TRUST COUNTS NOW

Hospitals and Their Communities

A Report to the American Hospital Association

By John G. King and Emerson Moran
Foreword

The document in your hands has the potential to help you awaken your board and management team to one of the most important and pressing priorities for America’s hospitals: reaffirming their rightful place as valued and vital community resources that merit broad public support. *Trust Counts Now* is a report by a nationally recognized leader on the relationship between hospitals and the communities they serve.

The American Hospital Association’s Board of Trustees believe that strong public trust and confidence is the key to a successful future for every hospital. And they share a commitment to helping AHA members strengthen that bond in any way they can.

The Board asked their respected colleague, former AHA Chairman John G. King, to take on what for some might be an intimidating task: assess the many forces and factors affecting public trust and confidence, find out what leaders across America were thinking about the issue and see which institutions were creating models of community connection.

John led three health care organizations during his distinguished career, retiring as chief executive of Legacy Health System in Portland, Oregon. He currently is on the board of The Health Forum and is a member of the AHA Center for Healthcare Governance Board of Managers. Since his retirement, many hospitals and health systems have sought his counsel on strategy, governance and other issues. The report he delivered to the AHA Board of Trustees is a straight-from-the-shoulder, sometimes jolting analysis of what the public and hospital leaders are worried about, what some hospitals are doing about it, and how others can and should follow.

To get this information, John, with the help of Emerson Moran, former head of advocacy communications at the American Medical Association, conducted a series of intensive and candid interviews with hospital leaders from all areas of the country and discovered and described several examples of hospitals working to cement their community bonds in innovative ways. They also compiled information from various public opinion polls about hospitals, including the AHA’s own Reality Check series of focus groups.

If you want to know how hospitals are hardwiring public trust and confidence into their mission, strategic planning and everyday work through the very organizational model that holds them together, this report is vital reading. It points to best practices for how to earn and bolster public trust. And it all adds up to some very sharp observations about how our moral compass should lead the way.

After you’ve read this, I’ll bet you will quickly develop your own list of others on your team with whom you’ll want to share it. It illuminates some very critical lessons about the bond that exists, or should exist, between you and the community you serve. As John says in the close of this report, “energy and openness” are needed if hospitals are to regain the trust of the public – the same energy and openness that grace this important document.

Dick Davidson
AHA President
The Character of America's Hospitals:
Becoming Who We Say We Are
Why Hospitals Need the Trust of the Public
and What They Can Do to Earn It

WHY TRUST COUNTS NOW
The Credibility of Each Hospital Is on the Line…

All health care is local. The people, organizations and institutions that provide health care are woven into the fabric of the community. The life and death consequences of health care make our relationships with providers of care unique – there is nothing else quite like it in our daily lives. But, for most people, health care is complicated, technical and intimidating. Hospital competition and marketing campaigns can confuse as much as they clarify. Differentiation often comes down to “position” – that magical quality which, in the customer’s mind, separates one hospital from another. And “position” is a function of how well a local hospital has earned the confidence of customers and the public.

Hospitals’ “position” with the American public has faltered over the past few years. A decade ago, the AHA, in the first of its “Reality Check” surveys, warned that Americans were “uneasy, unhappy and sometimes afraid” of changes in the health care system. The surveys made it clear: The future vigor of hospitals and health systems depended on public trust. Hospitals, the AHA urged, needed to “work every day” to strengthen their ties to the public.

Many hospitals responded vigorously and today enjoy a renewal of community regard and public trust. But other hospitals have not taken full advantage of the opportunity to strengthen the public’s confidence. In too many communities, people feel disconnected from their local hospital’s mission, values and competence.

Polling of public opinion and attitudes – shaped largely by persistently negative media commentary – finds that too many Americans question the ability of hospitals to make the right decisions regarding their health care; many actually fear their hospital will harm them if they are admitted as patients.

As the public’s regard for hospitals declines, individual hospitals are challenged to recapture that lost confidence.

In times as difficult and demanding as these, securing the trust of the public in the nation’s hospitals is paramount. Even if a hospital’s connection to the community already is strong, it must be bolstered. If it’s weak, it must be strengthened. If it’s broken, it must be fixed.
Public opinion polling over the past few years tracks a significant and in attrition of public confidence in the health care system in general and in hospitals in particular. The key surveys detailed below show that a clear majority of Americans now report they do not fully trust hospitals and they fear infection or injury during a hospital admission. Important findings include the following:

- 28 percent fewer feel our health care system is meeting their needs than five years ago. (McInturff, May 2004)
- 60 percent do not completely trust hospitals to do the right thing for patients. (Harris, January 2004)
- 55 percent fear they will be harmed during a hospital stay. (Health Pulse, May 2003)

This decline parallels the negative portrayal of hospitals in popular culture and the news media through the same period reinforcing negative images of hospitals in the mind of the public. The longer the negative hospital images persist the more difficulty hospitals will have recapturing a positive image and improved trust from patients and the public at large.

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<tr>
<th>Trust and Distrust – Independent Polling</th>
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<tr>
<td><strong>National Journal</strong></td>
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<td>Public Opinion Strategies/William D. McInturff</td>
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<tr>
<td>Is the American health care system meeting your needs?</td>
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<td>• 1999 – 77% percent said “yes.”</td>
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<td>• 2004 – 60% percent said “yes.”</td>
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<td>• Decline of 28% over 5 years.</td>
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<td><strong>Wall Street Journal Health Care Poll</strong></td>
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<td>HarrisInteractive</td>
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<td>Do your trust your hospital?</td>
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<td>• 4 of 10 Americans trust hospitals to do the right thing for their patients.</td>
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<td>• 56% trust hospitals only some, not much or not at all to do the right thing.</td>
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<td>• 13% trust hospitals not at all.</td>
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<td><strong>Health Pulse of America November 2003</strong></td>
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<td>Center for Survey Research</td>
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<td>State University of New York – Stony Brook</td>
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<tr>
<td>How do you rate the quality of your hospital?</td>
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<td>• 8% ….. excellent.</td>
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<td>• 63% … good, fair or poor.</td>
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<td>• 7% ….. poor.</td>
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<td><strong>Health Pulse of America May 2003</strong></td>
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<td>Center for Survey Research</td>
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<td>State University of New York – Stony Brook</td>
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<tr>
<td>Do you worry something might go wrong during your hospital stay?</td>
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<td>• 55% somewhat or very worried of wrong treatment or serious infection.</td>
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<td>• Only 34% rate hospital as excellent or very good.</td>
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<td><strong>HarrisInteractive 2002</strong></td>
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<td>When asked who do you trust to make the right health care decision:</td>
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<td>• 43% said physicians.</td>
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<td>• Only 22% said hospitals.</td>
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<td>• Just 8% said managed care plans.</td>
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PART ONE: SCANNING THE ENVIRONMENT
What The Public Says We Are…

Perception is Reality
Unfavorable public perceptions of hospitals are reinforced routinely by a news media that is persistent, aggressive and relentlessly negative. This uninterrupted trend of unfavorable news content feeds public opinion a steady diet of negative messages about hospitals. Media reports, such as the following, help shape the public’s perceptions of hospitals.

