

## 20 People Who Make Healthcare Better

Healthcare faces a long list of daunting challenges, from spiraling costs to drug-resistant infections to millions of uninsured patients. Who is showing the courage, the creativity, the perseverance to meet those challenges? Who is truly making a difference in today's complex healthcare world? In our annual HealthLeaders 20, we offer profiles of individuals who are doing just that. Some are longtime fixtures in the industry; others would clearly be considered "outsiders." Some of them are revered figures; others would not win many popularity contests. But all of them are playing a crucial role in finding ways both large and small to make the industry better.

### **Susan Hunt, voice for the underserved**

With its warm beaches and blue waters, it's hard to believe Hawaii would have a tough time recruiting primary care physicians. But low reimbursement rates, high real estate costs, and distance from the mainland make establishing a practice difficult, particularly in rural areas.

That's why the Hamakua Health Center's expansion into Kapa'au, HI, was such a landmark event for the Big Island. At the end of 2006, there was just one physician left in Kapa'au, and residents were left fighting for access to care.

"The community approached us and asked us if we would take over the practice and open a satellite in that community," says Susan Hunt, MHA, executive director of the Hamakua Health Center, whose main clinic is located in nearby Honokaa. Hamakua's executives had expansion in the organization's strategic plan, but with one physician remaining in the region, that plan accelerated—and quickly.

"This was an area of the island that wasn't providing care for the underinsured or uninsured population," Hunt says. "Its physician was having such a hard time that we thought this was an opportunity to carry our mission to that community."

But bringing accessible primary care to Kapa'au is just one of the many things that Hamakua Health Center has done under Hunt's leadership. "It's not just providing medical care," she says. "It's a whole array of social service programs: oral health services, mental health . . . You have to look at the whole package." In 2009, Hamakua Health Center will begin running a mobile dental health van between its two clinics, expanding the scope of care offered to residents of Kapa'au and Honokaa.

And Hunt's belief that healthcare should be accessible to all goes beyond her work at Hamakua. She's currently serving on a task force set up by County of Hawaii Mayor Harry Kim that brings healthcare and business leaders to the table to identify solutions to the limited healthcare options available to residents of Hawaii County.

—*Maureen Larkin*

### **Marc T. Zubrow, telemedicine advocate**

Anybody paying attention to the nation's physician shortage, particularly in rural areas, is well aware of telemedicine's role in filling the void. And anybody who is paying attention to telemedicine has heard of Marc T. Zubrow, MD.

Zubrow is leading an effort to bring top-tier critical care to the countryside. The director of Critical Care Medicine at Wilmington, DE-based Christiana Care Health System, Zubrow is also the medical director of the Maryland eCare project, which in the coming years will connect at least six

rural hospitals in the Old Line State to Christiana's eICU program. For Zubrow, the basic equation is simple.

"From Christiana's care perspective, we wanted to improve regional outreach and further support for our eICU program," he says. "From the Maryland hospitals' perspective, they are addressing a clear shortage of critical care physicians in these smaller, rural hospitals." Zubrow says eICU lets smaller hospitals maximize their staffing efficiencies by providing critical care during overnight and off hours, thus relieving on-site physicians from hours of extra duty. "Whereas, if you need a 24-hour-a-day setup to provide ICU patient care, you need at least five physicians, and a 200-bed hospital on the Eastern Shore is not going to be able to find that many physicians," Zubrow says.

Telemedicine also has indirect benefits. "It allows the hospitals to care for sicker patients locally, and that is a huge satisfier for patients and their families," Zubrow says. "From a financial standpoint, the rural hospitals are getting the reimbursements for care, rather than having to pay a tertiary hospital they refer to for that same care."

—*John Commins*

### **Harold P. Freeman, patient navigation pioneer**

The list of accomplishments for Harold P. Freeman, MD, is a long one: He is the president and founder of the Ralph Lauren Center for Cancer Care and Prevention in New York City, and he is senior advisor to the director of the National Cancer Institute. He's a professor of clinical surgery at Columbia University College of Physicians and Surgeons. Served as American Cancer Society president from 1988 to 1989. Chairman of the United States President's Cancer Panel for four three-year terms under the first President Bush and President Clinton. Director of surgery at Harlem (NY) Hospital from 1974 to 1999. Winner of multiple awards.

