

# Innovation in Our Nation’s Public Hospitals: Three-Year Follow-Up Interview with Five CEOs and Medical Directors—Part 1

Tom Janisse, MD

In the Winter 2008 issue of *The Permanente Journal*, we published an interview with five CEOs and Medical Directors (Table 1) from four public hospitals and systems, which was conducted at the Spring 2007 annual meeting of the National Association of Public Hospitals (NAPH) in Boston, MA. This year, at the 2010 annual meeting of the NAPH, we revisited leaders from the same four hospitals and systems, including three new participants and two returning from the 2007 interview (Table 2). Part 2 of this interview appears in the Spring 2011 issue and includes comments on: innovations in quality improvement, improving patients’ experience, and approaches to health care reform.

## Community Interventions

**Tom Janisse, MD (TJ):** *In 2007, when we first talked together, all the participants spoke of many innovations in their public hospitals and systems, some of which were just beginning. To follow-up, Dr Hullett could you relate the outcome of the story you told about wanting to create a cardiovascular intervention in your community in Birmingham and the community decided they actually wanted an intervention for breast cancer. That was a story about listening to the community.*

**Sandra Hullett, MD (SH):** We’re still listening. And this is often a very difficult area because men at times don’t come to the doctor or pay attention to certain health areas. We were listening more to the women who were saying that we need to take our husbands to the doctor. They’re all dying on us. And so we said to the men, the women want you all to come to the doctor. What issue would you want to hear about? We did a poll and the response was prostate cancer. So we put together a health fair that offered testing for prostate cancer, both digital and the prostate-specific antigen (PSA) test. We took blood pressures, and screened for HIV, glucose levels; we even checked for sickle cell trait. You’d be surprised how many adults do not know they

have the trait. The men were very open to the whole thing. What I found most interesting was the seminar, because in the past I have observed the men just sitting and not saying anything. This time they had so many questions, we ran late. We also had a smoking-cessation seminar; they asked a tremendous amount of questions about that. When the women came they said, “We weren’t expecting any women. This was supposed to be for men.” The men actually signed up for medical appointments. Many men work in our county health system, where services are at almost no cost, and they weren’t using it. So our next goal is to get the men in our system to use the system.

**Table 1. The 2007 participants**

<b>Alan D Aviles:</b> CEO, New York City Health and Hospitals Corporation, New York, New York
<b>John W Bluford, III:</b> CEO, Truman Medical Centers, Kansas City, Missouri
<b>Sandra Hullett, MD:</b> CEO and Medical Director, Cooper Green Mercy Hospital, Birmingham, Alabama
<b>Gene Marie O’Connell, RN, MS:</b> CEO, San Francisco General Hospital, San Francisco, California
<b>Ramanathan Raju, MD:</b> Chief Medical Officer, New York City Health and Hospitals Corporation, New York, New York

**Table 2. The 2010 participants**

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

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### Community Clinics and the Hospital

**TJ:** *In San Francisco, former San Francisco General Hospital (SFGH) CEO, Gene O'Connell, spoke about her proposal to reallocate acute care hospital funds to external community clinics. This recognized that community clinics have an important relationship to the hospital—people who visit community clinics are healthier and thus have less impact on the SFGH Emergency Department and inpatient service.*

**Susan Currin, RN, MSN (SC):** I can give you two examples of how we accomplished that. The first reallocation was from our inpatient medical-surgical and psychiatric areas. Over the years the number of acute patients has significantly dropped, so we used those resources to create a psychiatric urgent care drop-in clinic and acute diversion unit in the community. The need was in the community-based programs and it did not make sense to keep nonacute patients in expensive hospital beds. They were best cared for in the community. We also started a Medical Respite in the community for patients once they are discharged, and it was also a place chronic inebriates could go for care rather than being taken to hospital emergency rooms

**TJ:** *That's innovative and highly beneficial for community members.*

**Claire Horton, MD (CH):** Yes, a Medical Respite is a wonderful service for people who don't have the acuity of medical problems requiring a hospital, and this community-based setting offers more support. And we could use those hospital beds for people with acute medical conditions. After hospitalization, patients can get discharged to this community-based, supportive setting, where they can complete the hospital treatment plan (antibiotics, physical therapy, etc). It's a vast improvement on returning to the streets before being fully back to baseline. From the primary care side, we will sometimes admit homeless patients to Medical Respite to help facilitate important tests or screening procedures—such as colonoscopies for at-risk individuals.

**SC:** Another program that Gene Marie O'Connell spoke of was video medical interpretation services. Over the last four years, we have provided video medical interpretation services by mobile video conferencing at SFGH. It's become a standard of practice and we partner with Alameda County to offer a broad range of languages. This can be done in any location. We now have 50 units within the hospital and we're ready to expand to the community primary care clinics. This is a second example of using resources from the hospital to provide the services in the community clinics

where they are really needed. And because the same technology for video medical interpretation is used for telemedicine, we're also expanding our telemedicine services. We will be doing ophthalmology, dermatology and behavioral health via telemedicine over the next couple of years in the community primary care clinics.