• Under Investigation: Congressional and IRS investigations of insufficient charitable care, spending and executive compensation practices can suggest to the public that hospitals are disconnected from their communities.

• Medical Errors: High-profile hospital-based medical errors could convince the public that hospitals do not care for them or their families.

• Hospital Charges and the Uninsured: There are media reports that some hospitals are charging uninsured patients full retail prices, higher than what insurers and governments pay. High-profile litigation extends the story.

• Billing and Collection Practices: There have been media reports that some hospital debt collectors have sought the arrest and detention of patients who skip court appearances about their unpaid bills.

• Transparency: From confusing billing procedures to patient safety shortcomings to protecting performance data – hospitals often seem the antithesis of transparency.

The cumulative effect of unremittingly negative news will undermine a local institution’s community standing. Once convinced that a trusted and essential community resource no longer shares their values and concerns, the public can be unforgiving.

✓ “REALITY CHECK” RECHECKED
All that’s changed is the Institute of Medicine report on medical errors…

Through the late 1990s, the AHA conducted three cycles of focus group and opinion research to gauge public perceptions of health care and hospitals. The studies benchmarked public attitudes over four years, flagged the public’s reaction to changes in the health care system, and telegraphed to hospital leaders the need to strengthen the public’s trust in their hospitals. The research was coordinated from 1996 through 1999 by AHA Senior Vice President Rick Wade and Lee Zacharias of The Zacharias Group. Ongoing Zacharias research with state hospital associations and individual health systems shows that the Reality Check findings remain valid with even more intensity today.
How the public sees hospitals...

- Lacking individual identity, values and mission.
- Transformed from charitable institutions to purely business enterprises.
- Impersonal and detached from community.
- Lost the public legitimacy their expertise once earned them.
- Put economics ahead of patient care.
- Block access, reduce quality, limit spending to maximize profits – at patients’ expense.
- Abandoned traditional role as advocates for patient needs.
- No difference between for-profit and not-for-profit hospitals. All driven by pursuit of profits.
- Profits drive mergers and acquisitions, with public as the losers.
- Mergers and consolidations cause adverse health consequences.

Important commentary from survey

Reality Check 1996 to 1999:

- Once a community-based institution crosses the threshold of public opinion and appears to become primarily a profit-driven supplier of a commodity, it’s a long and costly road back to public support and esteem.
- The public wants and needs institutions that put value back into their communities, and will deal harshly with entities they believe remove value from their communities and take dollars out of their pockets.
- In the public’s mind, hospitals used to be, in some authoritative and important sense, more than the sum of their parts.
- Today’s public is concerned that hospitals have become less focused on community need and maintaining their historic place as part of the community infrastructure.
- Hospitals are at risk of losing public support in maintaining their place at the table of health care decision making.

Déjà vu all over again

Researcher Lee Zacharias’ findings in 2004:

- Little has changed since 1999.
- There is still a disconnect between what hospitals believe are the issues and what patients experience in the hospital.
- Hospitals have not put a human face on the issues and talked to the public in terms they can understand or addressed the public’s concerns.
- Dialogue is needed, not public relations.
THE VIEW FROM THE TOP

Today’s hospital leaders are concerned…

In individual interviews in the Spring 2004, 19 hospital leaders were asked to assess the relationship between the American public and local hospitals, based upon their own experience and perception. The interviewees were notable for their candor, insight and expertise. They concurred on several basic observations:

- Hospital reputations are more negative, and public trust is lower.
- Ascendancy of the business model diverts hospitals from the community.
- The public sees today’s hospitals as “more corporate than caring.”
- The failure of hospitals to “deliver” on patient safety causes a crisis in lost trust.
- Some hospital executives and boards are resistant to change.
- Local hospitals can change with AHA leadership and example.

CEO INTERVIEWS

The CEOs, in their interviews, pinpointed causes and consequences of hospitals’ disconnect from their communities and identified barriers to positive change.

Current Dynamics:
Factors contributing to the erosion of trust and the failure of reputation…
- Harshness of Clinton health reform battles and patient rights struggles.
- Taint from managed care horror stories.
- Public fear of injury or death if admitted to the hospital.
- Wave of mergers/acquisitions/consolidations ending tradition of public health model.

Consequences of appearing more “corporate than caring”…
- Public concludes hospitals are driving force in making health care a commodity, not a service.
- Decade-long push to build hospitals as a business disconnects hospitals from communities.
- Primacy of technocrats = decline of real leaders.
- Roughness of competition in public arena diminishes all hospitals.
- Neglect of responsive and meaningful community relations = loss of identity and public trust.

Barriers to Change:
Shortsighted, non-responsive leadership…
- Resistance to change (fear, ignorance, passivity) by some hospital management, hospital boards.
- Hospital leaders not publicly known or accountable.
- Technocrats’ avoidance of community leadership, civic involvement.
- Allowing the urgent to overwhelm the important.

Internal and external shortfalls…
- Supremacy of business model over public health model.
- Lack of will by public and private sector to ensure health care coverage for everyone.
- Failure of hospitals to demonstrate to public meaningful steps to improve patient safety.
- Poor public communications, lack of “outside-in” thinking.
- Failure to “listen” to the community.
PART TWO: PRINCIPLES, CHALLENGES AND OUTCOMES

*A Moral Compass To Point The Way…*

For hospitals in today’s America, adapting to change and public need means (a) comprehending the challenges more clearly, (b) embracing principles more firmly, and (c) fighting for the desired outcomes more fiercely. Here are recommended principles – a pathway – for hospitals to follow as a formula for the building of public trust.

**Mission**

*Principle:* **Be who we say we are.**

*Challenge:* Does the public believe the mission of hospitals is to improve the health of the community, or is the mission to leverage acute care and improve the bottom line?

* Desired Outcome: Live the mission.* Adopt a public health model to complement the finance and business model that has dominated the past decade.

**Leadership**

*Principle:* **Hospitals are de facto community leaders.**

*Challenge:* Are hospital executives and board members visible community leaders, and are they accountable to the community for their performance?

* Desired Outcome: Serve as an agent for social change.* Hospital leaders lead with vision, personal motivation, boldness, accountability, and a willingness to partner with competing hospitals and local public and private leadership to tackle social problems that threaten the health of the community.

**Quality**

*Principle:* **Crossing the quality chasm will bridge the confidence chasm.**

*Challenge:* Is the public aware of how hospitals are improving the quality of care, protecting patients, assuming accountability, and providing vital clinical and performance information to the community?

* Desired Outcome: The public registers high awareness and confidence in how local hospitals are improving the quality of health care, the safety of patients and the health status of the community.*
PART TWO: PRINCIPLES, CHALLENGES AND OUTCOMES

A Moral Compass To Point The Way…

**Transparency**

Principle: *Information is the oxygen of public trust.*

Challenge: Do hospitals resist making public reliable information on patient safety, quality issues and hospital performance?

