2012 GAIL L. WARDEN LEADERSHIP AWARD RECIPIENTS DISCUSS CHANGING THE CULTURE OF HEALTHCARE

The National Center for Healthcare Leadership is privileged to honor two outstanding leaders of the healthcare community for bringing substantial and lasting improvement to population health in the U.S. as well as mentoring and preparing the next generation of healthcare leaders. The 2012 Gail L. Warden Leadership Excellence Awards is presented to Margaret O'Kane, president of the National Committee for Quality Assurance and Dr. Mitchell Katz, Director, Department of Health Services, County of Los Angles for their innovative and exemplary contributions. Their work—Ms. O'Kane's in the world of public policy and Dr. Katz's in the world of public health—can be viewed as opposite sides of the same coin that is devoted to change. As an advocate for patient-centered, evidenced-based high quality care, Ms. O'Kane's efforts have helped to save millions of lives and billions of dollars in wasted or ineffective care. Dr. Katz's transformation of safety net systems in San Francisco and Los Angeles has expanded access to care, improved the quality of care and improved the patient experience for hundreds of thousands of uninsured, indignant or homeless individuals. With their commitment, dedication and passion, Ms. O'Kane and Dr. Katz have each brought new thinking, leadership and meaning.

MARGARET E. O'KANE
President, National Committee for Quality Assurance

EDUCATION

Bachelor of Arts, French, Fordham University
Master of Health Science, Health Administration and Planning, The Johns Hopkins University School of Hygiene and Public Health

CAREER

President, National Committee for Quality Assurance; 1990 – present
Director, Quality Management, Group Health Association, Inc.; 1989 – 1990
Director, Medical Directors Division, American Association of Health Plans; 1986 – 1989
National Center for Health Services Research, Department of Health and Human Services
Special Assistant to the Director; 1985 – 1986
Public Health Service Fellow; 1983 – 1984

AWARDS

2012 Gail L. Warden Leadership Excellence Award, National Center for Healthcare Leadership
2012 Johns Hopkins University Distinguished Alumnus Award
2012, 2006, 2002 – 2004 Among 100 Most Powerful People in Healthcare, Modern Healthcare
2011 Among Top 25 Women in Healthcare, Modern Healthcare
2009 Picker Award for Advancement of Patient-Centered Care, Picker Institute

PROFESSIONAL ACTIVITIES

Co-chair, National Priorities Partnership
Member, Institute of Medicine
Member, Maryland Health Quality and Cost Council
Member, National Quality Forum, Measure Applications Partnership Coordinating Committee
Board Member, Population Health and Public Health Practice
Board Member, Foundation for Informed Medical Decision Making, Inc.
Board Member, American Board of Medical Specialties
Board Member, National Board of Medical Examiners

MITCHELL H. KATZ, MD
Director, Los Angeles County Department of Health Services

EDUCATION

Bachelor of Arts, Yale University, *magna cum laude*
Medical Degree, Harvard Medical School
Residency, Primary Care Internal Medicine; University of California, San Francisco
Clinical Scholar, Robert Wood Johnson Foundation, University of California, San Francisco

CAREER

Director, Department of Health Services, County of Los Angeles; 2011 – present
Department of Public Health (SFDPH), City and County of San Francisco
Director; 1997 – 2010
Director, Community Health and Safety; 1996 – 1997
Interim Medical Director, Emergency Medical Services; 1995 – 1996
Director, Epidemiology, Disease Control & AIDS; 1994 – 1996
Director, AIDS Office; 1992 – 1997
Chief, Research Branch AIDS Office; 1991 – 1992

ACADEMIC POSITIONS

Clinical Professor of Medicine and Clinical Professor of Epidemiology and Biostatistics, University of California, San Francisco; 2002 – present

AWARDS

2012 Gail L. Warden Leadership Excellence ward, National Center for Healthcare Leadership
2010 Cynthia Selmar Health Giant Community Health Service Awards (HERC)
2009 Milton and Ruth Roemer Prize for Creative Local Public Health Work, American Public Health Association
2009 Annie Less Shuster Alumni Lecturer, Robert Wood Johnson Clinical Scholars Program
2009 Beverlee A. Myers Award for Excellence, California Department of Public health & California Department of Healthcare Care Services
2002 Outstanding Community Service Award, American College of Physicians, North California Chapter
Public Health Hero, University of California, Berkeley
Numerous other awards, publications, books, editorials and essays.

