

## ACHE – SouthEastTexasChapter 1st Quarter Newsletter

**Event Recap: 1<sup>st</sup> Quarter Educational Session** (Following comments based on slide presentation)

Keynote speaker Toby Hamilton, MD, Executive Director of Healthcare Innovations Professional Society, shared his perspective on innovation as a moral imperative. Dr. Hamilton began with discussion on our role in the communities as providers of healthcare services.

“I grew up in El Paso, in that part of town where our parents were proud of us graduating from school. This picture may not depict things particularly well. In this picture, I'm sitting on the American side close to the border, very close to the hospital where I worked and trained. You're seeing a bridge that goes across the border there and that little sliver of river there is known as the Rio Grande. What you see on the right side of the river is Mexico. Important from the perspective that the hospital where I was trained is in fact was the closest one to the border of the United States. It served the poorest zip code of the United States of America. I grew up in the community just a few blocks away from there, and this is where I am from. This is an expression of a visual of the poverty in that community. It's a pretty extreme expression of poverty not only in the community on the American side but also on the Mexican side - both of them have very severe degrees of poverty. This is a hospital that I trained at. I was on the staff. I don't remember seeing an insured patient during my entire years of service there, outside of trauma. Outside of level one trauma there was no such thing as private insurance. I didn't really even know what it was until I'd left there. But I would tell you the patients that we did treat there, who waited sometimes 24 or 48 hours in our ER for service, they didn't have access to a plastic surgeon or an ENT specialist, ever. We naturally delivered a lot of babies there.

I was a very young doctor and I was heading into the room to see Ms. Sanchez, who had delivered a few babies. And one of the senior residents walked in and said: “Ms. Sanchez, I've got to take care of these other babies, you've done this before, go ahead and take care of this kid.” And I certainly have seen babies being delivered... and Ms. Sanchez grabbed me by the hand and said, “You'll take very good care for me, amigo. We're happy to have a hand. We've got this.” I understood she was going to take good care of me. Of course I never delivered a baby before. I was kind of scared. And if I was her, I would be very, very scared. But she walked me through the entire process and I know now exactly when we delivered that baby alone in that room, she and I, it was mostly her giving me directions and me shaking to death. I pulled the baby out, and cut the cord, with her telling me what to do every single step of the way. I put the baby on her chest and she looked at me and she said, “Thank you. Thank you for helping me with this.” And I just said, “No, thank you. Thank you for teaching me.” And so I would tell you what gratitude for me is, what I learned in my timely experiences, that we have a group of people we were grateful for anything that we received. And it was a great place to practice and a better place to learn because of that experience.

This is my dad. He was a union worker and just down the street from that hospital is a West Texas refinery. We lived right in that community and I was one of seven children. We had a big family. With that perspective and that community it provided me the opportunity to learn.

This is me graduating from residency. I'm young. I'm excited to be there. I'm running throughout the world, I found my purpose, and I'm heading off to work to save the world. Have the opportunity to treat a bunch of patients for a number of years and became really frustrated with the general system, the operations and it seems like the patients were upset with the fact that our system wasn't functioning correctly. Our systems sometimes don't function correctly.

I was frustrated by the system when we saw patients in ER, but I couldn't make the necessary changes... I was trying for two years, experiencing resistance from the lab department, from radiology, and when the frustration reached its peak, I finally said, "You know what I'm going to build my own hospital." I can't get the changes that we need, so we built our own. We read the book from the State on how to build a hospital. We had no idea what we were doing. I think if we had to do it again, I wouldn't do it that way. We embraced the changes that we felt like were necessary. And we went down to the state with an architect, a buddy of mine, who drew the plans. I don't know how many people we had to meet with at the State level. They carry a humongous stick anytime you want to build or do something... and we said that we want to build a hospital. But the response was, "Wait, you can't do that. That doesn't make any sense." We said, "Well, why not?" They said, "Well, regulation 2193... there's no way you're meeting that requirement." What we had was a one hour meeting turned into a three hour meeting with us basically negotiating and aiming on what we could and could not do. They said, "You can't have two patient beds." At the time, it was two. And we said, "Why not?" We went to the regulation and showed that we could have two patient beds. And that's how we started. We built the smallest hospital that the State of Texas has ever seen at that time, and we did it for a song... My dad, for example, came up on the weekends and helped to do some of plumbing. We essentially borrowed imaging equipment... And this was not a beautiful facility and it did not go well. For the record, the first year and a half, we paid ourselves nothing. We all worked for free. We have every staff of four. It was pretty much a disaster, but we stayed running it anyway. We learned things ourselves. We were forced to innovate. I didn't know anything about labs, took the lab course, became a lab director. We started buying used equipment online. And we were sitting in the bathroom with water pipes trying to figure out the cheapest way how to get things put together. And this evolved into a concept of micro-hospital. It's really a nonsensical term, but I felt like it was a word that described adequately what evolved into what you're seeing here today.