Desired Outcome: **Hospital CEOs improve credibility** and public standing by sharing publicly accessible and usable information on quality, performance and patient safety.

**Competition**

Principle: *A patient-centered hospital builds public trust and market share.*

Challenge: Does aggressive competition among hospitals weaken public confidence and trust?

Desired Outcome: **Collaboration balances competition.** Hospitals compete responsibly for acute care market share and collaborate – publicly – with competitors on how best to improve the health status of the community, always putting patient welfare and public health as the main motivating forces.

**Development**

Principle: *Investment in social capital produces capital returns.*

Challenge: Is the public stature of local hospitals strong enough to compete with colleges, other hospitals, social service agencies and other nonprofit organizations for private donations and philanthropic contributions?

Desired Outcome: **Hospital development activities** are more productive as a result of strengthened public perception of hospitals as community leaders, agents for needed social change and advocates for the good health of the community.

**Human Capital**

Principle: *Investment in human capital generates social capital.*

Challenge: Does the reputation of a hospital influence the quality and stability of its work force?

Desired Outcome: **Employees and physicians stick with winners.** Recruitment and retention improve when hospitals are well-regarded, trusted and demonstrate community concern and leadership.
How a hospital views its role and structures itself to express that role is a statement of the hospital’s relationship with the community. The organizational models presented below strengthen those relationships and help hospitals meet the needs and cultures of their communities. Some models draw the community closer to the hospital; others push the hospital out into the community. Some models assert strong hospital leadership in the larger community; others follow a more toned-down role. Each model results in greater interaction between hospital and community and improved levels of public approval, trust and confidence.

The organizational models are:

1. **Cooperative Ownership**…
   Patients have a stake in the hospital or health system.

2. **Stakeholders as Governors**…
   Stakeholders select the board, build community loyalty.

3. **Hospital Foundation**…
   Development finds resources for both hospital and community.

4. **Bond Holder**…
   Individuals in the community invest in the hospital.

5. **Competitive/Collaborative**…
   Competing hospitals collaborate to meet the community’s needs.

6. **Healthy Community**…
   Hospitals return to their public health mission.

7. **Quality Improvement**…
   Hospital excellence helps drive local economic growth.

Common pathways to public trust run through the seven models. Foremost: The relationship between community and hospital is always considered a two-way street. The mutual investment of people, time and resources is the glue that binds community to hospital. When the relationship between hospital and community is healthy, the health of the public, communities and hospitals improves. For most hospitals, positive outcomes such as these require change, and successful change depends on hospital leaders with vision and commitment.

The payoff is substantial and lasting: Hospitals that faithfully follow one of these organizational models are more likely to be perceived by the public as responsive to the needs of the community – and will be rewarded with the public’s trust as a consequence.

The profile of each model is followed by a detailed “best practice example.” These “best practice” hospitals earn and hold the public’s trust by inventing and re-inventing ways to use their power and resources to be good corporate citizens and to work with the community to address critical health and social problems. Each model hospital has learned how to exploit its own strengths and standing in the community, and each is following its own distinctive pathway to collaboration, change and community confidence.

In the broadest sense, these are true “teaching hospitals” – beacons for the rest of the field – that have opened pathways of collaboration with their communities that benefit patients, the public, the overall community and the hospitals themselves.
COOPERATIVE OWNERSHIP

Group Health Cooperative
Seattle, Washington
1998 NOVA Award
www.ghc.org

Background
On August 14, 1945 in downtown Seattle, barely minutes before radio bulletins flashed news of Japan’s unconditional surrender and the end of World War II, Dr. Michael Shadid, a crusading physician from Elk City, Oklahoma, spoke to a small but eager audience of local union and farmer’s grange leaders, physicians and consumer advocates. Shadid, organizer of the country’s first cooperative hospital, brought a message that was radical for the time: How to set up a member-owned, consumer-governed, prepaid plan for group medical coverage. His audience was enthusiastic. Most Washington state middle-class people had no health coverage at war’s end; a cooperatively owned health plan seemed an instant answer. By December, Group Health Cooperative of Puget Sound was incorporated. A year later, with thousands of soldiers and sailors back home, Group Health’s several hundred charter members were being treated by their own medical staff at its first two fully-owned facilities.

More than 50 years later, Group Health is the country’s second largest consumer-governed health care organization, with about 550,000 members in Washington and Idaho, nearly 8,000 physicians and clinicians, 10,000 employees and almost $2 billion in revenues. It is the state’s third largest – and perhaps most stable – employer. Despite its size, the health system remains true to its founding premise – that consumers can improve the health of their own families and their own communities by working together. Group Health Cooperative is considered a national model for quality prepaid health care. With a consumer-elected board of trustees, a patient-guided ethics council and publicly accountable leadership, Group Health is tightly linked to its community and commands public confidence like few other health systems.

Initiatives and Outcomes
Member-Owners: Enrollees help govern the organization. Members take part in Group Health’s annual meeting, held at the University of Washington; elect the board and vote on the by-laws; attend board meetings and directly address the board on all matters except personal health care issues; join the medical centers’ advisory councils; and participate in the Senior Caucus, which advocates health care needs for aging enrollees.
**Transparency:** Group Health’s Web site is the members’ window into the organization’s operation and performance. Included are e-mail and phone links to the board of trustees; details on quality and patient safety measures; financial performance; Group Health’s results in The Leapfrog Group’s hospital patient safety survey; Group Health’s 67-page Form 990 federal tax return; and specifics on community involvement.

**Strategic Change:** In the late 1990s, Group Health began a series of strategic actions to “unbig” itself in the community’s eye by becoming more responsive and relevant to its membership. Its focus: To empower patients with information by transforming the Web site “MyGroupHealth.com” into an interactive tool allowing members to view their electronic medical records, contact physicians, refill prescriptions, get lab results, track appointments, access 24,000 pages of medical information – even e-mail board members. With a $30 million information technology investment, Group Health is moving away from paper charts and records. The effort earned Group Health recognition as one of CIO magazine’s worldwide Top 100 for “strategic excellence in information technology.”

**Community Involvement:** Top executives are required to be active in community affairs. The organization’s business plan promotes and rewards an activist social mission that includes community relations, community benefit, volunteerism and philanthropy. The board’s “Community Service Principles” direct a range of actions embracing sponsored care, education and employment opportunities for youth, community-based research, and volunteer opportunities for medical staff, employees, and consumers. Highlights include:

- Funding a pediatric nurse practitioner for homeless children at an emergency shelter.
- Supporting school-based teen health centers.
- Offering free meeting space for community agencies.
- Staging in-depth preventive care workshops for professionals and the public.
- Collaborating with local partners on improving the community’s health status.
- Leasing out a fully-equipped medical center for $1 a year for Hispanic health care.