**CH:** As a side note on the video interpretation, SFGH is a training facility, so the presence of the video interpretation services significantly contributes to the education of the next generation of physicians. Many of our trainees will work in the safety-net system of hospitals and clinics where many patients have limited English proficiency. If we train our residents to use interpretation services appropriately and with every encounter, they enter the work world understanding the importance of medical interpretation and with the skills to use interpreters well.

### System Integration

**TJ:** *Those are great and functional connections that are extremely instructive for any hospital in a community or health care system. Let's continue to talk about integrated delivery systems, including how hospitals connect with community clinics and with the community, and, within hospitals, connections between departments and services. These are leading programs that create improved quality coupled with reduced cost, though it seems like every system has a different set of components or different barriers. So, we're interested in your approach and your progress in trying to integrate your system.*

**SH:** The New York City hospital system is a gigantic health system; in Birmingham we're still a small entity—the only public hospital in the whole area—but we're on the same street with all the other hospitals, like University of Alabama, and other major hospitals, such as the private children's hospital, and the state health department. We integrate services with those institutions. We also have community-based clinics that the whole family uses. The integration comes by having a working relationship with these other hospitals. We are working with them on better referral patterns and on transfers from emergency rooms. Mental health is a big issue in our area; we get people out of emergency rooms into facilities where there are beds. One of the ways facilities like ours will survive is to have something unique; for example, we connect with the homeless programs and with churches that work with family issues: social behavior work. In addition, we work with the free clinics that give three visits to their patients, so we create continuity of care, and we have six satel-

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lite pharmacies in the community to assist primarily outpatients who are scattered all around.

**John Bluford, III (JB):** Tomorrow, my short presentation is going to be on creating a healthy community and I am sure all of us are thinking in those terms, and trying to put it into action. So the premise is that ultimately we will be judged by the health status of the community we serve as opposed to what happens within our four walls. So that's the underlying premise. And one of the things I am going to be most proud of is this Passport to Wellness program that we put in place. Originally it was targeted for frequent flyers, people who frequently access our system, hence the name. And what we're doing is hands-on case management of four to five different cohorts (25 to 30 people). One cohort is frequent visits to our emergency room. Two others will have chronic diseases: diabetes and sickle cell trait. And the fourth will be employees with chronic disease conditions and/or excessive time loss and/or excessive use of our hospital. I'm really excited about it because we have a large research component built into the program. I've hired dedicated staff to work on this, and I've allocated \$450,000 to make it work. We will do whatever we have to do to improve health outcomes and the quality of life for our patients. The other area about this that I'm pleased with is that we made a decision to work on this for two to three years to determine what difference it makes. We have our matrix in place and we're not going to be grounded by the limitations of a grant or external funding.

**CH:** I wanted to mention a community-hospital linkage in San Francisco. There is a lot of attention now on transitions of care and how patient safety and quality of care suffer during transition periods. SFGH has a nurse practitioner (NP)-staffed "bridge clinic" for patients without a primary care physician after hospital discharge. This NP sees the patients after discharge, follows-up on important post-hospital treatment and workup plans, and arranges ongoing community-based primary care for the patient in the setting that's most appropriate for him or her.

**SC:** As part of that transition-care program, we're piloting an after-care plan which is an intensive discharge teaching process—within 48 hours the patients receive a phone call from the nurse to review their plan, their medications, the action they need to take if certain symptoms appear. This teaches people how to access the system. If they need to be seen, they go to this bridge clinic that Dr Horton described, and they have a follow-up call at ten days. We are observing now what impact that will have on readmission rates.

Leadership is critically important for us, so several staff of the San Francisco Department of Public Health are part of the current NAPH fellowship program: myself; Mivic Hirose, the CEO from Laguna Honda Hospital, (a 780-bed skilled-nursing facility); Tangerine Brigham, the Deputy Director of Health over our Healthy San Francisco program for uninsured patients; and Barbara Garcia, the Deputy Director of Health over community programs and community-based primary care. (She has just been named Director of Public Health, with the departure of Mitch Katz to Los Angeles). We have all the components for an integrated delivery system, but they're not linked yet. We're here to learn the current best practices so that we can prepare for health care reform, provide better care for our patients, and make sure that their care is provided at the right place, at the right time, and by the right staff.