This was sort of one of the baseline models. We ended up partnering with healthcare systems across the country - Baylor, Scott & White, Memorial. And you can see that the model shifted significantly as we grew more sophisticated and complex; and we're able to bring in resources as we came along. And this was the beginning of the company. This is a micro-hospital facility. It was about 30,000 to 60,000 square foot facility. The first one just for the record was somewhere in the range of 10,000 to 12,000 square foot, the staff 24/7 with ER docs and internal medicine docs, ancillary services having typical imaging... just like it would in any hospital.

It functioned somewhat like a little baby hospital, only a lot differently. We have transfer agreements with our partner ultimately. At first we didn't. When we first started, we would go to visit docs in the community and it was universally rejected. They didn't like us, which is why we didn't do very well the first couple of years. But eventually we started breaking down those barriers; we made rules that we had to visit each one of the community docs, at least 10 a month; and we eventually won them over that we working on their behalf.

These are another couple of examples of the facilities that we built. Sometimes they took a little bit more space; sometimes they took a little bit less space. Here is an example where we modified the facade to match that of our partner. And what we found along the way is inside of our company with my partners on our employees that there were something that we call 'the best idea wins.' We would put our views aside, the concept was not that have to be told that that was Toby's idea or one of the other leaders idea. It was the staff's ideas that were frequently

helpful to us. We cross trained all of our staff. Everybody on our team knew how to do the labs including the physicians.

Because we needed to see the physicians breaking down the rooms from ripping off the paper sheets on the exam tables, changing bed sheets, dressing the patients that we were in fact all doing a little bit of something because we were a lean, mean machine. We had to do it to make the business functional and operational. This was survival. One of the good examples we came up with, was from one of my nurse's. We wanted to improve response time to chest pains at that time. One of the nurses said, "Well, why don't we just put a big red light in the middle of our work space; and the front desk person, when a chest pain patient comes in, they'll just flip the switch and the red light comes on; and we'll stop doing what we're doing and go get them." He said, "Wow, that's great idea." And so we implemented it.

Some of the ideas were really small ideas, and they sounded foolish, but they were really big deals. Our CT tech noticed that when he wrote times down on the marker boards in the bedrooms, it set the expectations for the patients. So when they wanted to hear about the CT scan, if he just wrote "12:15 time back," the patients would just relax in the room so they wouldn't come out every 10 minutes to say, "Where's the study? Where's the study? What's going on?" They were just staying there calmly reading and watching that extra small TVs that we had in our space because they knew that the expectation had been set. Well, this was a customer service piece that required nothing more than a marker board. When we installed the marker board in every room and mandated that our staff would notify about the approximate time that they could expect their labs back.

One of the things that brought some of the national attention was that we implemented a campaign that said, "We would see you in 15 minutes or your entire visit was free." We wouldn't bill your insurance. We wouldn't do anything. We bought a bunch of Chinese made stopwatches and when patients came in to the front we filled out their forms and we handed a stopwatch as a souvenir; and we let the clock start ticking down.

Let me tell you how resistant my staff was to that concept: it's dangerous; it's not going to work; we're going to harm the patients. You can see that the concept itself had some problem being adopted. And it did. We have one of our facilities, with a really strong leader; and he said, "No, we're going to do this." They gave it a trial run; and it was effective. It worked. Not only did it work, the patients were ecstatic, the staff was engaged, everybody was really moving. If you thought people were cross training and engaged before... you should see them now. Even though there was really no benefit to them either way. There was a clock on the wall. And I don't feel like our patient care suffered. Sometimes it would be the physician dropping in to say, "Hey, I'm really busy with the sick person number two. I'll be back in just a little bit." Now I might not be back in 20 minutes but they had seen that the system could work, they communicated their expectations and we had moved on this to the point it resulted in a lot of national press at that time. We thought, "Wow, there are so many good things coming out of our staff." So we started a program internally called Bright Ideas. We just sort of made it up. It wasn't an attempt for us to ask innovative ideas from our staff, because they were once producing a lot of them. We gave the winners, the ideas that actually made it to implementation, a simple iPad. It really wasn't much at all. But we came up with so many ideas. We were overwhelmed so quickly and got such an edge from our staff that we were overwhelmed. We didn't know what to do with some of these ideas.

