Advancing the Culture of Health

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Pat has 29 years of experience in the management of non-profit organizations, with particular expertise in campaign management and major gift fundraising. He has held senior fundraising positions at the University of Medicine & Dentistry of New Jersey (now part of Rutgers University), Iona College and the Boy Scouts of America. During the course of his career, Pat has led fundraising programs which have secured over $200 million in charitable support.

Pat began his career as a community organizer in Chicago and Jersey City, New Jersey with the Chicago Neighborhood Organizing Project and the Industrial Areas Foundation, where he supported residents in their efforts to improve public education and address neighborhood safety and environmental concerns.

Pat grew up in West Virginia and is a graduate of West Virginia University and St. Mary's Seminary, where he studied literature, business, philosophy and theology. He enjoys hiking, reading and spending time with his wife, Diane, and their four children. Pat currently serves as Scoutmaster of Troop 121 in Clinton, NJ. He is a member of the Visiting Committee, WVU College of Arts & Sciences, Department of English and a trustee of the Minsi Trails Council, Boy Scouts of America.

Advancing the Culture of Health

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Healthcare in America is on the brink of transformational change. And while we don't know exactly what hospitals will look like in twenty years, we know they will be different. These changes can be unsettling, especially for those who must navigate an uncertain path forward. Yet, they can and should be approached with optimism and hope.

Many of the changes taking place today are being driven by the Affordable Care Act and other, more-substantial, payment reforms. These changes represent a fundamental shift in priorities: Value-of-care to the patient is being incentivized above volume-of-care provided. This shift is being driven by the unsustainably high cost of healthcare and the pending silver tsunami.

Over the next 25 years, the number of Americans age 65 and older will double. We risk the slow degradation of our acute-care system if we fail to adapt, making required changes to promote a *culture of health* where each person receives the care they need - nothing less and nothing more.

If the details of this *culture of health* seem beyond the reach of our imagination, perhaps they have been obscured by the market-based forces that have shaped so much of our current approach, which some have called the *culture of sick-care*.

Steven Brill is one of the most vocal critics of this *culture of sick-care*. In *America's Bitter Pill: Money, Politics, Backroom Deals and the Fight to Fix Our Broken Healthcare System* and other writings, he says "It's about money….It's about politics and ideology: In a country that treasures the marketplace, how much of those market forces do we want to tame when trying to cure the sick?"

- The *culture of sick-care* is reactive and favors heroic, resource-intensive interventions. A *culture of health* encourages appropriate care and the development of robust wellness and disease prevention efforts.
- The *culture of sick-care* has great difficulty caring for people with chronic conditions and those approaching end-of-life. A *culture of health* forms supportive communities offering integrated, life-enhancing care that is highly valued by the patient.

- The *culture of sick-care* uses competition and market-forces to drive innovation and service improvements. A *culture of health* relies on collaboration, transparency, and aligned incentives to meet emerging needs.

Our modern healthcare system, like all complex systems, is a blending of cultures with competing values. It includes both a *culture of sick-care* and a *culture of health*.

Since the early 1900s, the culture which has been most well-fed is the *culture of sick-care*. Its centerpiece is the modern American hospital, a numinous temple on the hill filled with miraculous healing technology. This temple and the vast industry that has grown-up to support it are now under siege - not because they are evil - but because they are unbalanced.

Our almost total emphasis on *sick-care* has resulted in a *culture of health* that is neglected, and as a result of this neglect, it is weak and atrophied. We are less-healthy as a result, especially given the tremendous resources that have been poured into healthcare. We are justified in demanding a higher rate-of-return.

In this essay I will share some helpful insights regarding new leadership opportunities in healthcare and healthcare philanthropy. They reflect my optimism for the future and suggest incremental steps leaders can take in their efforts to create something meaningful and lasting for all people.

Philanthropy has always been an important source of ideas and innovations. This is especially true during periods of transition. Generosity and compassionate-response help identify services that are desired, but unsustainable, until the market discovers a way to monetize them. This ability to establish and sustain markets is the genius of our economic system. Yet, it is an imperfect genius, a system which produces both desired results and unintended consequences.

The development of the American healthcare market and hospital system followed this pattern exactly. Until the early 1900s almost the entire budget of St. Luke's Hospital where I work was generated by donations. It took decades to establish the fee-for-service payment system that has been so successful in funding the growth of our healthcare system, with its lopsided emphasis on the *culture of sick-care.*

Unfortunately, an efficient funding mechanism was never established to support the development of the *culture of health* as an important balance and compliment to the *culture of sick-care*. In the future, however, one envisions that saving generated through gradual elimination of abuses tolerated under the *culture of sick-care* will be more than sufficient to pay for *culture of health* priorities. Only those whose primary motive is profit, and not

health, will resist these changes and the required elimination of unhelpful and unnecessary medical treatments.