Health Cooperative were some of our early backers. Gail in particular was a terrific mentor to me—we could not have done this without his help. At the same time Dr. Dennis O'Leary of the Joint Commission was trying to make changes in the hospital accreditation world, despite the fact that he was held back by his own industry. Then there were employers that were forward thinking about healthcare quality and accountability and these included Xerox, Bank of America, Ford and the UAW. These companies understood the need for measurement standards for things like how a health plan should function and exist in an organization. They were really doing breakthrough quality work.

Q. Is the work of NCQA understood by the public and does that matter?

A. The answers are no and yes. We have a lot of work to do to make quality measurement salient and important to the public. People look at quality measures and can't see the value. They don't value preventative services because they aren't convinced of the benefit. If they don't have a chronic disease, they don't care how a plan does it. Now, they do understand the value of third party accreditation. So we are doing a lot of work in this area to help the public understand quality measurement and why they will need to care about it as individuals take on more responsibility for managing their own care.

Q. The Accountable Care Act is strongly linked to quality measures. What do you think will be its impact?

A. I am cautiously optimistic about the Accountable Care Act and its ability to improve healthcare, especially in terms of payment reform. If you think about it, the payment system has tyrannized medical care. Now practitioners will be able to use tools like email and patient self-monitoring tools without sacrificing payments from visits.

Q. What other benefits do you see?

A. The use of medical homes for integrating care across a community in states like Vermont, North Carolina, and Colorado has been stunningly successful. The payment rules for medical errors, for readmissions are steps in the right direction. We are in a pay-for-performance, micro-managed system and we need to get to the place where it's about the level of performance. And we still have a lot of work to do to get quality measures in many areas of specialty care. There are very few guidelines, for instance, that tell you the right time to do a knee replacement, hip replacement, or cancer care. These are giant issues and it's not simple. But we need to gather better evidence about more complex patients. For example, we never do trials on the elderly; they are done on young, healthy people and generalized to care for the elderly. When you pull one little string in healthcare you realize you have a complicated tangle on the other end.

Q. What have you learned from your mentors and how have you applied that to the people you mentor?

A. My mentors gave me several things. First, and maybe most important, was someone in my corner who kept saying—"atta girl"—that constant support was critical. Then there was also that piece of providing honest feedback about what works and doesn't work. It's really hard to get that information but it's essential to have it so you can move forward. Another critical piece was the introduction to other people who were as zealous about this kind of work as we were. Then, then was the practical support we received as a start-up business. When Gail Warden was president of Henry Ford Health System, he provided us with HR support, accounting, and administrative services and so on. We could not have gotten off the ground without that help. But I also learned a lot of lessons the hard way. I didn't come in as a great leader. I had zeal and passion, some political understanding and zero management skills. I had to learn that I could not be a good operations person, so I needed to hire operations people. I had to learn to let go of control and let my people do their work. I learned to recognize when I was failing and make adjustments along the way. That's important.

Q. How should healthcare education change to accommodate 21st century medicine?

A. On the administrative side, concepts like Lean and process engineering are absolutely crucial for future success. Some of the finest health systems in the country, including Denver Health and Intermountain Healthcare, are doing things like that now as they relentlessly reengineer their systems to drive out waste

Peggy O'Kane: A Passion for Healthcare Accountability and Quality

Q. What shaped your vision about how healthcare should be delivered?

A. I worked in five different hospitals and they all had blatant quality issues. What impressed me was how little coordination there was. As a respiratory therapist, one doctor would come along and change the settings and then another doctor did the opposite. Nobody felt the need to look at guidelines and have an argument. I worked in ICU then, with the sickest patients, and I saw heroic nurses providing coordination. But heroism is not what you want to use as basis of patient safety and well being; there's a limited supply of it.

Q. How did you decide to do something about it?

A. There was no clear consensus on what needed to be done, so there was no field of study called 'quality' when I went to graduate school. But there was research from people like Bob Brook, Alan Gittelsohn and Sam Shapiro. At that point I still believed that most medical care was evidence-based. I didn't fully understand that much of it was up to the individual hospital or practitioner or medical school, and standards and guidelines didn't exist or weren't followed. I came to understand this reality slowly through stages of awareness. When I joined the Health Services Administration (in 1979) I saw the beginning of quality measurement that came from the government, which wanted to make sure the community health centers they funded were using their money wisely. Then HMOs were on the rise, the driver being employers who were concerned about the rising cost of healthcare. I worked in that field because I was intrigued by prevention and population health.