You can see a sink at the end of the cabinetry there. What that did is allowed me, the nurses, the staff, and the physicians not to turn our back on the patient when we started the interview. I

could come in and what happens normally as I come in, I turn my back, go wash my hands and turn around and get involved in the conversation. In this case I could come to the end of the table, wash my hands and we could communicate while all that's happening simply about 30 seconds per visit, added up over the course of the day or years. We saved an incredible amount of time.

This is a look down the inpatient corridor. On the left here was where the patients came in. These were all practical experiences... we collect urine on lots of patients, especially female patients. If you guys have seen it... everybody is walking around the hallways with urine in their hands, getting everywhere. It's not a pretty site... We put the bathroom right next to the laboratory at the very front of the facility. So if we had a female of childbearing age, for example, knowing we're going to get a urine on them, we would go ahead and direct her to the bathroom immediately, collect the specimen cup and she would hand it through and pass it to the lab. It was not uncommon. In fact it was very regular that by the time I would get the chart and step into the patient's room, I would already have the results of the urine. A urine test takes about a minute and a half. So we expedited that entire process.

By comparison, that patient goes to the room, typically; the nurse does the full H&P (history and physical); they go set the chart down; the doc picks up the chart and goes to the room, repeats the H&P, orders the UA (urine analysis), somebody collects the UA, takes to the lab. The lab results get posted. The physician has to check those results and you'll talk to them and perhaps order some more tests - an extremely inefficient process.

We installed the door into the restroom regardless that the test costs virtually nothing. We instantaneously turn around that urine; I would have my results back in the minute and a half... quickly like you walk in the room, diagnose in the first 30 seconds; and then we can have them out the door. This was an example of the type of facility planning changes that we made.

You see a central corridor... with beds along the side. This allowed for a couple of good things. It allowed for the space between the beds to be maximized. For example; that central quarter where we have the meds and the supplies, all those types of things available to get to as I worked with my inpatients and for my ER side as needed and I could cross staff that for fluxes in inpatient flow. So an inpatient nurse can come over and help out at the ER side. And the ER nurse can be called over if needed to help out in the inpatient side... if other staff needed to take a lunch break a short break.

The output on this was very positive. These were some of the performance metrics that we measured. Our average ECG time to get to that EKG for a chest pain, while somewhere else that would be around seven minutes; honestly, we were doing it in about 30 seconds in those cases. From admin to ED departure, as you can imagine, we've got in loaded right away - we were just across the way.

Doing all of that was also because we had very engaged staff, and because our employees felt like we had very engaged staff, our complaint ratio was dangerously close to zero. The patients loved us and we recruited people that fit in our culture. And when they came in we indoctrinated them to the things that we do and we set the expectations for the people who would move forward.

We received a lot of award - Press Ganey Award and five star awards from CMS. We did really well.

There were numerous lessons we learned from Bright Ideas. Number one, everyone had an idea. When we implemented that program, there were over 700 ideas that we had at the first two months. You think your employees are disengaged... ask what they want to change about their jobs to make it better. They will reengage. You need an infrastructure and executive buy-in. By the way, 90% of the ideas are not things that you're going to practically implement or do anything. But there are some that you are going to. You do have to have the ability to filter that stuff, identify the good ones, align the correct team as you need to make those changes; and most importantly you have to finish with the executive buy-in. I have seen a lot of these programs implemented across the country. They failed when it isn't a direct line to the executives. If it's something moved to the side as thought to be secondarily, it will get finished secondarily. There has to have the leadership buy-in. There are a lot of bumps on the road getting there. We're talking about change. And people are slow to change in healthcare. We've got to have executive buy-in to succeed.

We are taught and learn. You will be shocked by how many people are interested in learning about how to innovate and how to integrate and make those changes, not only do you need the infrastructure but you need the people in the infrastructure to have the right training.