During this time of rebalancing we are in what the Tibetans refer to as bardo, a transitional state between two worlds; a more familiar word for this is purgatory. Hospital leaders are being asked to navigate this period of change during which they must continue to operate in a fee-for-service world favoring a *culture of sick-care*, while at the same time preparing for a future where value-based compensation in support of a *culture of health* will be the norm.

The U.S. healthcare system is in the early stages of this evolution. And while it will take a decade or more to fully align incentives in support of this rebalancing, the required shift in perspective has already occurred. Bundled payments, value-based purchasing, care-coordination, gain-sharing, outcomes research, electronic health records and transparent data analysis are being woven ever-more deeply into the fabric our healthcare system, even as opposition to Obamacare festers in Congress.

Hospital systems that willingly embrace this shift will have a distinct advantage over those who do not. They will have stronger financial returns and achieve better outcomes. They will also lead with greater authenticity and be more successful in building the partnerships required to achieve better health outcomes. I am fortunate to work for one of these systems - and we have been anticipating this future for some time.

For decades, the president and CEO of our health network has encouraged pro-active investments to advance the *culture of health*. Our most consistent investment has been in children and healthy lifestyles. In recent years investments in community education and patient empowerment have been encouraged. Our newest efforts involve investments in support of appropriate care and stronger, more dynamic partnerships. Consider the following examples.

Investing in Children and Healthy Lifestyles

It's a cliché, but an inspired one: children are our future. And to paraphrase the poet Kahlil Gibran "we are the bows from which our children as living arrows are sent forth." We should aim high and aim true, for every investment in their health and well-being is an investment in our future too.

In recent years, philanthropy at my hospital has helped replace and expand an aging fleet of mobile clinics that travel regularly to area schools providing medical, dental and vision services. Programs encouraging reading, academic success and career exploration have been earmarked for expansion. Important new initiatives promoting fitness and healthy lifestyles have been launched including *Get Your Tail on the Trail*, whose energetic

participants collectively logged over 800,000 miles last year, the equivalent of 35 trips around the world.

St. Luke's recently established the nation's first hospital-sponsored organic farm in partnership with the prestigious Rodale Institute. In its first season, the farm produced 50,000 pounds of healthy organic produce and generated more positive media coverage than any event in our hospital's 142-year history. Farm managers plan to double acreage under cultivation this season and offer a special internship program to educate future organic farmers. The organic produce they grow will be used in hospital kitchens as part of our food-as-medicine approach to disease prevention. New mothers and cancer survivors will receive free organic shares this season, with helpful tips on diet and lifestyle modification.

Investing in Community Education and Patient Empowerment

Hospitals have a unique opportunity to encourage new educational offerings in support of patient empowerment and *culture of health* behaviors. One particularly meaningful topic in support of greater patient empowerment is resiliency in the face of illness and adversity. Young and old would benefit from the development of new skills enabling them to unlock the transformative power latent in illness and challenging situations. Many times loss-of-perspective and unhelpful coping-behaviors in the face of difficult situations dramatically increases suffering and rob life of the pervasive joy that is our birthright. The resulting inner turmoil can lead to poor choices and preventable health complications and treatments. Hospitals have a financial and a compassionate interest in helping people develop greater resiliency and call upon it when needed. This resiliency is the gateway to the inner strength needed to embrace, rather than resist, challenging life events and thereby unleash their transformative power.

The most challenging event we face is death. If a person has done little or no inner-work in advance of this seminal transition or failed to make their wishes known though an advance directive, they risk avoidable suffering. Life-extending medical treatment does not always mean life-enhancing. In our time, it requires great personal wisdom to choose life-enhancing care, especially when this choice requires the patient or the patient's family to stand against a medical establishment and *culture of sick-care* that is often at odds with itself in these crucial moments.

One way hospital philanthropy has advanced this helpful learning in my community is through an endowed lecture series organized by the Friends of Hospice. Past speakers have included Rabbi Harold Kushner, author of *When Bad Things Happen to Good People* and palliative care expert Dr. Ira Byock, author of *Dying Well* and *The Four Things that Matter Most: A Book About Living*. This year's topic concerns the psychology of illness and the art of healing. Award-winning author Dr. Bernie Siegel will explore the powerful role the mind

can play in fighting illness, as well as the importance of patient empowerment and the choice to live fully and die in peace.

Up to 1,000 people attend this annual lecture. And while organizers have been pleased with event turnout, we believe there is a desire for more small-group discussions where the application of these principles to current life situations can be considered more fully. We are currently investigating innovative new partnerships with mental health providers and spiritual leaders interested in resiliency. Social media may also be helpful in promoting these concepts. One particularly exciting idea is the development of a school of resiliency encouraging self-paced readings, with opportunities for small group and one-on-one interactions.