Q. What did you take away from that experience?

A. Well, I learned that at heart, I am really a public health person and that remains true today. I also learned I had some good organizing skills. We were able to bring employers and the plans together to write standards; it was a collective undertaking. Despite the fact that there was a zero increase in cost, there was a managed care backlash, especially from specialists who were feeling the pinch and were vocally critical of HMOs. I knew something needed to be done but that it could not be done with self regulation and I wasn't getting industry support. I left but returned three years later when The Robert Wood Johnson Foundation gave us $300,000 and we raised another $300,000 from the industry to launch an independent organization that would focus on quality. That's how it started. Ultimately, NCQA is the story of people with a shared goal who were willing to come together because they believed that they could save lives.

Q. How did you pull people together to create quality measurement in healthcare?

A. For one thing there was clarity of vision. We worked with some incredible employers and leading health plans. We were convinced of the rightness of our agenda; it was very clear from my experiences in healthcare that quality measurement was absolutely necessary. I had the passion for improving healthcare and for this work and I found others who shared in it. And, I had a good political sense. The timing was right, we worked with these other people who believed in the strategy, and so there was collective action. Those are the things that give you energy to keep going, especially when you are climbing an uphill battle against some powerful forces.

Q. Did you intend to become a change agent?

A. It was a gradual evolution. I had hoped to make healthcare better and save lives, and that required change, so the answer must be yes, but it took us years to find our way. I think the main thing I do is find other people who are trying to change things, too. I think I am proudest of my ability to recruit other people who are in the same general space who are trying to figure out how to move forward. Basically we spend a lot of time groping until we get clarity on the issue we are trying to solve. But it means we are constantly changing. One thing I learned as a change agent is that you get humble very quickly. You learn to take the feedback and change the program to make it more realistic and practical and doable.

Q. You have talked about launching NCQA as a collective effort; who were some of the individuals who made it possible?

A. John Ludden was the medical director of the Harvard Community Health Plan (now the Harvard Pilgrim Health Care) and Gail Warden, who was chairman of the Group

and improve quality. For nurses and doctors and other clinicians and practitioners, there needs to be more teaching of empirical and analytical techniques. The medical school paradigm of stuffing their students' heads with knowledge is outdated because medical knowledge and information are changing so rapidly. Instead, these students need to be taught how to access knowledge and they need the ability to think in statistics. Biostatistics and epidemiology are compelling subjects that aren't typically taught in medical school. But healthcare practitioners need to learn the think analytically across the board.

Q. How do you lead your team?

A. One of the most valuable things we do is our "All Employee Meetings" three or four times a year, which are more about team building and fun then PowerPoint presentations. I do lots of emails and probably not enough walking around. Right now we are doing a lot of strategic planning, looking at the complicated questions that we need to make in light of the Accountable Care Act. But that's what we are best at. Because we are an organization that is focused on change, many people come to us with a commitment to make change happen. They have a shared vision and strong drive to make healthcare better. We are proud of that and hire people who feel the same way.

Q. Was saving lives always your goal?

A. I always felt like we had a tremendous amount at stake here and I had this idea if healthcare worked better then we would saves lives. But I didn't always have the confidence that we could change things. I remember when I took this job I was just terrified about what we would do and how we would do it. One of the Board members said to me if this works it will be miracle. We have a way to go, but it is changing, it is working. So I guess it is a miracle.

Dr. Mitch Katz: Putting Patient into the Mission Statement and Making Success the Norm

Q. You're mentioned by San Francisco Mayor Willie Brown as a mentor. Tell us about that experience.

A. You didn't say 'no' to Willie Brown. You could only say 'yes,' or resign. I had tremendous respect and admiration for what he had accomplished in his life and after all, I didn't want to resign. Instead I learned that when someone brings you something that seems impossible, try to imagine that failure is not a possibility by focusing on outcomes. Start with the end and work backwards to figure out the steps that are necessary to achieve success. Most people start with the task and think about the things that need to be done going forward. The problem with thinking about next steps is that it allows for obstacles. I always try to focus on the outcome; this is the approach I use as a mentor.

