

Innovation in Our Nation's Public Hospitals: Interview with Five CEOs and Medical Directors

By Tom Janisse, MD
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What quality improvement strategies are the leaders of our nation's prominent public hospitals following at this critical time of American health care change? Even more burdened than community hospitals with care for the uninsured and immigrant populations and with scarcer resources, how can they prosper, let alone survive? At the Spring 2007 annual meeting of the National Association of Public Hospitals in Boston, we talked with five leaders (Table 1) and found surprising and hopeful answers, and offer this conversation so that we can learn from them and follow their lead.

The Permanente Journal (TPJ): Please briefly introduce yourself, your position, and give a brief description of your hospital health system.

Sandra Hullett, MD (SH): Cooper Green Mercy Hospital is a small community hospital in the medical center affiliated with the University

of Alabama at Birmingham, so we are a teaching facility. About 70% of the patients are uninsured; the other 30% are Medicaid, Medicare, and third party. We are a service provider for a large number of disadvantaged people. Fifty percent of our funding is from an indigent county tax. We've been there since 1972 and have been primarily a source for acute care though we are changing our image through more community-based work.

Gene Marie O'Connell, RN, MS (GO): San Francisco General Hospital (SFGH) is the only trauma center in the city, with a full array of services in the acute care hospital as well as primary care and specialties, and the only psychiatric emergency unit in the city with the most psychiatric and mental health services of any area hospital. We have a total of 550 beds. Through an affiliation with University of California, San Francisco, we provide a third of all the teaching for the university. Last year we saw over 100,000 unduplicated clients.

John W Buford, III (JB): Truman Medical Center (TMC)—a 501-C3, nonprofit entity that was originally the city hospital—is a two-hospital system that includes a long-term care facility, as well as a major behavioral health offering, and we oversee the Jackson County Public Health Department.

Alan D Aviles (AA): The New York City Health and Hospitals Corporation is the largest municipal health system in the country. We serve about 1.3 million New Yorkers every year, including about 400,000 uninsured. The system includes 11 acute care facilities and 4 long-term care facilities and more than 80 community-based primary care sites. We have 4500 acute care beds and another 3000 long-term care beds. We provide 5 million outpatient visits per year and 1 million emergency room visits per year. We also run a very large Medicaid-managed care plan with more than 275,000 enrollees.

Immigrant Care and Language Barriers

TPJ: Safety net hospitals have improved medical care outcomes despite the challenges of caring for patients who are often immigrants and whose primary language is not English. How have each of you accomplished that?

GO: We started working on this several years ago. Like the city of San Francisco, the hospital has a very diverse population—20% of all patients at SFGH do not speak English and we have an on-site language service department with 28 interpreters who provide interpreter services in approximately 20 languages. In response to demands

Table 1. The participants
Alan D Aviles: CEO, New York City Health and Hospitals Corporation, New York
John W Bluford, III: CEO, Truman Medical Center, Kansas City, Missouri
Sandra Hullett, MD: CEO and Medical Director, Cooper Green Mercy Hospital, Birmingham, Alabama
Gene Marie O'Connell, RN, MS: CEO, San Francisco General Hospital, California
Ramanathan Raju, MD: Chief Medical Officer, New York City Health and Hospitals Corporation, New York

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for linguistic services (over 75,000 requests yearly), we have recently implemented a VMI (Videoconference Medical Interpretation) system, through a collaborative grant from The California Endowment in which we partnered with Alameda County Medical Center. VMI refers to the conducting of medical interpretation through a videoconferenced call—the clinician and patient on one end (using a simple, mobile video unit) and the interpreter on the other end (using a stationary unit in the interpreter services call center). Videoconferencing equipment now has adequate visual and audio capabilities and is no longer cost prohibitive—making its application in public health venues feasible. The primary purpose is to improve the communication between limited English proficiency (LEP) patients and clinicians by increasing access to interpreter services and significantly shortening the wait time. Currently the clinicians using VMI can access an interpreter within several minutes, which has dramatically improved the efficient and timely delivery of interpreter services to our LEP patients.