Imagine the tremendous impact our health system could have if we were successful in shifting the perspective, and behavior, of just a small fraction of the 360,000 people who received care last year, helping them become more prepared and resilient in the face of loss and personal challenge.

La Crosse, Wisconsin is one community that accepted this challenge of helping people become better prepared. In response to the suffering of families whose loved ones approached end-of-life without an advance directive, the local hospital initiated a robust community education program. Over 95% of the people who die in La Crosse each year now have an advance directive, compared to a nationwide rate of just 30%. There appears to be a beneficial inverse correlation between the percentage of people who die with advance directives and the intensity of care provided during the last six months of life. According to the *Dartmouth Atlas of Health Care*, La Crosse's intensity of care score is 5.6, one of the lowest (best) in the nation; Allentown's score, where my hospital is located, is on the high side at 10.1.

Given the vast amounts of money spent on end-of-life care, often 50% or more of a person's lifetime medical expenditure, ensuring that the care provided is both appropriate and desired is an important evolutionary step forward for our healthcare system.

Investing in Appropriate Care

Appropriate care means providing the patient with just the right mix of medicines, therapies and supportive services needed to restore health and support them during life's most significant challenges. Changes in mindset and standards of practice are required to prevent the indiscriminate use of technology-intensive diagnostic tools and treatments when those interventions will not provide meaningful improvements. In the future, care that is avoided and care provided outside of the hospital, sometimes in non-clinical settings, will become more significant as we enter a new era in medicine where clinicians are incentivized to provide appropriate care and penalized if they do not.

This shift toward appropriate care will be especially helpful in the management of the chronic conditions accounting for so much of our nation's annual healthcare bill. Philanthropy, community and patient engagement, and new models for volunteerism can provide helpful ideas and resources to explore this emerging world.

In this anticipated future the judicious use of high-touch, low-tech interventions will be essential to protect and preserve our current high-tech acute-care system. We all want access to this system of life-saving treatments when needed. Yet, the indiscriminate use of precious resources threatens their future viability.

Better Management of Chronic Conditions

A colleague responsible for the management of three rural health centers recently discussed his first tentative steps to shift behavior in support of appropriate care. Many patients treated at his facilities have poorly managed chronic conditions and multiple co-morbidities. In the past, providers would typically throw their hands up in frustration at the lack of compliance and patient engagement. Recently, the medical director suggested an approach developed by Australia's Flinders School of Medicine that involves "throwing our arms around them."

The Flinders Program encourages self-management and partnership between patient and provider. Clinicians use a series of structured interviews to "assess the patient's self-management capacity, and patient and provider work together to identify client-defined problems and to collaboratively formulate small, behavioral goals" and the "development of a personalized self-management care plan." The program is being used throughout Australia, New Zealand, Canada and Singapore to great effect. Its use has reduced utilization rates by patients who demonstrate a high probability of becoming frequent flyers, chronically ill men and women set adrift in a medical system that has difficulty caring for them.

The first day this program was implemented in our rural health centers it led to an outpouring of tears. The patient hugged her provider with great emotion, saying "I'm so happy. This is the first time someone has actually listened to me."

Reducing Costly Readmissions

Readmission is a challenging issue that currently has everyone's attention. Research has shown a relatively low-tech post-discharge visit with a primary care provider within seven days after leaving the hospital significantly reduces the likelihood of readmission - averting a potential $12,000 charge to the hospital. So if a well-timed $150 office visit can prevent a $12,000 expense, we should pay attention.

Philanthropy and new models of volunteerism can provide resources to help our hospital evaluate and amplify the benefits of supportive programs like Flinder's and the post-discharge calling program outlined above.

For example, our resourceful rural health center director could recruit and train a few well-qualified volunteers to assist with Flinders, mitigating any potential loss in revenue from this more time-intensive approach. Similarly, the hospital could offer an optional patient-support program in which volunteers call patients on a regular basis offering encouragement and supportive community. These volunteers could become an important resource, alerting medical providers of emerging patient needs and helping to direct resources to where they are most needed.

In time it may also be possible to develop a home visitation program that utilizes volunteers to compliment the work of the healthcare team. Innovative community visitation programs like this could also be helpful in reversing the isolation that is increasingly being reported in communities where connections are few and meaningful interactions harder to find. This isolation has a measurable impact on quality of life, health and healthcare spending. The hospital's leadership in advancing these discussions will be welcomed by all.

Philanthropy could also be used to support nurse navigator and para-medicine home visitation programs not currently reimbursed by insurance. Documenting the impact of these programs on quality-of-care and cost-of-care is essential to their future acceptance and sustainability.

For several years now, an innovative partnership between our hospital and the local chapter of the multiple sclerosis society has supported a nurse navigator who works closely with MS patients and their families. Charitable seed funding was recently provided to support a navigator to assist patient's dealing with Parkinson's disease and Alzheimer's. These programs have become extremely popular with staff, patients and families; demand for them is growing.