But it's Freeman's "patient navigation" concept that may be the accomplishment that provides the most help to people who need it the most. Freeman pioneered the patient navigation program in 1990 in Harlem after studying racial and economic disparities in cancer treatment access. The program uses patient navigators to guide medically underserved patients through the fragmented health system, from the initial finding of potential cancer to formal diagnosis to treatment, and helps remove barriers to diagnosis and proper care, whether those barriers are inadequate finances, poor language skills, or sheer fear.

Freeman's patient navigation model spawned The Harold P. Freeman Patient Navigation Institute, launched in January to provide patient navigation training and certification to representatives of organizations looking to develop or expand patient navigation programs. So far, the organization has trained 105 people from as far away as Hungary.

The patient navigation model is unique because it integrates assistance for every stage of the healthcare process, Freeman says. "People need to have tests done, but if they have an abnormality, it needs to be resolved in a timely way. It sounds simple, but it's really not. We are overseeing every step of this patient's movement through the medical system."

Although the concept of patient navigation has grown well beyond its origins in Harlem, Freeman says the individual stories of people triumphing over disease still offer the most lasting affirmation that his work is making a difference. He recalls one uninsured 54-year-old man who was convinced by a navigator to have a colonoscopy. "The colonoscopy showed a 10-centimeter tumor in his colon. Thirty days later, he had it removed—it was cancer of the noninvasive type, so he's cured," Freeman says. "I still see him on the street sometimes and talk to him. You see things like that, and you really know you're saving lives."

—*Jay Moore*

**Nancy Goler, collaborator in California**

The key to Kaiser Permanente Northern California's Early Start Program is collaboration—and that means more than just the health plan and medical team working together. The Early Start Program brings together OB/GYN clinicians with licensed substance abuse experts in a comprehensive obstetric clinic-based prenatal substance abuse treatment program that universally screens all expectant mothers for drug, alcohol, and tobacco use and helps them avoid those substances.

As Early Start's regional medical director, Nancy C. Goler, MD, plays a major role in that collaborative spirit. Goler leads the medical and research teams that are improving outcomes and reducing costs by preventing risky pregnancies and long-term—even lifelong—health issues. Goler works closely with regional director Cosette Taillac to set the program's vision and metrics. "This really shows how having the medical group and the health plan working together is able to propel a program," says Goler. The health system employs social workers in each of its 42 outpatient obstetric clinics. They work hand-in-hand with medical staff to reach out and help the women tackle potential substance problems. The Early Start Program screens nearly 40,000 women annually.

Those who are identified as having a risk of using alcohol, tobacco, or other drug use during pregnancy are referred to an on-site specialist, who is a licensed clinical social worker or marriage and family therapist. The specialist conducts a psychosocial assessment with the patient. The counselors use motivational therapy, cognitive/behavioral therapy, and psychodynamic therapy as techniques to reach out to at-risk patients.

Goler points to a study earlier this year as a compelling argument for the program; the research showed that the program is improving maternal and newborn health by getting the women treated.

—*Les Masterson*

**Ron J. Anderson, public hospital leader**

Ron J. Anderson, MD, was in the battle of his life, and he couldn't even fight back. That's because as president and CEO of Dallas' only public hospital, Parkland Health & Hospital System, Anderson wasn't allowed to directly lobby the public to approve a tax increase to build a new hospital to replace the 675-staffed-bed, 1954-era facility. It turns out he never needed to worry—plenty of prominent Dallas residents did that job for him as the measure passed by a landslide.

Anderson has long been an advocate for the poor that constitute the majority of his hospital's patients, and Parkland walks the talk while remaining profitable—at least on operations—at a time when many public hospitals are closing or asking for bailouts because they can't make the numbers work.

"I'd love to tell you we're just better managers than the people running other public hospitals, but our local county has been very generous to us," he says. "They've given us more than \$400 million in taxes this year, but that's still \$150 million short of what we spent on charity care, so we have to fill the gap."

Anderson and his team have unquestionably been good stewards of the county's money. Operating revenues at Parkland increased 14.2% from 2004 to 2005 and 18.7% from 2005 to 2006, while operating expenses increased 8.1% from 2004 to 2005 and only 5.1% from 2005 to 2006—the latest periods for which numbers are available. Mean while, the hospital provided \$512 million in uncompensated care in the past fiscal year and logs about 140,000 ED visits each year.