JB: Many of our safety net institutions possess an outstanding set of qualities: high-caliber staff with passion and a commitment to the population that they serve. That makes a big difference, and that's reciprocal because the clientele, ie, the patients, respond to that passion and that caring, to which I attribute a large part of the results we get. In our environment at TMC, we have been almost singularly focused on two things: good customer service and good clinical outcomes. As we have worked on this mission and focus and strategy both technically and strategically, we've added the notion that it must be advanced through technology. Furthermore, we must be the employer of choice

for choice employees—if you hire the right people and keep the right people happy, other things will fall into place. Specifically to your question, the genesis of our institution was a segregated hospital, so its purpose was to address the disparities of the old segregated south. It's part of who we are—non-discriminatory, open and equal access, and equal service to all people, including all of the social service add-ons we provide beyond the clinical necessities, whether it be transportation, interpretation, or outreach and hand holding. Those additional social services are critical to the definition of a safety net. It's a much more holistic approach. Finally, one of the value systems that we adhere to lately is that we're better for everyone. I commonly say we do not discriminate against those who can pay because if you attract an upscale patient base, then service is going to be better for everybody. You don't want to become a poor people's hospital; you want to become a good hospital for everybody.

SH: Yes, we also have great diversity here. The problem is that small facilities become experimental places. Because Birmingham is in the south and people don't think much about southern states having issues with diversity, no one has prepared or tried to make any changes in the existing systems. I have lived in a community where the hospital's largest foreign language was Spanish—less than 1% six years ago. Now, overall in the hospital it's 15% and in our Obstetrics Department it's 67%. So, we have a rapid growth in the use of Spanish, which is not regularly taught in the school system. We depend on interpreters on a language-line, though inadequate. Because the need was so great I insisted the county support this. We

now have four full-time interpreters. We also addressed the issue by going to the community where there are four colleges that offer Spanish majors. We met with them and said, "We can do something for you and you can do something for us. Let us develop an internship for your students." That internship allows students to help us with navigating, enrollment, and registration of patients. We also worked with a Robert Wood Johnson Foundation Grant to teach certified medical language—Spanish. The result was a place in the county to become certified in medical language by Stanford University. Now we have four full-time interpreters to assist the clinic visit. Six years ago there were 2 qualified people, and now there are 25 people certified to interpret. Even though we have less money than other area hospitals, we address the language issue in a larger proportion. It's been an uphill battle because I live in the community where people, even on my staff, still say those people need to go back where they came from or learn to speak the language.

AA: For us, it's also a big challenge. Of course, New York City is an entry point for new immigrants from all over the world—the current estimate is 500,000 undocumented immigrants living in the city—and we're the major safety net for them. More than 100 different languages are spoken among our patient population. How do you address this diversity in the absence of dedicated funding to support the required infrastructure? We have a quite limited number of dedicated interpreters, so we address this mostly from a combination of a very diverse and bilingual staff, and we do rely on

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telephonic interpretation services. All of our hospitals have dual-handset access to a language-line service. However, a small number of our facilities, including Bellevue Hospital, and Kings County Hospital in Brooklyn, are using a homegrown system called Team Electronic Medical Interpretation System (TEMIS), which was recognized as an exceptional innovation by the National Association of Public

Hospitals (NAPH), and won NAPH's safety net award. It's a remote simultaneous translation interpretation system for use in the exam room. The physician and patient put on a wireless headset and they connect

to a centralized call center where highly trained interpreters perform simultaneous translation (as in the United Nations) so that the patient is literally hearing in his or her own language what the physician is saying, as if s/he is actually speaking the same language—it gives the impression that they're speaking to one another in the same language. We now have received special grant funding so that we have 28 interpreters with our TEMIS call center handling 8 languages. However, just those 2 major facilities and a couple of our diagnostic and treatment centers have access to it at this point. Many of our hospitals also rely on volunteers for interpretation services, which is fine for general interpretation, but we now require any staff or volunteers interpreting in the exam room to undergo a 40-hour interpretation training course intended to teach more precise interpretation that maintains the accuracy of the communication between the physician and the patient. A

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couple of hundred people have completed that program, which represents a lot of investment in an important resource.