Supportive Eldercare

This year, rather than designate the proceeds of our most visible black-tie fundraiser to benefit an acute-care service line or technology-intensive capital project, volunteers selected the St. Luke's Center for Positive Aging as the beneficiary. This program was recently expanded to serve as a network-wide resource. The pending $400,000 grant is a big shot-in-the-arm for their efforts to provide seniors with supportive, coordinated care enabling them to age-in-place successfully. If the actions of this center successfully reduce isolation and prevent unnecessary admissions and ED visits, enabling seniors to live independently for a year or two longer with better quality of life, the investment will have been more than justified.

Fostering Innovation

Physician leadership is essential for innovation, and we should establish more opportunities to expose physicians to new ideas and approaches. Younger physicians will benefit the most.

This fall, philanthropy helped support a new partnership between St. Luke's and Mbingo Baptist Hospital in Cameroon, West Africa. Fourth-year surgical residents now have the option of participating in a month-long international surgical rotation. Medical care at Mbingo is very different than in the United States. There is one portable x-ray machine, one ultrasound, no CT scan and no radiologists. Our residents and attending surgeons operate every day and they must adapt and discover logical, appropriate, and sometimes ingenious approaches to patient care utilizing limited resources.

Our development staff is learning as we go, especially as we consider how to stimulate creative ideas without traveling to Africa. We recently discussed the feasibility of a competitive seed grant program funded by donations and the hospital's charitable endowment. Grants would be organized around value-driven themes like palliative care, chronic disease management and community mental health services. Proposals would require community-initiated partnerships between nurses, case managers, physicians and local nonprofits; partnerships would be evaluated on their ability to improve care and prevent unwarranted expense.

Investing in Partnerships

Partnerships will be much more important in our future efforts to improve care and manage costs. Toward this end, the president and CEO of our health network recently agreed to serve as the co-chair of a $2.5 million capital campaign for a small community-based organization called the Hispanic Center of the Lehigh Valley.

The Hispanic Center hopes to establish a center for integrative health whose mission is to "address the needs of the whole person from physical and mental health to social services while also addressing the social and economic needs of the community." Leaders propose "wrap-around care that creates a continuum of support services."

The core of this new center will be a federally qualified health center, whose activities will complement and enhance the existing senior center, food pantry, WIC and community empowerment program providing job and life-skills education.

In the emerging value-based healthcare world of tomorrow, partnerships between St. Luke's and organizations like the Hispanic Center will become more than just "nice things to do"; they will become mission-critical activities. For example, if the Hispanic Center successfully improves access to care and helps reduce inappropriate ED visits and

preventable admissions, hospital goals are met. If the Hispanic Center improves the management of chronic conditions, freeing up specialists to focus their attention on the neediest patients, hospital goals are met.

Building and coordinating these vital new partnerships requires resources. And while our hospital will gratefully make a financial contribution to the Hispanic Center's capital campaign, we are also willing to invest our time and expertise. Accordingly, the president has asked selected members of our organization to help as we can. For me this means providing fundraising expertise; for others it means helping to negotiate a memorandum of understanding with the local FQHC. Some have been asked to provide expertise in construction management, while others have offered to contact selected vendors encouraging more favorable pricing.

In the future, our hospital might consider novel new investments designed to increase the ability of the Hispanic Center and other non-profit organizations to solve tough problems. One strategy might include a meaningful investment in the development of non-profit leaders, particularly those who are working with our hospital on challenging healthcare issues. Philanthropy or interest income from the hospital's charitable endowment could be used to establish an informal leadership academy. The faculty required to launch this academy could be drawn from the ranks of the hospital's talented workforce, with little or no need to hire additional personnel.

The hospital might also consider a grant program to assist non-profit partners with selected capital and programmatic needs benefiting our joint initiatives. For example, improved IT or volunteer coordination capabilities enabling meals-on-wheels to serve vulnerable patients recently discharged from the hospital might be part of our care coordination efforts to prevent readmission.

Clearly, there are many ideas to consider - some of them worthwhile - others not. Actions and activities which were once seen as beyond the responsibility of the hospital are now becoming operational concerns. It's a challenging time and I'm reminded of one of my favorite metaphors from literature, Friedrich Nietzsche's aphorism "You must have chaos within you to give birth to a dancing star."

I choose to see the "chaos" and other shifts in perspective now occurring in healthcare as opportunities. From this chaos we have the opportunity to realize a helpful new balance between the *culture of sick-care* and the *culture of health* and give birth to a dancing star. Investments in children and healthy lifestyles, as well as investments in community education and patient empowerment, appropriate care and stronger, more dynamic partnerships offer hopeful new possibilities. Let us pursue them!

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