**Bottom Line**

*Group Health’s business plan* integrates the organization far deeper into the life of its community than most health plans and hospital systems. As the CEO explained, “Yes, we have to run a business, but we also need to be part of the community…being accountable to the public is part of our genetic code.” One example of a return on its investment in the community: During a prolonged Group Health management-labor dispute in 2004, the Seattle news media coverage was fair, objective, and without editorial attacks on the organization or its leadership.
STAKEHOLDERS

Advocate Health Care
Oak Brook, Illinois
www.advocatehealth.com

Background

The connection between healing and religion – the core of Advocate Health Care’s mission – is as old as recorded history. The concept of the modern hospital, however, didn’t emerge until the first Christian Roman emperor, Constantine, abolished all pagan hospitals. Before Constantine, the ill and diseased were shunned. But after Constantine, the ill were embraced by Christian communities, and care for the suffering was an assumed obligation of the church. The tradition migrated to the New World with the earliest colonists. In many American communities, churches or religious orders formed the first local hospitals. Today, about 13 percent of all U.S. community hospitals – more than 600 – have some form of religious or sectarian affiliation. Many of these hospitals manifest strong levels of public confidence due to their church connections.

Advocate’s antecedents are two faith-based hospitals formed by German and Norwegian immigrant churches in Chicago about a century ago. Each hospital sprang from the need for immigrant communities to care for their own; each was founded by church congregations; each provided broad community social services to families in need; each followed a church imperative to include healing as part of a wider community ministry. The most strategic similarity: The governance of each hospital was closely aligned with the church organization itself. The most strategic benefit: Congregants were hospital stakeholders and patients at the same time. The most significant result: The hospitals were extensions of their communities, and vice versa.

That intimate hospital-community relationship endures, despite the passage of time and changing realities. By the mid-20th century the German hospital had evolved into Evangelical Health Systems (EHS), an affiliate of the United Church of Christ; the Norwegian hospital became Lutheran General Health System (LGHS), part of the Evangelical Lutheran Church in America. In the mid-1990s, market pressures and the appeal of creating a like-minded, faith-based regional health system prompted the merger of both hospitals into Advocate Health Care.

Advocate is based in suburban Oak Brook, about 20 miles west of downtown Chicago. The health system’s mission statement includes serving the health needs of area communities as well as individuals and families. Advocate is a mainstay of the area’s health care infrastructure and its economic stability. All measures of the organization’s statistical profile are big:

- It is the largest not-for-profit health system in the area, with 8 hospitals, 3,500 beds and 260 sites.
- It is the region’s second-largest private employer, with 25,200 employees and 4,600 physicians.
- In 2003, Advocate admitted 147,000 patients and handled 563,000 outpatient visits.
- Community programs valued at $52 million reached more than 1.5 million people in 2003.
- Advocate provided $60 million in charity care and $220 million in uncompensated care in 2003.

STAKEHOLDERS AS GOVERNORS
Stakeholders select board, build community loyalty

Purpose: The hospital is a permanent, rooted civic asset.

Methods:
Community stakeholders – e.g., individuals, religious entities, government, community-based and/or civic organizations – compose a legal corporate body that selects and holds accountable the Board of Directors. The stakeholder body (1) acts as an advocate to the community for the hospital, (2) guarantees the hospital is responsive to the needs of the community, and (3) ensures transparency and accountability in hospital operations.

Benefits:
- Corporate members elect board, approve by-laws.
- Stakeholders are community advocates for the hospital.
- Bond of community ownership attracts local investment and loyalty.
- Hospital success is a community-wide goal.
- Health of community is immediate beneficiary.

Challenges:
- Demands management’s time and energy to best utilize corporate members.
- Benefit is only as good as hospital’s willingness to use corporate members.
- Hospital leaders may resist accountability to corporate members.
- Uninformed, untrained corporate members can harm hospital’s reputation.

Opportunities for Church-Sponsored Hospitals:
- Catholic hospitals strengthen ties to local parishes.
- Protestant hospitals recharge weakened ties to local congregations.
- Corporate members provide conduit for community investment in hospital.
- Board performance benefits from keener sense of accountability.

Bottom Line:
- Relationship with community is stronger.
- Public confidence is higher.
- Community is motivated to invest in hospital.
- Church-sponsored hospitals extend reach throughout community.
Initiatives and Outcomes

Stakeholders Supreme: Advocate’s governance structure is built from the outside in. A top tier of two dozen church members, bishops and ministers from each denomination selects a conventional board of directors. This 20-member board is composed of other church leaders and members, plus doctors, lawyers, bankers, educators, business leaders and Advocate’s CEO. Top executives from the eight Advocate hospitals act as a “governing council.” Net effect: Principal stakeholders from the United Church of Christ and the Evangelical Lutheran Church of America are the core authority of the health system’s governance. They are the channel through which the community connection flows to and from the hospital system, and they are as accountable as management for hospital system performance.

Congregations as Partners: Though the names have changed over the past 100 years, Advocate hospitals are a given in community life. Some have cared for the full life cycles of five generations of the same families. The congregations that founded the originating institutions are partners with the hospitals today. Meanwhile, Advocate’s community ministry collaborates with other churches, denominations, temples and mosques on how to tackle the issues that affect the “wholistic” health needs of their congregations. One example: blood pressure screenings after church services. As one interfaith program director put it, “The commitments are very old, but the implications are ever new.”

Good Health to All: Advocate’s ecumenical Community Ministry helps congregations set up their own “Health Cabinet” and mutual support networks. The Parish Nurse Ministry in 2003 connected 58,000 members of 29 congregations to church, community and health care services. A childhood trauma treatment initiative provided mental health services to 1,400 victims of childhood sex abuse. School and church wellness programs targeted diseases specific to different minorities.

Into the Community: Individual Advocate hospitals establish a presence in their own service-area communities with health fairs, neighborhood and school clinics, immunization programs and health screenings. Working together, the hospitals respond to broader health needs with regional programs addressing infant and childhood health, asthma, senior wellness, adult day care and referrals for the uninsured.

Outside-In Investments: The two-way connection between hospital, congregation and community creates a conduit for investments from the community back to the hospital. For example, in 2001, families, former patients, physicians, local businesses and foundations contributed $31 million to Advocate hospitals.

Stakeholder Accountability: Stakeholder-management relations require maintenance in good times so they remain viable in hard times. One of Advocate’s affiliated church organizations recently moved to strengthen its “mutual accountability” with Advocate on matters related to charity care and access to care for the uninsured.