Anderson is the first to admit he's no kid anymore—he was named CEO in 1982, at age 35—but his legacy is strong at a hospital that shouldn't have been able to retain him this long in an era when the average hospital CEO's term is about three and a half years. "I've had several faith-based institutions with great missions offer me twice what I make," he says, "but I've stayed here because I can still see the promise for what we can do."

—*Philip Betbeze*

### **Glenn Steele Jr., integration advocate**

Glenn Steele Jr., MD, president and CEO of Geisinger Health System, is a gambling man—but you won't find him at the roulette wheel or the black jack tables. He's betting that the future of healthcare delivery will closely resemble the model that is being assembled at the Danville, PA-based integrated health system.

Anticipating the shift toward outpatient interventions, Geisinger is building outpatient facilities on a 52-acre site in State College. Steele is also betting that incentives over the next five to 10 years will move away from units of work performed and toward an emphasis on accomplishing certain tasks across a continuum of care. "We're betting that we'll be paid to do better care for chronic disease patients, and that puts us right into the huge use of our redesigned primary care," he says. "I'd say that about 30% to 40% of what we are doing is designed around bets about change in the future, not necessarily what is happening right now."

Steele's confidence is built upon a long history of success. Geisinger's integrated model, which combines the hospitals, physicians, and an insurance company under the same financial framework, has allowed the health system to adopt innovative, consumer-friendly care models like their "one-price guarantees" for heart surgeries. The integrated model also promotes cooperation and collegiality between primary care physicians and specialists, resulting in better outcomes. "You can only do those cross-incentives if the folks are in the same financial organization," Steele says. "You are not allowed to do that by and large if you're not a part of a single, integrated health system."

—*John Commins*

### **Dennis Quaid, actor and activist**

Hospitals usually ask celebrities to be spokesmen for a new fundraising drive or to headline the annual charity golf tournament. So actor Dennis Quaid's efforts to improve hospital and patient safety is a new celebrity role that hospitals have not seen. That could be a good thing.

By now you have likely read the story of how Quaid's newborn twins Thomas Boone and Zoe Grace received an overdose of the blood thinner heparin last year at Cedars-Sinai Medical Center in Los Angeles. The reported details of the incident—an apparent mix-up between the adult and NICU versions of the drug—were eerily similar to the deaths of three infants at an Indianapolis hospital in 2006. Luckily, Quaid says his twins are doing fine, but he and his wife, Kimberly, have started a foundation ([www.thequaidfoundation.org](http://www.thequaidfoundation.org)) to raise awareness about patient safety.

"I myself had been in the hospital before. I had been naïve and had complete faith that the doctors and nurses knew what they were doing, that they check and recheck," Quaid says. "And I wasn't aware of how many people get killed or severely injured each year in hospitals all over the country because of human error, which is basically what it comes down to."

Still, Quaid says he doesn't necessarily lay the blame for mistakes on physicians and nurses. "They are overworked. Human error is just always going to be part of the equation. I like to relate

it to the aviation industry where they brought down the number of crashes in commercial aviation because of the introduction of things like autopilot and color-coded radar in the cockpit."

Quaid hopes to use his celebrity status to raise awareness about the need for technology like bedside bar coding. The Quaid's started with a profile on 60 Minutes and later traveled to Children's Medical Center Dallas to spotlight the hospital's use of technology.

Quaid's plan, he says, is to keep it simple. "The first step is about people rising up, or nothing will get changed," he says. "I really don't have any illusions that I will really change healthcare. There are a lot more people out there doing research and on the ground making it their job to do that everyday. Those are the people who will change healthcare. But I just would like to contribute something after what happened to us so it doesn't happen to someone else."

—*Jim Molpus*

### **John Halamka, champion of IT adoption**

At 16 years old, John Halamka designed his first computer. He installed it—a system designed to stimulate a patient's hearing and gather electric impulse data to determine if the patient has hearing, brain stem, or nerve issues—at Los Angeles County Harbor-UCLA Medical Center during a summer fellowship at the community hospital. By the time he was at Stanford University completing his undergraduate degrees in public policy, economics, and biochemistry, Halamka knew he wanted to spend his life melding technology and healthcare. So he entered medical school at the University of California San Francisco and simultaneously pursued graduate work in bioengineering at the University of California, Berkeley, focusing on technology issues in medicine.