**CH:** On my way to this interview, I was reflecting on working in the San Francisco County system compared to working in another county where the Department of Public Health, the public hospital and the community clinics were much less linked. I've really appreciated how linked those three San Francisco entities are. If there's a major initiative going on, all three of those bodies are present at the table and the Department of Public Health actually directs a lot of those community-based programs. That creates cohesion and communication in San Francisco, which moves us towards a more integrated system. In addition, the Healthy San Francisco program of universal health care has been tremendous in teaching us to work together. Patient data is much more readily available and easily shared, and our approach to quality improvement initiatives in the San Francisco safety net has become more coordinated and cohesive as well.

**JB:** Some of the most exciting activities are the external partner relationships we are nurturing. The future will create different and meaningful partnerships that may have been unthinkable in the past. Just over the past year we have forged strong business relationships with the local Hyatt Hotel to support sleep studies; the local Blue Cross and Blue Shield franchise to support our fresh produce market; the Kansas City Chiefs to support community health initiatives; and meaningful connections with Federally Qualified Health Centers. This follows longer-standing relationships with Walgreens, JE Dunn Construction, US Bank, Cerner, Morrison Food Services, and Cardinal Health, all in extraordinary support of both our patients and employees through creative relationships and programs.

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### Integration of People in the System

**TJ:** *Let's complete our talk on system integration by also discussing the integration of people, like multidisciplinary teams, or integrating physicians and practitioners across primary care-specialty care departments and services.*

**SH:** We do a lot of work in a multidisciplinary way in Birmingham. We train that way; in fact, I've done it that way all of my professional life. We have an inpatient-outpatient community base. We've got 600,000 people in Birmingham, and our one public hospital sees over 185,000 patients in the Outpatient Department alone. We work very hard to keep people healthy enough to stay out of the hospital. To make this work, for the people, we have 18 to 20 subspecialty services in our clinics because most of the people come for subspecialty care. Our community-based clinics are more primary care based. We have a staff integrated with NPs, physician assistants, and physicians; and have integrated primary care with subspecialty care. In many areas our people are cross-trained, so they can move where we need them. So we have multidisciplinary and interdisciplinary integration. It is cost effective to do it that way too.

In addition, in public facilities you find more social support services. Education is also very important. You want people to understand why they are there, and how to take care of themselves when they go home to prevent them from coming back. And you don't get paid very much for these services, if at all.

**SC:** Part of our system includes a large number of community clinics that are not part of the Department of Public Health but are part of our safety-net system. We do not have enough primary care capacity just within the Department of Public Health to meet the needs of the residents of San Francisco, so we've expanded our network in the community to include these other clinics. One of the major changes over the years is that SFGH is not the hub of the system anymore. The hub is really primary care in the medical home. That's been a major shift in the last three years, before people even thought health care reform could become a reality.

There's been major work in specialty care and primary care integration that is so important to well-coordinated medical care. All of our community clinics and hospital-based clinics are now linked with most of our specialists at hospital-based clinics through an electronic referral system that brings tremendous improvement in communication and access to specialty care. Other primary care-specialty care linkage projects represented at this conference further increase communication and integration between specialty and primary

care. We're moving beyond just linking the hospital-based primary care clinics and the specialists by linking to the community-based clinics as well.

**CH:** This electronic referral system that Susan Currin referred to did increase the communication between the primary care physician and the specialist, but also it increased specialist capacity for patients. As each of the specialty clinics agreed to participate and established guidelines for a referral, this increased communication back to the primary care physician. About 30% of all the referrals were able to be handled with specialist-primary care communication, rather than an actual patient appointment. That opened up appointments for other patients without hiring additional specialists. It was a good learning experience for everybody. It served the patients a lot better too. Part of the grant to develop the electronic referral system also allowed us to create, at the hospital, a Center for Innovation and Quality to support research in primary care-specialty care linkage projects.

**JB:** On graduate medical education, most of the hospitals affiliated with the NAPH are teaching institutions so the partnership, collaboration, integration, and alignment with the medical school is critical. I don't have an answer for that yet. I do know that everybody's talking about doing something. I think it needs to be a major paradigm shift in the delivery of medical education and how it compliments and better fits the needs of our patients, which should be priority number one. Another thing is critical: many of us have independent 501(c)(3) Medical Group practices that are not employee positions by the institutions per se but are connected at the hip. Nonetheless, a lot can be done relative to alignment with the physician group, for example, with the medical home a single bill can be submitted. First and foremost, however, there needs to be a fundamental understanding between management and physician leadership that we are one. This is the same for the medical school. And once we get to that point, with a stronger trust factor, I think we can start the hard work of integration, which is the details on how do we work within the confines of the legal construct to make things happen. This is the conversation of the times.

**TJ:** *Those are extremely important innovations in all of your public hospitals and systems, and very informative for those seeking ideas and outcomes from implementing them. In the next section of the interview to be published as Part 2 in the Spring 2011 issue, we would like to hear from you about quality improvement efforts, improving patients' experience, and finally about your approaches to health care reform. ❖*