Media Is the Message: Church affiliation, longevity in the community, strong management and fiscal stability pay off in positive public and media perceptions. During recent union and legal challenges, Chicago media reports remained fair and balanced. Advocate’s own public perception surveys show consistently strong positive ratings. “Good works” are the reason, says the CEO.
Background

St. Joseph, Missouri, is a small city of about 74,000 strategically settled on the eastern bluffs above the Missouri River’s westward bend in what is known as the Midwestern Four Corners, where Missouri, Iowa, Kansas and Nebraska meet. In 1860, America’s train tracks ended and the fabled Pony Express began at St. Joseph; some 100,000 pioneers and gold-rushers passed through on their way to the frontier. For a time, St. Joseph, with 100 passenger trains arriving daily, was considered the most prominent city between St. Louis and San Francisco. St. Joseph is where Jesse James was killed (1882) and Walter Cronkite was born (1916).

Today, St. Joseph is the economic, educational and health care center for a multi-state 30-county region with 150,000 residents. Once a national meatpacking hub, cattle and agriculture are still mainstays. But the area’s economy is slowly declining, triggering serious and chronic challenges to the population’s good health. Unemployment pushes 7 percent. The number of people living in poverty stays in double digits – 13 percent of the entire population, 10 percent of all families, 10 percent of everyone over 65, and nearly 16 percent of all children and teenagers. Local officials report that large numbers of young people move away to find better jobs, while many of those who stay behind engage in risky health behaviors. Educational levels generally are lower than average, contributing to poor lifestyle choices that lead to disease and death.

Given these realities, the public standing of a hospital system like Heartland depends heavily on how well the organization is perceived to “walk the walk” in improving community life. Fortunately, when Heartland Health was formed nearly 20 years ago, it was home-grown, springing from the merger of the community’s cornerstones, competing hospitals, Methodist Medical Center and St. Joseph Hospital. Both institutions had rich histories and deep roots that went back a century or more. The Daughters of Charity of St. Vincent De Paul opened St. Joseph right after the Civil War; the locals forever called the hospital, simply, “Sisters.” Start-up funding for Methodist came in the 1880s when the law partner of a Missouri governor, grateful for his doctor’s care, directed that his entire estate go to improving health care locally. Both institutions had rich histories and deep roots that went back a century or more. The Daughters of Charity of St. Vincent De Paul opened St. Joseph right after the Civil War; the locals forever called the hospital, simply, “Sisters.” Start-up funding for Methodist came in the 1880s when the law partner of a Missouri governor, grateful for his doctor’s care, directed that his entire estate go to improving health care locally.

Now, with 2,700 employees, Heartland is the largest employer between Kansas City and Omaha. Its medical center annually admits almost 19,000 patients; emergency services treats more than 47,000 a year. The organization markets an HMO with 25,000 members, owns an insurance company and operates The Heartland Foundation, which executes a passionate compact with the public to improve the quality of community life in the region.

“How can we best serve this region.”

HOSPITAL FOUNDATION

Heartland Foundation
Heartland Health System
St. Joseph, Missouri
www.heartland-health.com

Purpose: Development supports the health of the hospital and the health of the community.

Methods:
The foundation broadens its traditional mission beyond “bricks and mortar” to investing in community programs that benefit the public’s well-being and community health. The foundation (1) serves as a bridge to the community, (2) conveys the community’s expectations back to the hospital, and (3) opens new channels for fund development and community investment in the hospital.

Benefits:
• Foundation draws community closer to hospital.
• New partners include PTA, service/civic organizations, churches, government.
• Community partners become development resources.
• Access to care expands through collaboration with other funders and community partners.
• Health of the public benefits from foundation-funded community programs (e.g., health education and prevention programs, independent community health clinics).

Challenges:
• Scarce resources in some communities limit foundation development.
• No precedent for hospital-community collaboration in many markets.
• Finding willing partners can be a challenge where hospital reputation is shaky.
• Small foundation staffs lack necessary expertise in community development.

Bottom Line:
• Once-blocked pathways into community are opened.
• Community appreciates invigorated hospital involvement in community.
• Public trust improves.
• Hospital development strategies succeed.

“Bricks and mortar” was the Foundation’s initial purpose back in the 1980s – raising money to pay for the hospital’s own projects. Then, in the early 1990s, Foundation trustees, acknowledging the risks
involved, publicly asserted the Foundation as a leading agent for change and advocate for community revitalization. Trustees asked themselves, “How can we best serve this region?” They call their answer the “Think Ahead Manifesto,” an unusual, out-of-the-box proprietary pledge that proactively bets the success of the health system on the success of the community.

The Foundation’s stated aim is to empower individuals and groups to assume accountability for the economic vitality, quality of life and improvement of the health of the entire community. Heartland Health’s leadership articulates its role in its vision statement: “To make Heartland Health and our service area the best and safest place in America to receive health care and live a healthy and productive life.”

Initiatives and Outcomes

How It Works: Foundation governance is by community representatives. The board’s chair is St. Joseph’s school superintendent. Other board members include the head of the state’s cattlemen’s association, a broadcaster, college student, architect, funeral director, farmer, banker and flight instructor. All Foundation operations are underwritten by a multi-million-dollar endowment from Heartland Health; 100 percent of donor gifts support community causes.

Key Strategies: The Foundation plays catalyst and convener for a cross-section of the region’s major players, building partnerships and assets, expanding the area’s “capacity for community involvement,” and leading communities to produce tangible results. A core value: Individual acceptance of personal accountability for the betterment of the community. Successful initiatives include:

• Revitalize the Community. Main vehicle: Healthy Communities for the Midwestern Four Corners, a nationally recognized regional health improvement collaborative of business, education, health care, and state and local governments; convened by Heartland; part of the AHA Health Forum’s Accelerating Community Transformation Project.
• Focus on Kids. Prime goal: Identify and meet health needs of children and adolescents; school-based “Project Fit” physical fitness programs; survey 4,000 youth on what affects their lives; inspire involvement in community affairs and decision making; promote healthy lifestyles.
• emPower Plant™. Investing in the future: A new one-of-a-kind experiential learning center where 15,000 middle school and high school students a year learn about building healthier lives and better communities; housed in an old city factory; teaches kids how to be valued, active members of the community; develops workforce skills and attitudes. Top goal: young people find their future in the community.
• Walk the Walk. Heartland Health endowed the Foundation with $2 million for operations; the Foundation now has assets of $5 million. Heartland is leading a $10 million Campaign for Community Change and Innovation to fund the emPower Plant™ and healthy community initiatives. Heartland is also a leader in a downtown St. Joseph renewal program.

Bottom Line

What goes around truly does come around. The St. Joseph News Press, in a September 2004 Sunday editorial, praised The Heartland Foundation for providing “strong leadership for the youth of our region,” and cited Heartland’s CEO of 20 years for bringing “vision to this community that continues to work to this day” and “is an important promise for the future of St. Joseph.”
Background

Most hospitals outside of North America are financed, owned and operated by government. In the United States, however, the great majority of hospitals – more than 70 percent – are nonprofit, private institutions. Many are associated with universities, church and religious groups or private business. They are reimbursed for their services from a multitude of private and public insurers and patients. But when it comes to financing capital expenses, U.S. hospitals generally rely on their own resources. For example, in the simpler 1950s and early 1960s, a surge of hospital construction across the country was aided by the private sale of local hospital bonds to individual members of the community. The high costs and complexities of distributing bonds to individuals became so cumbersome, however, that the practice was abandoned nearly 50 years ago. An unanticipated consequence: An unrecognized but high-potential link between hospitals and their local constituencies was severed.