Today, Halamka is (take a deep breath): a practicing emergency room physician; chief information officer of both Harvard Medical School and Beth Israel Deaconess Medical Center in Boston; CEO of Massachusetts-SHARE, an IT connectivity initiative within the Massachusetts Health Data Consortium; chairman of the New England Health Electronic Data Interchange Network; CIO of the Harvard Clinical Research Institute (HCRI); and an associate professor of emergency medicine at Harvard Medical School.

He works tirelessly to promote the adoption of health IT, specifically electronic health records and personal health records. Although he spends considerable time speaking on the conference circuit, Halamka has made concrete strides in fostering EHR adoption.

In Massachusetts, he used a \$10 million allocation from Beth Israel Deaconess to foster an EHR rollout and clinical data exchange to fully subsidize EHRs for community physicians not affiliated with Beth Israel Deaconess. Halamka also chairs the Healthcare Information Technology Standards Panel, where he coordinates electronic standards harmonization among 600 organizations nationwide. And during his travels around the country promoting his causes, Halamka has received so many inquiries from colleagues about healthcare technology that he decided to write a blog in his spare time. Now, his "Life as a Healthcare CIO" blog is one of the most-read med-tech blogs on the Web, with about 2,500 readers logging on each week.

How does he manage it all? Halamka's answer is simple: "There are 168 hours in a week. All you have to do is use them wisely."

—*Kathryn Mackenzie*

### **Lyle Berkowitz, IT innovator**

When internist Lyle Berkowitz, MD, was treating Chicago businessman and creative director Peter Szollosi for cancer, the two often discussed the fragmented state of healthcare. Szollosi's

approach to problem solving meshed well with Berkowitz's background in biomedical engineering and healthcare informatics, and the two often debated how they would reengineer healthcare with a particular focus on technology and innovative thinking—if only there was enough time and money to be truly innovative.

After Szollosi passed away in 2007, his friends and family approached Berkowitz about founding the Szollosi Healthcare Innovation Program. The charitable endeavor, which launched in January, adopted Szollosi's mantra—"I don't care what you can't do"—and the goal of using diverse technologies to improve the patient experience.

Berkowitz's first project was a Web-based tool to revamp "expect notes" that doctors send to ED staff to notify them of a patient handoff. He rolled it out at Northwestern Memorial Physician Group, Chicago's largest primary care group where he practices and serves as the medical director of clinical information systems. His focus has since turned to creating a portal for patients and physicians to coordinate care at "inflection points"—scenarios where a new diagnosis transforms a patient into a high-level care user.

His goal with IT innovation isn't necessarily to revolutionize the entire system. "It doesn't have to solve everything, but if it solves that problem, that's what we're focused on," he says.

—*Elyas Bakhtiari*

#### **A.D. "Pete" Correll, hospital rescuer**

Pete Correll didn't have to help Atlanta's Grady Memorial Hospital. Usually in these kinds of Dickensian tales there is a personal hook that leads the wealthy benefactor to help a hospital, such as finding himself being treated there by some odd set of circumstances. Yes, Correll, the former CEO of giant Georgia-Pacific, did have a heart attack a few years back, but he was treated at Emory University Hospital with the rest of the insured crowd.

Correll told the *Atlanta-Journal Constitution* that he and an inner-circle of Atlanta industry scions were talking about who could save Grady from its decades-long downward spiral of debt, revolving door CEOs, and community distrust. "We decided it would be us," he said.

Correll is now chairman of the Grady Memorial Hospital Corporation. Step one was to wrestle away control of Grady from a public board mired in politics and convert its governance to a community-based nonprofit model. The carrot was a \$200 million gift from the Woodruff Foundation that allowed Grady to buy some luxuries like its first new hospital beds in decades.

Step two was to bring in a proven turnaround CEO in Mike Young, who spent his first week on the job looking at any check more than \$1,000 to see who was getting paid and who should not be.

Philanthropists carving their names on hospital buildings is nothing new, but to veer away from the tweedy grounds of the academic medical center into a troubled public hospital is a rare leap of community support. Some in Atlanta may still view the move as a takeover by an elite group, with racial overtones aplenty. But as public hospitals start to fail in communities across America, more cities will wish they had rich guys like Correll.