GO: Besides the language access that we have all addressed, there is the issue of low literacy. One of my doctors has been exploring the best way to communicate—one way is using pictures. And a major question is: At what grade level should the communication occur? Many patients may not understand what the doctor has said at all. Anybody who has gone to a doctor might have had that experience.

AA: Yes, that's very important. We're developing a tool that relies heavily on pictograms, especially for discharge medication instructions. Even when we generate instructions in the language of the patient, we still find many patients with illiteracy in their own language. Bellevue Hospital in particular pioneered work on materials for patients with low literacy that we now use more broadly in our system.

TPJ: A nodding patient isn't necessarily an understanding patient.

SH: We really struggle with having professional staff that speak different languages. We now put great emphasis in the school system on people becoming more competent in other languages. We're in the deep south, and we still had 18 different dialects documented in our hospital last year, with Spanish and Vietnamese the 2 most common. We have no physicians or nurses who speak those languages; the couple I had left or retired. We are working with the Spanish-speaking community to get nurses trained.

AA: Your question was about improving outcomes for the immigrant population. We have encountered another issue: for some communities, there are specific health issues not unique to them but that have a

disproportionate impact on them. For example, we have a large South Asian population in New York. South Asians, particularly from India, Pakistan, and Bangladesh, have a disproportionate incidence of cardiovascular disease at an early age—presenting with CV disease in their 30s that we are more accustomed to seeing in patients in their 50s—a result of both genetics and diet. We reach out to those communities to raise awareness of their heightened risk, and the need for early screening. Similarly, we find a high incidence of hepatitis B among the Asian immigrants seen at Bellevue Hospital, which serves a large Asian population, particularly Chinese, from the lower east side of Manhattan and other parts of the city. We reached out in those communities as well, and our screening has resulted in more than 20% of Asian immigrants testing positive for hepatitis B.

Connections to the Community and to the Community Clinics

TPJ: What is your perspective on community-based education and care, and your connection with community clinics, as it relates to your provision of care in either your public hospital or your health system?

GO: More people are discovering the value of community outreach to churches and other organized groups. They are happy to have you as a speaker, for example. However, what's our goal? Just to get to know people, to get people to come in for care, or delivering a specific message. The African-American diabetes project was with an organized group—people already working in the community, who knew so-and-so had diabetes. Sometimes word of mouth works really well. Kaiser

Permanente (KP) has done a lot for San Francisco General, for example different grants that we never would have been able to participate in, like with the Institute for Healthcare Improvement. One of the things KP has identified is that their patient population will be healthier if the whole community is healthier. This has been very helpful to our public health department, which I'm part of, because you can measure and measure our health disparity—it's not health care disparity—but then how do you do it in a more organized fashion? One of the things that helped us was getting all area hospitals and the African-American health disparity project to look at the same thing, for example hepatitis B. We got a number of the hospitals organized around this.

TPJ: Sandra, could you tell the story about this that you told me earlier?