That link now can be restored, thanks to ever-evolving electronic technologies and the sophisticated use of the Internet as a commercial instrument. Just as individual investors were able to buy into Google’s 2004 online IPO, the Internet makes it possible for individuals once again to acquire hospital bonds with no more difficulty than it takes to trade stocks online at home. Individual ownership means the owners hold a personal financial and emotional stake in a hospital’s performance, its relationship with the community and the level of the public’s trust in the organization.

This “back to the future” financing opportunity has yet to play out in the hospital field, but one instructive example exists in the legendary Green Bay Packers football team’s financial relationship with the citizens and fans of its hometown of Green Bay, Wisconsin. In today’s high-tech world, the Green Bay model is transferable to the arena of local hospital financing and presents a strongly attractive opportunity for hospitals to open a new avenue of funding and build the trust of the public at the same time.

How They Did It In Green Bay

Curly Lambeau was a fullback at Notre Dame in 1918, when a fierce bout of tonsillitis forced him to drop out of college. Back home in Green Bay, he took a job with the Indian Packing Company and put together an after-work football team. He talked his boss into putting up the $500 for uniforms and equipment; in return, he named the team the “Packers.” Money to keep the team playing, though, was always a problem. In 1923 the Packers incorporated as a private, nonprofit, tax-exempt organization and sold individual $25 shares of stock to their hometown fans. These community stockholders elected a board of directors, which managed the team. Lambeau was the coach and a board member.

“Winning is a habit.”
**Article 1 of the Packers’ by-laws** sealed the team’s deal with Green Bay: “This association shall be a community project, intended to promote community welfare...its purposes shall be exclusively charitable.” The team’s board has remained steadfastly true to this original community purpose. For example, in 1949, when the board needed to raise more than $100,000 to avoid insolvency, rather than turning for-profit, it issued 4,628 new shares of common stock at the old price of $25, thus solidifying the team’s standing with the community.

**Today, the Packers** are the only publicly owned company in professional sports with shares to buy and sell and a board of directors. The bond between team and city is equally unique. Green Bay’s metropolitan area is home to fewer than 200,000 people; yet, the value of the Packers franchise is in the top 20 percent of all professional teams. Season tickets are bequeathed from one family generation to the next; the seats are contested in divorce proceedings; the waiting list for tickets is 36,000 names long. The level of loyalty linking organization to community is a force of nature. The team’s value in 2004: $756 million.

**Xs and Os for Hospitals**
Run the Google: Hospitals can market bonds to individual buyers on the Internet the same way Google sold its initial stock offering on the Web – through a high-tech version of what financiers call a “Dutch Auction.” It’s considered a revolutionary approach, so new the market has yet to act on its potential. Here is how it works:

- Internet auction eliminates high cost of bond issue.
- All would-be individual investors have an equal opportunity to invest.
- Electronic online bidding starts high, moves lower until no more bids.
- All bidders acquire bonds at the final – and lowest – price bid.

**More Yardage:** The U.S. leads the world in pioneering health care financing mechanisms (e.g., the DRG payment system). Since our health system is market-driven to begin with, it makes sense to open the financing market to individuals, now that it is affordable. Immediate benefit: Hospitals will get a double bang for the buck, gaining a fresh revenue source and solidifying the community’s stake in the hospital’s success.

**Extra Points:** Members of the community will be more willing to financially support a hospital if the hospital lives up to the public’s expectations of hospital-as-valued institution and civic asset. If the hospital, in turn, delivers on the community’s investment with quality performance and open accountability, the public will respond with loyalty and strong support. It’s a win-win for everyone. And as Vince Lombardi, the Pack’s famous coach, said: “Winning is a habit.”
Background
The imminent closing of local public health clinics in Northern California’s Solano County in the late 1980s triggered a looming emergency in care for the county’s thousands of poor, underserved and uninsured residents. In response, the leaders of the area’s three principal hospital systems put aside their competing interests and worked together to avert what threatened to become a severe health care crisis. At the core of the crisis: A fragmented local health system plagued by chronically insufficient reimbursement rates, too few providers willing to accept Medicaid patients and an upswell in the numbers of uninsured individuals and families.

First, the CEOs of NorthBay Healthcare Group in Fairfield, Sutter Solano Medical Center in Vallejo and Kaiser Permanente in Martinez convinced county officials to keep the clinics open. Encouraged by the outcome, the three hospitals founded the Solano Coalition for Better Health Inc., a nonprofit corporation dedicated to providing health care access to the indigent and uninsured in Solano County. Today this unusual coalition is an established, successful force in the health care of the county’s residents, produces measurably improved health outcomes and is a model for other diverse communities to follow.

From the outset, the challenges were formidable. Solano County, home of Travis Air Force Base, straddles I-80 midway between San Francisco and Sacramento. The county’s 400,000-plus population experiences a mix of rural and suburban lifestyles; 62 percent of the county is rich Sacramento River valley farmland or open space. Minorities constitute more than half of the population; about 17 percent are foreign-born. Agriculture is a mainstay, with large numbers of low-income and uninsured workers. Unemployment wavers between 5 and 6 percent. About 10 percent of the county’s residents live in poverty. High levels of uncompensated care have long been the norm for local hospitals.

Strong competitors historically, the three hospital systems had the deep community roots, economic standing and long-term stability necessary to command attention as viable partners. Sutter opened in 1921, NorthBay in 1956. Kaiser is the county’s largest employer; Sutter and NorthBay are in the top 10. Together, the three hospitals have nearly 600 beds and more than 5,000 professional staff and employees. Their combined economic and political clout attracted a strong community response from local government and public education, community health centers, The United Way, physician groups, the faith-based community, a medical college and other community organizations.

Methods:
Hospitals in the same market (1) work together to improve community health, (2) compete responsibly for patients, employees, resources and public confidence, and (3) reduce health care inflation by eliminating unnecessary duplication of technology and resources.

Hospitals Competing...
... and Hospitals Collaborating

Benefits of Competing:
• Patients have choice of providers.
• Physicians, employees have choice of hospitals.
• Health plans can form multiple networks of care.
• Providers have incentive to be the best.
• Health care inflation is moderated.

Challenges:
• Public sees hospitals as more corporate than caring.
• Marketing promotes image over quality.
• Ads, marketing divert dollars from patient care.
• Focus on financial performance limits investment in community needs.
• Duplication of expensive technology siphons resources from community health programs.

Benefits of Collaborating:
• Community health needs – e.g., care for uninsured, patient safety – are addressed.
• Public approval of hospitals increases.
• Hospitals together do more for community than if they act alone.
• Med schools and community hospitals work together to improve patient care.
• Costs are contained when hospitals collaborate and eliminate duplicative high-end services.