—*Jim Molpus*

#### **Douglas Shulman, IRS commissioner**

He's only been on the job for a little more than eight months, but perhaps no single person has more influence on interpreting those pesky Form 990 and Schedule H revisions than the attorney

and former vice chairman of the Financial Industry Regulatory Authority who became the 47th commissioner of the Internal Revenue Service last March.

Douglas Shulman wasn't around for the congressional legislation that drove the Form 990 revisions or the implementation of the Schedule H form that details how hospitals are spending their money. Nevertheless, many hospital chief executives are rightly directing their top lieutenants to make sure nothing embarrassing turns up in these publicly available forms.

The new forms are "by far the biggest change I've seen in the 20 years I've worked in the healthcare tax arena," says Jim Sower, national healthcare provider tax leader for Deloitte & Touche LLP. Shulman and his lieutenants have broad authority to make changes in the forms, and since the answers hospitals give—ostensibly to make the case that their tax breaks are deserved—are narrative and open to interpretation, it seems natural that Shulman and his leadership team will have broad authority to interpret what those answers mean. Not to mention that they have a legislative mandate to worry about from Congress. Administrators in the government who are tasked with doing Congress' bidding hate being called before that body almost as much as individuals and hospitals dislike being asked questions by the IRS.

So how does Shulman make healthcare better? Some would argue that he doesn't. Surely hospital leaders who feel their organization is doing the right thing don't relish spending the extra dollars that will be required to fill the forms out properly. But making healthcare better isn't always about popularity. The increased focus on transparency that the forms will foster should cut down on the fraud and waste perpetrated by certain organizations that, despite their generous tax breaks, perhaps aren't acting in the best interests of the community.

—*Philip Betbeze*

### **Gil Mileikowsky, whistleblower**

Whistleblowers often pay a high price for exposing flaws in the healthcare system. Like a lot of physicians who have been in his situation, Gil Mileikowsky, MD, essentially lost his livelihood. It started in 2000 when he was approached by a lawyer representing a patient whose Fallopian tubes were removed without consent. He hadn't heard of the case, even though it happened in his own department, and he began to suspect that other patient safety incidents weren't being reviewed through the proper channels. He agreed to serve as an expert witness against Tarzana Regional Medical Center, a joint venture of HCA and Tenet HealthSystem, and four days later the hospital CEO informed him that he would be escorted by security while on hospital grounds. A few months later he was suspended.

That was just the beginning of a long legal battle that is still ongoing. The American Medical Association, the California Medical Association, and other physician and consumer organizations—including a partnership between doctors and trial lawyers spearheaded by attorney Alan Dershowitz—filed amicus briefs on Mileikowsky's behalf. For many of his supporters, the central issue is peer review and whether hospitals should have authority to remove a physician without due process. His case recently led to a new California law that extends whistleblower protection to all physicians, and he has campaigned for similar protections on the federal level.

But in Mileikowsky's eyes, he is locked in a much grander struggle to improve the quality of the healthcare system. He founded the Alliance for Patient Safety to document his case and push for safety reforms, and he has developed what he believes is a solution to poor quality control—a "black box" for physicians. Hospital errors should be reviewed in double-blind studies by randomly selected specialists to remove bias or potential conflict of interest, he argues. Although he never intended to become a whistleblower, he says his goal is now to expose flaws in the entire system, not just one hospital.

Whistleblowers like Mileikowsky play an important role in an industry that is often unsuccessful at policing itself; they now initiate nine out of 10 fraud cases for the Department of Justice. Although in some situations they stand to receive up to 25% of any amount recovered, that wasn't the case for Mileikowsky. "I didn't wake up one day and say, 'I want to become a whistleblower,'" he says. "A whistleblower is just someone who tries to sound the alarm about a wrong situation."

—*Elyas Bakhtiari*

### **Stan Hodes, executive chef**

For the past 17 years, Stan Hodes' mission as the executive chef and operations manager at Baptist Hospital in Miami has been to create a dining experience for patients, not just a meal. "When I got here, the focus was keep hot food hot, cold food cold, and make sure the tray is accurate," he says. But his experience in the hotel industry gave him a different perspective. "The relationship that you have with your patients and staff is where quality starts," he says.