SH: I worked in a community health center for 22 years before working in a public hospital. This gives me a different perspective of the community and how the community has been involved in their care. People see hospitals as a place to go when you're sick, when you need something done. Public hospitals often work with a group of community-based facilities practicing primary care and, when necessary, referring patients to the public hospital; therefore the community calls them community hospitals. These facilities just do primary care, they don't do community wellness programs, or go out into the community to listen to its needs. That's where, in the past, we erred: we came up with ideas that we think are important for the health care community. Now I actually work in the community on something that the community is

interested in. Before, our ideas were important to us, but in order for the community to buy into something, they must feel it's important. How do you get them to do that? You must first listen to their concerns. We started workshops: we invited the community in and shared the historical data: the health statistics of the area—the ten most-recorded health problems and the mortality rate associated with those problems. Then we asked them to pick what they thought was most important, something they wanted to work on. We would then develop it and see what the impact would be in the community. They picked breast cancer—in a community where cardiovascular (CV) disease was killing everybody. CV wasn't their interest; they were interested in breast cancer. They took it on; they learned about it and they came up with the framing process for getting the community involved. It was a project the hospital facilitated, but the community did the work. With the community and hospital working together, we created a forum in which lay women went into the community to educate women about mammograms and their importance. We then looked at the data to determine how many women had had mammograms before this project and then how many had one after our forum. The result was an 18% increase after six months—six months! Not just people who had talked to the doctor—because the emphasis was teaching people how to ask the questions, for example, “Why haven't you asked me about a mammogram?”—but people who actually had documented mammograms. I really think you can make a difference through hospitals—public hospitals especially—facilitating dialog—being there and listening to what those people know even though we think

we know what the issues are.

JB: Right. When people think about public hospitals, their first question is how many beds do you have? But it's really about the outpatient care volume—those 300,000 patient visits—the chronic diseases that embody societal ills, health care ills, and economic problems. Local communities can't absorb that. The question is: how are we going to substantiate the extremely valuable assets in our local communities that add to the quality of life in the community as a whole? Something's got to give. We've got to do it differently. Perhaps we need a payment mechanism that pays for the entire care continuum, expanded to include all health, including public health and mental health. It's all got to be rolled into chronic care and acute care services. There's a connection between inpatient and outpatient, first of all physically. Patients say they come into our hospitals but they may be coming to our clinics; they may be going to our diagnostic area but to them they're still coming to the hospital. And when things don't work out well, those outpatients become inpatients. We have to change how people think about the outpatient and inpatient settings and shift the emphasis to outpatient care. Because, on the other hand, if things work out well—in the case of prenatal care, for example—those outpatients become inpatients, then outpatients again after discharge, often seeing the same clinical team. And, a third thing, all outpatient and inpatient care should be connected by common medical record.

TPJ: Ramanathan Raju, MD, Executive Vice President and Chief Medical Officer for New York City Health and Hospitals Systems Corporation just joined in for Alan Aviles, who had to take an emergency call. Do

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you have any comments about that, Dr Raju?

Ramanathan Raju, MD (RR): HHC is actively involved in many outreach public health programs with our colleagues at the Department of Health, all of which are targeted to meet community needs. These programs reflect our joint focus on important public health issues, and make readily available the tools and information that people need. For example, we have worked together on increasing access to HPV because it is one of the major public health issues confronting people ages 12 to 25. Also, the NYC Commissioner of Health is extremely interested in smoking cessation, and our coordinated cam-

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paigns dispense smoking cessation medication and enroll people in smoking cessation programs. At our facilities, tobacco use assessment and counseling are now hardwired into the intake process. A last example is how we address community concerns has to do with the enactment of new immigration laws last year. We felt that people might be afraid to seek health care because of the concern that their information would be shared with federal government, which might lead to exposure and the threat of deportation. Mr Aviles and the New York City's Commissioner of Immigrant Affairs reached out to the community and reassured them that their information is always kept confidential and reiterated our mission that we treat all patients, irrespective of immigration status. The most important thing is to figure out what the community wants, because sometimes we have a paternalistic attitude that we know what's good for them and they should accept

whatever program we think they should have.

SH: I have a friend who says if a health problem exists in the community, then the solution can be found right there in that community. I know we've done a lot of work over the years—developing and distributing educational materials, for example—but we're still dealing with the same problems. My first research grant was from the National Institute of Heart, Lung, and Blood in 1982 on hypertension. I have a new grant to address cardiovascular disparity from the National Institute of Heart, Lung, and Blood. It's on hypertension again. So, something's wrong; we're not doing what we need to do.