Challenges:
• Success requires long-term commitment.
• Staying on mission in hard times.
• A partner may seek unfair advantage.
• Public support can turn on a dime.

Bottom Line:
• Realistic win-win for hospitals, patients and communities.
• Hospitals earn public approval when seen working in public’s interest.
• Quality and access increase, costs decrease.
• Care for uninsured expands, safety net is strengthened, patient safety improves.
• Climate improves for local system-wide quality improvement collaboration.
**Initiatives and Outcomes**

**Collaborating for Success:** The Coalition’s most critical accomplishment: Creation of an organized county health plan, with a one-stop resource to help children and families enroll in health insurance programs. The Coalition also established a capitated county-wide medical services program underwritten by tobacco settlement funds; strengthened the safety net capacity of community health centers; powered up a county-wide “virtual clinical network” to share patient information; and devised a strategic plan to end disparities in care and health outcomes.

**Principal Outcomes:**

- ✔ Rescued the community’s main public health centers from bankruptcy and closure.
- ✔ Consolidated basic health information on more than 200,000 local residents.
- ✔ Increased access to care for 60,000 uninsured and underserved residents.
- ✔ Enrolled 13,000 children and parents in health insurance plans.
- ✔ Ensured that 45,000 MediCal clients could choose their own primary care physician.
- ✔ Decreased local ER use by 50 percent and MediCal inpatient stays by one-third.
- ✔ Increased MediCal reimbursement by 140 to 200 percent.

**CEOs’ Keys to Success, in Their Own Words...**

1. **Commitment:** “It’s made very clear when you come on as CEO that you have to give 110 percent. And very quickly you realize that you must contribute or it won’t work. If one CEO backslides, it will all fall apart.” (CEO, Kaiser Permanente, Martinez, California)

2. **Clout:** “There’s power in the representation of major providers in the community. People listen to us because they know we represent health care.” (CEO, Sutter Solano Medical Center)

3. **Collaboration:** “We come together on things that may not be visible to the bottom line.” (CEO, NorthBay Healthcare Group)
HEALTHY COMMUNITY

“The community now sees us much more as a community partner.”

Buffalo County Community Health Partners
Kearney, Nebraska
Good Samaritan Health Systems, Inc.
2004 NOVA Award Winner
www.gshs.org

Background

The Sisters of St. Francis opened Good Samaritan Hospital in Kearney, Nebraska, on the north bank of the Platte River in 1924. This is as middle America as it gets: The hospital is exactly 1,733 miles from Boston and 1,733 miles from San Francisco. Back in the mid-1800s, Kearney was the first U.S. Army outpost on the old Oregon trail, and some of the hospital’s earliest patients could recall when surrounding Buffalo County was the home range for huge herds of roaming prairie bison hunted by the native Pawnees. Today, Good Samaritan Health Systems, one of the 68 hospital members of Catholic Health Initiatives, is a 287-bed regional referral health center. Though the immediate community is small (barely 27,000 residents), the hospital serves about 350,000 people spread over a vast region of the central plains that is about the same size as Pennsylvania.

The people of Kearney and the surrounding communities have long responded to the need to take care of their own, a tradition rooted in the self-sufficiency of the region’s pioneers. Private initiative is part of the civic culture; that’s how the community paved its main highway for the first time. So, it was not unusual in the mid-1990s when the leadership of Good Samaritan, recognizing the dangerous vacuum caused by the absence of a local public health agency, convened more than a score of influential public and private organizations to address deepening challenges to the health of the community.

It was a natural role for Good Samaritan, which has long formally asserted improving the public’s health and partnering with others as central to its mission. The result: Buffalo County Community Health Partners (BCCHP), anchored by Good Samaritan but drawing upon other key players for strategic and tactical resources. The Partners’ first success: Agreeing on how to work together to improve the physical, mental and social well-being of the community. Their first big job: (1) Assessing the health needs of the community, (2) settling on a manageable and measurable menu of targets, and (3) finding the resources within the community to provide the services that a governmental public health infrastructure otherwise might furnish.

Good Samaritan seeded the first three years of work with $300,000. Others followed suit. BCCHP now has more than 400 partners from local health care, human services, government, education, business, church, civic and consumer groups, plus several hundred citizen volunteers. The Partners, by now imbedded in the life of Buffalo County, coordinate how different segments of the community act together to improve their own well being. As a result, everyone in the community is a stakeholder in the quality of life in the community. One of the biggest local civic events is the annual Healthier Buffalo County Summit when BCCHP issues its annual report on the health of the community.

Purpose: Hospital regains public trust by reviving its public health mission.

Methods:
The local hospital reclaims its historic role as an active community leader taking positive actions to address public health problems and their local causes. Public trust increases as the hospital (1) broadens its services beyond acute care, (2) helps its community solve basic public health problems, and (3) devotes expertise to moderating social problems that result in poor health.

Benefits:
• Hospital resets strategic priorities and gives balance to business model.
• Negatives of business model neutralized by positives of public health model.
• Hospital ends isolation from community.
• Community gains as hospital tackles public health problems and underlying causes.
• Public confidence in hospital increases.
• Hospital’s leadership convinces key sectors to help improve community health.
• Reconfigured public health mission improves market share, hospital fiscal margin.
• AHA’s Health Research and Education Trust can serve as resource for hospitals.

Challenges:
• Institutions are resistant to change.
• Communities are skeptical of hospital’s motives.
• Absentee hospital ownership needs convincing.
• New generation of management lacks experience with public health model.
• Public health mission may suffer in fight over resources for acute care.
• Hospital leaders may lack will for long-haul commitment.

Bottom Line:
• Hospital wins when it lives up to public expectations.
• Threats to health of the public diminish.
• Health of community improves.
• Public trust in the hospital rebounds.
• Business case for public health model is strong (“mission equals margin”).

PART THREE: MODELS FOR SUCCESS

Best Practice Examples

HEALTHY COMMUNITY
Hospitals as caring as they are corporate

“The community now sees us much more as a community partner.”
Of the scale of partnering, Good Samaritan’s CEO said, “It's truly collaborative.” And the hospital’s director of community development said, “We've gotten nothing but positive feedback from the community since we've entered the [wellness] arena because we’re not just focused on taking care of disease. The community now sees us much more as a community partner.”

Initiatives and Outcomes
Evidence-Based Planning: The Partners conducted a lengthy series of surveys that identified 156 specific health problems. These were reduced to 15 areas of clear focus, including: Alzheimer’s Disease, aging and assisted living; alcohol abuse and related motor vehicle accidents; suicide prevention; childhood immunization; teen pregnancy and teen smoking; adverse drug reactions; domestic violence and child abuse; obesity; water quality, affordable housing and public transportation. The list of priorities periodically is updated through analysis of hard data and input from the community. One recent addition: spirituality's role in wellness. Specific outcomes are articulated for each area; progress is measured; results are publicized.