Baptist offers a room-service-style menu from 7 a.m. to 7 p.m. to about 40% of its patients. Patients can call to get what they want off of the menu, says Hodes, adding that "if you need something else, call down and order it." The remaining 60% of patients receive a tray that is prescribed by the physician. Since roughly 60% of the patients are Latin, he tailored the menu to include local favorites like red and black beans, rice, sweet potatoes, and marinated fresh meat that is seasoned in local spices and cooked to order.

And just like physicians, Hodes dons his chef jacket and hat and actually rounds on the patients. "Patients don't know a lot about the medical care they are going to get," he says. "One thing they know is food—everyone is an expert when it comes to food."

But Hodes doesn't just want to provide better service and food to patients. He's also trying to improve the lives of employees and community members. As much as possible, he purchases food and supplies from local businesses to keep dollars in the community. And not only does he provide healthy food options—denoted by a health and wellness icon—he also incentivizes the employees, visitors, and members of the community to buy those healthier food items. "The most inexpensive food you can buy is the healthy food. We have a hot and cold entrée of the day with a bottle of water at the register for \$3," he says. Even the healthy food items in the vending machines are priced lower, he adds.

So what's the favorite menu item? A grilled fresh turkey cutlet served on corn polenta and topped with a natural tomato and basil balsamic salsa.

—*Carrie Vaughan*

### **Bridget Duffy, experience evangelist**

It's one thing to say you want to improve the patient experience at your own hospital. But it's quite another thing to say you want to improve it everywhere. Bridget Duffy, MD, knows that if her family and friends ever needed care, they wouldn't necessarily be admitted to the Cleveland Clinic, where she serves as chief experience officer. So she wants to make sure that no matter where the people in her life go, they'll be treated with dignity and respect.

Duffy is an evangelist for improving the way patients are treated—emotionally and physically—no matter where they are. She willingly shares tactics and techniques with other organizations, talks about what works and what doesn't, and offers advice to those who would follow in her footsteps. And there are plenty of those: She's been "inundated" with requests for information from leaders at hospitals and health systems across the country.

Duffy is all business when she's outlining the administrative changes she's made at the clinic, such as creating institute-level experience officers and organizing patient and family advisory councils. But her passion for the subject shines through when she talks about patients and the way they experience healthcare. Take, for example, her objection to those ugly and awkward hospital gowns, which she says strip patients of their identity and dignity from the moment they are admitted. "I'm motivated by my sense of injustice," Duffy says. "We need to restore humanity to healthcare."

The Cleveland Clinic's top 50 leaders recently agreed to put patient satisfaction at the forefront of the organization's strategic plan—and Duffy says the onus is on healthcare leaders nationwide to make similar strides. "This is something that is so missing and so absent from healthcare across the country."

—*Gienna Shaw*

### **Curtis J. Schroeder, a CEO abroad**

When Curtis J. Schroeder took a job in 1993 to run a small hospital in Thailand, he told his wife it would be an assignment of no more than five years. Fifteen years later, he's still there. The Schroeders stayed in Bangkok and raised their two daughters there while CEO Curtis raised Bumrungrad from a 200-bed private hospital to an international system of 85 facilities in seven countries that cares for about 2 million patients per year.

Schroeder was the first nonphysician, non-Thai hospital CEO in the country, hired to bring the Western style of business management to Bumrungrad. It took many years and a lot of patience to break through longstanding cultural barriers. Perhaps most challenging, Schroeder helped teach the organization about the power of teamwork and decentralized management. "Pushing this down into the organization and developing the middle-management was one of the critical change factors," says Schroeder. "I would say it took me five years, along with some very good help, to begin to change the culture for the Thai and Asian staff to begin to take risks and begin to express opinions freely."

With medical travel now making headlines in the United States, there is a new interest in Bumrungrad's operation. Schroeder estimates Bumrungrad treats about 66,000 Americans annually, with about half of them outbound medical travelers.

"I don't think the American CEOs have to wake up worrying about hospitals in Thailand and Mexico making a significant impact on American healthcare's competitive landscape," Schroeder says. But he also says the potential for the globalization of healthcare is even bigger than the hype. If that is so, new international opportunities for health leaders abound, and there will be healthcare executives following Schroeder's trail markers.