RR: That is very interesting, because we have created a self-management tool for patients with hypertension and diabetes. However, with our old attitude of paternalism, we may say to patients that these are the food items that you can eat, and these are things you cannot eat. For ethnically diverse populations, that does not always make sense. Their cuisine and eating habits are so different that the normal dietary instructions do not always make sense to them. We have to figure out how to teach them healthy ways to cook and eat their own ethnic food, not teach them about X grams of carbohydrates and Y grams of fat and talk to them about food they rarely or never eat. They don't understand those calculations. So, one of the things we did was to build a working kitchen at Kings County Hospital. Now a dietician teaches them how to cook with their own ethnic food, making sure of right caloric intake. You cannot use a cookie-cutter methodology that does not work with some ethnic populations and then keep revisiting the same thing again and again

wondering why the outcomes are not optimal. I'm sure 20 years from today, there will still be hypertension grants because all that has been done so far is to institute very modest changes. Do we really engage the patient in an effective way? We talk to them, give them a piece of paper, and believe that they're going to follow our instructions when they go home. We call it engagement and get compensated for that encounter. Did we really achieve our goals during that encounter? We have the same issue with the flu vaccine. Some people do not believe in flu vaccines. They fear that the flu vaccine will give them the flu. So, unless we figure out their fear and deal with it, all our efforts to bombard them with flu vaccine campaign materials and incentives will yield only marginal results. We need to have a much more effective way of engaging patients—real engagement, not what we call engagement now. It is a flawed thinking ... that medications alone will get us the desired outcomes without enlisting patients' buy-in to make lifestyle changes—different communication styles and methods are needed for different groups of patients to get that buy-in.

SH: We believe in the education process, but we are working more to collaborate with communities, with health centers, and with other not-for-profit organizations. That is one of the things I like: we are collaborating more, not just doing our thing. Even so, we need to listen more to the community and we'll be much more effective.

GO: To follow Dr Hullett's point, the people at the San Francisco Department of Public Health came to the realization that there was always this push/pull between the hospital and the community people—that we were separate, serving different

populations, and the hospital used up all the money. A group of us now see the importance of support and giving to community programs, and recognize that their job is to keep people out of the hospital. I've proposed taking money out of acute beds to fund community programs, knowing that it's a real gamble in the first year, but in the long run, it can pay off. It's so important not to have a separation between the hospital and community providers. When they're linked, we can match the work in the communities I already mentioned.

RR: Public hospitals have done a much better job of this collaboration. We don't believe that the hospital's responsibility ends within the four walls around it. In fact we believe in the concept of "hospital without walls." Community providers are an extension of our delivery system. They are the hospital without walls. However Gene O'Connell is making a valid point. The present reimbursement system heavily favors inpatient stay, and does not pay adequately for disease management efforts. It is a real clash of mission and money at the end of the day.

Training Future Physicians in Quality Improvement

TPJ: Public hospitals characteristically train future physicians. How do you incorporate quality improvement awareness and methodology into your training programs so that residents are prepared for a future of not just gaining new knowledge, but improving the quality of their own practices?

SH: Cooper Green is a teaching facility with University of Alabama, Birmingham as our primary affiliate, though we work with many other organizations. Within the hospital

we build a culture where quality improvement is an essential part of what we do. Residents see physicians and nurses emphasize quality—it's our major focus—and a natural part of our culture. In our integrated model I see more residents taking on quality improvement themselves without us having to remind them of its importance. Quality has the same importance here as at the large university.