Finally, we shared our successes and failures in every single staff meeting, and emails, and handouts. We would talk very openly about the projects that we were working on, the tests we were doing. We discussed who could come up with the idea, what the outcomes were even when they were wrong. We would say, "This was our innovation platform. This is what we're working on. And these are things that we failed at, but look at what we just implemented, a cool one over here... and Joe from radiology invented this one, how about that? And the answer is yes and not no. I got really, really frustrated as we grew bigger, start having in-house legal and we have more regulatory folks and we got more bureaucracy than we needed. It was a really important. I remember we had a heart to heart with our attorney one time, and I said, "Listen, my understanding is that it's your job to advise me of the risks... not to tell me no. It's my job to decide on the risks, our risk that we wanted to take and to move forward with the project." And I would say, "There are many times when I'm willing to accept that risk and you may not be... but you don't have the right to tell us no anymore. It's your job to tell me, I'm concerned about it because... and help me find a way to minimize that risk. That's your job. I don't want to hear no again. Moving forward, we're not hearing no, it's yes. Tell me how you're going to help me cover my tail when I do this.

I had the unique opportunity to think, "What do I want to do with my life after I step down and sort of hand the reins over the next group?" This is where I decided to form a non-profit, called the Healthcare Innovators Professional Society. As I was traveling across the country there what we saw was the chief innovation officers of these healthcare systems were new positions, most of them had their job less than five years. They were operating in a silo. They were trying to do experiments. They're trying to do some change. They were living the world that we just went through. And we created a union of them; identified 33 key members from the U.S. and limited it to that group - 33 chief innovation strategy officers from around the country. This is a big influential group. The changes that they make they'll really make an impact on healthcare. That group controls one of every five hospitals in the U.S., one of every four hospital beds, and one of every two overnight stays in hospital beds across the country. And I say that to say if we have one of our members is on the East Coast who's done something, they've done the experiment this takes time and energy and resources to do it right, and it takes innovation; and they're willing to share it with people on the West Coast in the non-competitive state... can we now make a 1% move on East Coast, become a national thing for 1% move on the West Coast and create the dynamics where we're beginning to bend the curve on the innovation platform

across the United States. That's the concept anyway. When recruited key members from around the country, most of major healthcare systems - Cleveland Clinic, Mayo, Dignity, Ascension, UC Health. And what it showed me was that there was a desperate need for this. My innovation officers have been in it long enough to be able to provide support, insight, and guidance to each other.

I also want to talk about some of the barriers that we saw to innovation. One is structural; you're not built to innovate. It's nice to say we got a chief innovation officer, innovation staff, there really has to be a support structure behind it. The leadership has to get behind it. The organization has to believe in it. You have to throw real money at it. And it's a really difficult thing in this era of tiny margins... the notion of pulling out some new piece of budget and setting it to the side.

And what I've seen happened over and over again is that healthcare systems will hire a chief innovation officer, a chief strategy officer, someone who has that role; empower them for a period of time, but not really give them the resources and the time that they need to succeed. It's going to take three to five years before you see the type of returns that you want. And then we had a little budget bump, and the first thing that goes out is our innovation budget. Why? Because we kind of view the way we do sometimes about the marketing side of hospitals and I know this for us where things got little tighter, first place and easy cut was still looking at marketing and slash our marketing budget. An innovation got thrown in that bucket. Innovation in your system after you got other structures with the organization, etc. You have to have a financial commitment from the leadership to make it work.

And lastly, cultural - you have to speak about it. You have to talk about it. It has to be something that you applaud when it happens and you have to be able to share your losses. Those are some of the barriers that we face in innovation.

Some of the winning strategies that you'll see, where there's no hiding behind regulations, and you have heard me talk about them: leadership commitment, and fundamentally important, infrastructure that is internal and external. There's a real important part and that is the infrastructure. And I wish that I could tell you there's a silver bullet as to the way that infrastructure should be. I think that the systems that I interacted with are so complex and vary there isn't going to be one answer. But it's very important that you're trying and that it's there. And that you reevaluate what you need to take away and add. And it takes time. We talked about that. There's a cultural commitment to it.

To conclude, I want to say that innovation is a part of your moral imperative. It is how we can extend out to the communities that otherwise wouldn't have gotten that care. Because of the efficiencies that we built in we were able to build a facility and a hospital that has less than 20% of insured rate and make it financially viable. Now that involved a lot of volume, as you can imagine, to get to that 20%. But it is financially viable, it is prospering because we have people working hard doing efficiencies and being willing to test limits of what we can do. And I would challenge you all, as part of your oath, to participate in the innovation process as I have mentioned before. Thank you."