—*Rick Johnson*

### **Sophie Harnage, infection control team leader**

Researchers can spend years looking for ways to prevent the spread of hospital-acquired infections, but when it comes to keeping patients safe, it's often those who work on the front line who really make it happen. Just ask Sophie Harnage, RN, BSN, clinical manager of infusion services at Sutter Roseville Medical Center in Roseville, CA. Harnage heads a nurse-driven specialty team that has successfully prevented catheter-related bloodstream infections for more than two years at her facility.

"There's no question in my mind that this success isn't about me," she says. "It's an entire team that's made this happen."

That team uses a bundle created by Harnage and documented in the December 2007 edition of the Journal of the Association for Vascular Access. The bundle's steps include using peripherally inserted central catheters, ultrasound to select insertion sites, surgical-like coverage of both the patient and caregiver, a two-step cleansing and disinfection process, disinfection of the IV connector septum, and daily monitoring of the catheter line. The bundle was developed after years of observing what works—and what doesn't, Harnage says.

"What we've done is practice-driven, not research-driven," Harnage says. "The science is needed and it's important, but . . . it's not always applicable to everyday practice."

While each of the bundle's steps is important to the team's success, Harnage says her team's dedication to eliminating catheter-related blood stream infections and keeping patients safe is key.

"We at times lose sight of the talent, the input, and the guidance that these frontline nurses offer," she says. "Their commitment and their drive to make this successful keep it going."

The best thing about the work being done at Sutter Roseville? Harnage says it's simple, uncomplicated, and can be done at any hospital that is willing to give its staff the training and resources it needs to prevent infections. "When I take a step back and look at this bundle, it's simple, practice-driven, and something that any frontline nurse can implement at their hospital," she says. "It works because it's common sense."

—*Maureen Larkin*

#### **Stan Brock, traveling caregiver**

He is a big personality who lives a simple life with a single mission: providing healthcare to underserved, rural populations. Stan Brock founded Remote Area Medical in 1985 with the primary purpose of delivering airborne medical and veterinary help to the indigenous tribal groups of the Amazon, where he lived for many years. From there Brock's mission spread to Africa, Guatemala, and ultimately the United States, where now about 60% of the care the publicly supported, all-volunteer charitable organization provides is administered.

Since Knoxville, TN-based Remote Area Medical's inception, Brock has recruited and led volunteer teams of doctors, nurses, dentists, and veterinarians to deliver free care (at a value of more than \$33 million) to hundreds of thousands of people around the world. But beyond the clinical care his organization provides, Brock, who co-hosted NBC's wildlife series Wild Kingdom in the 1960s and early 1970s, has certainly done his share to focus national attention on challenges in the U.S. healthcare system. Brock remains steadfast in his belief that if it were made easier for medical providers to practice across state lines, the system of free care that RAM created and practices could be replicated throughout America. "If doctors were allowed to cross state lines to provide free care for those in need and had some type of protection against malpractice, I think we could do this anywhere in the U.S.," he says.

Brock has testified on that topic in front of the U.S. House Ways and Means Subcommittee on Healthcare, and he also drafted a bill in Tennessee that was later passed into law called the Volunteer Healthcare Services Act, which allows volunteer medical personnel and veterinarians licensed anywhere in the United States to provide free care in Tennessee. Brock says a 1997 congressional resolution to let other states adopt the Tennessee model never got out of committee.

—*Kathryn Mackenzie*

**Scott Morris, minister and physician**

Scott Morris, MD, realized at a young age that he was called to heal both the body and the spirit. Morris, an ordained United Methodist minister, is executive director of the Church Health Center in Memphis, TN, a faith-based organization that provides affordable healthcare for working uninsured people and their families. Morris founded the center in 1987 after coming to a harsh realization about the faith community's role in healthcare.

"I had read the Bible and read about healing the sick, and I looked around at what my church was doing, and there wasn't much to it," says Morris, who serves as associate pastor at St. John's United Methodist Church. "I thought there must be a way to reconnect people of faith to a true healthcare ministry that is tangible."