GO: That's interesting. I have to say we have rules here at SFGH too—many think it's the Wild West. The best thing that has happened to the whole quality discussion is changing it to patient safety. There is widespread awareness of patient safety, such as having ventilator-pneumonia posters everywhere, and holding chiefs accountable for improvement. A couple of years ago, a benchmark for us was our study of medical orders—people weren't signing and dating their verbal orders, so we got rid of verbal orders. We decided that at the Medical Executive Committee meeting, everybody said, "Oh, the patients are going to die," and "This is going to be awful." We haven't had verbal orders now for two years and no one has died. Making a dramatic change like that, which can really impact patients and staff, makes you realize you can improve things. As Dr Hullett said, it's not just for medical students; it's having a culture where everyone makes the patient safer. To collect quality data most public hospitals have to input manually. IT systems don't perform all the functions everybody wants. However, one of the positive things about manual data collection is that people open the medical records and actually read what people are writing. It would be great though if you could just push a button and get good data.

JB: I've been doing this work for over 30 years and have never seen a computer system that has lived up to the expectation, or the cost, that it has taken to bring it on. It would be nice for all of the great minds to get together and resolve the electronic health record technology with a common platform and perhaps a universal ID number so that the records can truly be transportable across multiple systems, and if there were federal funding to purchase these systems. They kill us.

RR: A couple of things are happening nationally that will firmly embed quality into practice, like Medicare pay-for-performance at the physician level. Residents are very smart, and quickly understand the marketplace and adjust how they have to practice. The second part of quality improvement is, how to get all stakeholders involved in quality? We started including the residents on the quality assurance committees, making them understand and be accountable for the results of what they do. The third thing we did was to create a robust physician support system with prompts and reminders—a medical record system that automatically tells you when and how to prophylax the patient for deep venous thrombosis, for example. This hardwires orders into practice. I agree with the panelists on this. This should become part of day-to-day life. When residents examine a patient with a mild heart attack, they should pick up a pen and order aspirin as automatically as they reach for a stethoscope. It's such a great tool—getting the medical student involved in patient care from the start—as opposed to spending years just reading books. Theory and practice are taught together.

JB: We always have this three-part focused mission on education,

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research, and clinical care. We are emphasizing clinical outcomes and clinical care, because these institutions should exist for the patient; not primarily for education. You can't have the teaching and training of physicians, students, nurses, and pharmacists take precedence over the patients and customer service. Patients are first. However, one of the benchmarks of any good institution is the application and the culture of innovation and creativity. We need to rethink old models because the rate of change is so fast—technologic advances have had a dramatic effect on our respective institutions—and, in fact, what we've been doing is not getting any of us to where we want to be in terms of quality and value.

Conclusion

What is perhaps most surprising to learn from prominent leaders of

our nation's public hospitals is that beyond the collaborative approaches they have implemented in their hospital departments, these leaders see the future as developing an integrated system with community clinics and with the neighborhoods and communities they serve, even in large, complex cities.

Secondly, the generative quality initiatives these leaders have implemented have been based on a scarcity of resources that necessitated collaborative solutions that not only reduce expenses but improve quality and satisfaction. For example, the increasing complexity of communication between people in an ever-larger and diverse population led to a simultaneous translation system—similar to that used in the United Nations—creating virtual direct dialogue between people with different primary languages.

The decision to better understand their patients' real needs led to better medical care, with much less time and money wasted on common wrong-headed, health care-expert approaches. Improved care is not about the number of hospital beds but about the number of outpatient visits that generate that need; teaching patients how to cook healthy foods is a superior educational tactic to developing better diet instruction sheets; and finally, that training future doctors by actually involving them in the hospital's quality improvement committees and clinical projects produces a more sustainable, long-term health care solution.

We hope this interview serves as a tribute to our nation's public hospital leaders, physicians, nurses, and caregivers, and their patients. ❖

Duty of Our Generation

This is the duty of our generation as we enter the twenty-first century—solidarity with the weak, the persecuted, the lonely, the sick, and those in despair.

It is expressed by the desire to give a noble and humanizing meaning to a community in which all members will define themselves not by their own identity but by that of others.

— *Elie Wiesel, b 1928, Rumanian-born American writer, 1986 Nobel Laureate for Peace*