career choice?

In addition to being a universal-access program, Healthy San Francisco is funding six chronic disease management programs. These programs have been

in existence for three years and are meant to address flaws in the system, such as poor specialty care access and inadequate attention to chronic disease management in primary care. Three of the six programs are nurse-practitioner (NP) based and are a bridge between the primary care physician and the specialist. The idea is to expand capacity for chronic care management. For example, for a patient with congestive heart failure, the NP works closely with the cardiology clinic, not to assess people for pacemakers or to work on complicated congenital heart conditions, but to provide self-management support, patient education, and some elements of care management. This approach helps patients with their self-management, as well as provides a strong communication link between primary care and specialty care. Our Healthy Spine program addresses patients with low back pain (the cost and impact of low-back pain places a huge burden on the overall health care system). NPs with specialty training work closely with physical therapists and podiatrists in conjunction with primary care physicians to improve patients' back pain. Another one of the six programs is an integrated behavioral health and primary care program in which we have behavioral health specialists integrated into our hospital-based primary care clinics. They see patients who have chronic illness and a psychosocial or mental health problem that interferes with that patient's ability to self-manage their chronic medical condition. The behavioral health specialists conduct a series of focused brief therapy sessions. Finally, we have a program with NPs in a residency-based clinic who are working in teams with the residents to provide continuity for the patients when their residents are not there, which also improved access for patients to the clinic.

JB: As I'm sitting here thinking and listening to all these great programs, I realize that when you get down to it the health care reform act basically, once you get past the money, talks about access and then it talks about care coordination. Therefore our efforts need to quickly get to quality. One of the things that has been an eye opener for me over the last two quarters is that we've partnered with our IT vendor as we pursue implementation of electronic health records. We have constructed a fairly unique gain-sharing relationship with this vendor relative to certain products that will increase our health quality quotient. For example, we've got baseline data on patient falls, on pressure ulcers, and on hospital-acquired infections, etc. We put in place some of these technologies, techniques, and policies, and over the last two quarters all of those negative incidents have reduced significantly. We're splitting those savings with our vendors. It's amazing what can happen when everybody is on the same page. And these are proper and appropriate incentives. So that's exciting.

TJ: Thank you for your thoughts and this conversation. That concludes our time together, and with this article now represents a three-article conversation about innovation in our nation's public hospitals from the current practices of multiple hospitals, health systems, locations, size, complexity, and patient populations. ❖