Principal Outcomes:
- Added 50 specialty Alzheimer’s care units in the county.
- Increased assisted living units 520 percent, from 58 to 300.
- Introduced system to measure domestic violence, which declined.
- Expanded reach of child immunizations from 81 percent to 98.5 percent.
- Immunized 25 percent more older adults against pneumonia.
- Reduced teen births per 1,000 from 24 to 12.
- Lowered suicide rate per 1,000 from 18 to 10.
- Launched state’s first rural public transportation system, with 87,000 rides per year.

Among Youths:
- Tobacco usage: Down 38 percent - from 24 percent to 15 percent.
- Binge drinking: Down 16 percent - from 38 percent to 32 percent.
- Seat belt use: Up 7 percent - from 74 percent to 79.9 percent.

CEO Keys To Success:
1. Mission Is Margin: Make the business case for a public health mission. Meet the community's needs and the public will be your best stakeholders.
2. Get Buy-In: Enlist a broad constituency. Nail down early financial and in-kind support from the larger community. Secure sufficient resources at the outset. Campaign for state support.
3. Set Goals: Keep steady aim on your desired outcomes. “Go slow to move fast.”
4. Learn from others: Their best practices can ensure your success.
QUALITY IMPROVEMENT

Baptist Health Care
Pensacola, Florida
2003 Malcolm Baldridge National Quality Award
www.ebaptisthealthcare.org

Background
Baptist Health Care is the only community-based hospital system in a highly competitive market of about 835,000 residents spread along the Gulf Coast of Florida’s western panhandle. Baptist Hospital opened in Pensacola in 1951 with 140 beds. In 1973, Baptist was a charter member of Volunteer Hospitals of America; in 1989, it became Baptist Health Care (BHC). Today, Baptist operates five hospitals, a nursing home and a network of mental health services. It is the busiest hospital system in the region and, with nearly 5,500 employees, the largest non-governmental employer in northwest Florida.

In 1995, BHC faced a competitive crisis: Pensacola was a two-hospital market occupied by three private hospitals, plus a struggling county hospital. To secure its market position, BHC chose a single field on which to compete: service excellence. They set no small goal: “To be the best health system in America.” Leadership, management and staff committed to a long-term drive to achieve excellence in quality, collaboration, customer service, leadership development and patient care.

The CEO set “staying the course” as a corporate absolute. One outside observer noted that when it came to excellence and quality, BHC’s management possessed a “maniacal consistency of purpose.” Non-traditional, out-of-the-box enterprise and inventiveness across the organization characterized the effort. Or, as the CEO put it, “It’s the culture, stupid!”

A new mission statement transcended patient care by pledging BHC to “improve the quality of life for people and communities served.” And its declaration of vision was very different from what most hospitals publicly take on: “The ability and willingness to look forward to the future and make decisions necessary to accomplish important goals.”

Though BHC’s leadership assumed a lock on success, they did not foresee how big a success they would be or how their quality improvements would help drive local economic development and define Baptist as a very different type of community asset. By establishing itself as an iconic beacon for quality, excellence and customer satisfaction, Baptist holds a dominant and lasting position in the public’s esteem.

Initiatives and Outcomes
Start On the Inside: BHC developed an internal consumer-centered culture that was “obsessed with patient care and customer satisfaction” and the anticipation of the public’s health needs. Staff at all levels were trained to improve organizational performance. Employees were encouraged to act as goodwill ambassadors to the community and provide leadership to civic organizations. Community advisory committees and interaction with area businesses and consumers provided outside-in thinking.
**Accountability Counts:** Senior leaders are held accountable by a “No Excuses” policy. Clinical accountability is measured by a performance index of 50-plus hospital results, including specifics like medication errors and prevalence of pressure ulcers. Budget accountability is tracked by a comparable fiscal index.

**Lead the Leaders:** BHC’s “Health Care Leadership Institute” trains health care providers from across the country in results-driven systems change, employee and patient satisfaction improvements, and how to exploit excellence as a competitive advantage.

By staying on mission, it took BHC just eight years to transform its organization, people and culture from a hometown, parochial provider of hospital services to a nationally recognized exemplar of quality improvement and creator of its own new paradigm for excellence and effectiveness. As a result, Baptist earned the 2003 Malcolm Baldrige National Quality Award and has been ranked among Fortune Magazine’s “100 Best Companies to Work For” each year since 2002. Modern Healthcare lists BHC’s CEO among the 100 most powerful people in American health care.

Other measures of BHC’s quality success include:

- Chamber of Commerce points to BHC as model for success.
- Patient satisfaction has been near the 99th percentile each quarter for six years.
- Staff morale improved from 47 percent in 1996 to 84 percent in 2001.
- Staff turnover rate fell from 27 percent to 13.9 percent.
- 500 employees participate in on-going leadership training.
- 100 community leaders and physicians advise hospital on community issues and needs.
- 1,000+ employees of local businesses have been trained in service and quality.
- Ranked #10 among U.S. leadership development centers by “Executive Excellence.”
- 6,600+ health care providers from 1,589 organizations in 49 states trained in quality.

**The CEO’s 10 Tips for Success, in His Own Words**
1. “Our culture of service excellence is non-negotiable.”
2. “Service excellence earns public trust.”
3. “Improved quality and reduced costs earn the ear of business.”
4. “Harsh competition in the public arena is damaging to hospitals.”
5. “Balance caring with the corporate and corporate with the community.”
6. “Involve the business community in quality improvement; it earns credibility.”
7. “Credibility builds competitive edge.”
8. “It takes the trustees to move the needle.”
9. “Train leaders to lead at work and in community.”
10. “Invest in transferring service and quality expertise to local businesses.”
A CLOSING COMMENT

To the American public, no matter where they live, the local hospital is an institution, a “given” in the life, and sometimes death, of their family, friends and neighbors. As an institution, the hospital is widely perceived to stand for a certain purity of mission: the best care possible; compassion; qualified and competent physicians, nurses and staff; and an obligation to serve the greater good of the community. When the people who rely on that hospital conclude that the purity of mission has been compromised, the sense of loss is palpable; a shadow falls over the entire community. In too many communities, that shadow has been darkened by growing public fears of their own safety in the hospital and the public's perception that hospitals are more about business than caring for the community.

There is hope. In many markets, the local hospitals are seen as true champions for the good health of the entire community. Where public confidence has eroded, most hospitals will regain the public’s trust with new energy and openness; by renewing, through leadership and visible action, an honest commitment to the health, well-being and quality of community life; and by reassuring the community that the hospital is, indeed, true to the peoples' need for healing, hope and care – and true as well to the timeless Aesculapian standards of wisdom and health.

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APPENDIX

The information presented here is based on in-depth interviews with hospital leaders from every section of the country and every type of hospital market in the Spring and Summer of 2004, as well as reviews of mass media and professional/trade literature that examined the best practices of hospitals proven to be beneficiaries of significant levels of public trust.