The center began with Morris and one nurse seeing 12 patients on the first day. The organization now cares for 55,000 people and offers myriad services beyond the clinic itself. The MEMPHIS Plan is the center's employer-sponsored healthcare plan that uses donated services from physicians. Hope & Healing is an 80,000-square-foot wellness facility that sees 120,000 visits per year. And the center's Faith Community Ministries program trains "congregational health promoters" to be healthcare liaisons in their congregations.

Morris designed the Church Health Center model to be reproducible; the center holds "replication seminars" to help caregivers in other cities launch their own facilities. Roughly 20 organizations in Tennessee, Georgia, Texas, Missouri, and other states have been created based in large part on the Church Health Center model.

The center's latest endeavor: an online magazine and social networking site, [www.hopeandhealing.org](http://www.hopeandhealing.org), that launched in November and addresses "anything about faith and health," Morris says. But even as his organization expands and more caregivers follow the path he has set, Morris remains focused on a longtime central theme—that healthcare should be more than curing physical ailments. "Life for life's sake doesn't make any sense—it's not just about avoiding disease," he says. "True healthcare includes the life of meaning, not just breathing in and out."

—Jay Moore

**Jon Kingsdale, Bay State reformer**

Jon Kingsdale, PhD, once dreamed of being a history professor. Now he's not just teaching history—he's making it. Since 2006, Kingsdale has been executive director of the Commonwealth Health Insurance Connector Authority, which oversees Massachusetts' healthcare reform programs that improved coverage access to 440,000 newly insured residents. The effort is being watched by healthcare leaders across the country, and Kingsdale is excited about working on the challenges that arise from being first in the nation. "It's like drinking champagne from a fire hose," he says.

The connector authority oversees two programs: the subsidized Commonwealth Care and unsubsidized Commonwealth Choice. The programs' popularity has been both a blessing and a curse. The programs have contributed to an overall increase in insured lives by 7% of the state's population and revamped the individual insurance market by bringing thousands of healthy people into the program, which has decreased premiums and improved coverage, he says. But the especially popular Commonwealth Care program has brought about higher-than-expected program costs.

A large part of Kingsdale's work is developing and maintaining relationships with the multiple stakeholders with varied interests, including business leaders, labor leaders, healthcare officials, legislators, and state agency leaders. The connector authority reaches out to the

commonwealth's 192,000 employers and 6 million citizens to both educate and engage the uninsured to enter the programs.

The result has been an educated and largely supportive public. Kingsdale says a recent study showed that 93% of Massachusetts residents understand the healthcare reforms while more than 70% of employers and likely voters support the initiative. Having a broad coalition and the support of the State House has been critical; states eyeing such reforms must remember that a divided legislature won't provide the support needed to back these kinds of programs, he says. "To do something significant like this on a narrow partisan vote, I think, is very, very difficult."

—*Les Masterson*

### **Tammy Roehrich, volunteer EMT**

Access to healthcare in rural America and underserved regions is spotty at best. Sure, a hospital may be an hour away, but what happens when you have a car accident or heart attack in the middle of the night? Who's going to come to your aid?

Often the answer is a volunteer emergency medical technician like Tammy Roehrich. Ambulance service organizations in rural areas don't have the resources to pay paramedics, nurses, or EMTs, so their viability depends on community volunteers. In North Dakota, 90% to 95% of ambulance services are volunteer organizations, says Roehrich, a resident of Fessenden, ND—a town of about 500 people. Roehrich has been volunteering on the Fessenden ambulance service for 17 years. "I just saw a need in the community. I took a CPR class, loved it, and just continued on," she says.

The Fessenden ambulance service has 15 members from all walks of life. It provides service 24 hours a day, seven days a week, 365 days a year. It services two hospitals—one is 20 miles away and the other is 35 miles away—and patients are brought to whichever facility is the closest to them. They respond to about 50 calls per year, and the service is strictly a volunteer organization.

Fessenden has physicians who come to the community twice a week, but if someone gets sick in the middle of the night—especially a member of its elderly population—they have no access to care, Roehrich says. "We are it."

Volunteer EMTs are becoming an endangered species. Many ambulance services are struggling to recruit enough volunteers to keep their service open. "Volunteerism today isn't what it was 25 years ago," says Roehrich. The Fessenden ambulance service recently offered a free basic EMT community class to bolster its numbers. "You ask, you beg, you plead," says Roehrich. "You show people the need and say, 'We need your help.'"

—*Carrie Vaughan*