Q. Are you using that approach in Los Angeles?

A. Yes, because it works. We are implementing electronic medical records. My staff gave me a four-month time frame for completing the contract through the county approval process system. I felt the date was too far in the future to achieve our goals within the context of the health reform act and moved up the deadline by two months. Then we had to figure out how to reach the goal. With that mindset we could see that the answer was to work some processes parallel to each other rather than consecutively. Even though my team resisted because it was contrary to normal processes, I was able to convince them that "normal" wasn't what was best in this case.

Q. But isn't that the issue in government—overcoming what's normal?

A. In private business, people are pushed to get things done because they understand that finances drive things. But in government there is no incentive to make things happen quickly. In San Francisco several times we had to dispense with the rules to get some things done quickly under a public health emergency; for example, mandated H1N1 vaccines. We needed to open 12 clinics days, nights, weekends, and I needed more staffing because it was an emergency. Government understands

emergency. Why can't we feel that same sense of urgency about non-emergency things? Well, the answer is we can.

Q. What brought you to public health?

A. As a primary care doctor I saw many system challenges that prevented me from providing patients with what they needed. I saw how outcomes were worse for uninsured people or homeless people who came for treatment late in the course in the illness or who were isolated. Often these patients needed medical treatment and something else—housing, family support—that the healthcare system didn't support because it wasn't a medical issue. I felt this was potentially changeable. Moving into public health was my answer to improving systems to help patients.

Q. So you have become a change agent of bureaucracy?

A. Bureaucracy is about rules and I am fundamentally opposed to programmatic decisions based on rules. You should make programs based on public good. Figure out the public good and then figure out how to make it happen. Medicine and public health should be based on mission—what do you want to achieve—that is the starting place. In Los Angeles I began by putting the word "patient" in our mission statement. We are here for the patient and this is how we will make decisions. That was a huge sea change. Before that the focus was on numbers and rules. One of the first things I did was require administrative doctors to see patients. I see patients, they needed to see patients. For non-clinical administrators I also said I want you to interact with patients—help register patients, answer the phones—so you are in touch with the patient.

Q. Has there been resistance?

A. People may not agree with what I have done but it's hard to argue with our patient focus. When they see me taking care of patients they get a sense that I am not just telling others what to do, I am doing it as well. A credible administrator—whether a physician or nurse or registration clerk—has to understand our operation and the only way to understand it is to work in it. Even though they already felt overworked, once they started working with patients, many on my team said they were reenergized and felt reconnected.

Q. Will Los Angeles be a replica of your successful programs in San Francisco?

A. In Los Angeles I am trying to replicate the spirit of more service, more access, higher quality, and a can-do attitude. I am not replicating the same programs because every local system is different. Yet the goal is the same: to eliminate waste, low value care, care that isn't focused on the needs of patients but is more focused on rules. In a nonprofit government setting anything I save through a less expensive model goes to provide more care. In a government system I can't motivate people with money—I can't change pay schedules. But I can motivate them through mission.

Q. What will success look in like in Los Angeles?

A. We've already had success because we changed our attitude to focus on our patients. We initiated operation full enrollment to increase enrollment into the State's low income health program because increasing access was critical to our work. I said we need to enroll every eligible person. People were startled because L.A. had never had an open enrollment. In the two years before I changed the program, L.A. enrolled 60,000 people; after a year of our new program, our enrollment exceeds 200,000 people.

Q. Is lack of funds the biggest problem facing public health?

A. Care costs money. But it can also be an excuse why you can't do better. The county gives us $3.6 billion a year; how do I show $3.6 billion of value? Before asking for more money, we have to figure out whether we are maximizing the money we have. What I have learned is that we are not at the level of efficiency that I would like. We can do better by simplifying systems. Government is burdened by many complicated procedures that result in duplication and inefficiency. So the caricature of the lazy civil servant is generally false. The challenge is not that they aren't working hard, but they are working hard under cumbersome systems that don't add value.

Q. As a leader of such a vast system, do you keep your eyes on the trees or the forest?

A. I have come to believe that there is a false dichotomy in leadership. You have to be an on-the-ground granular leader who knows the systems really well, but who can also see the bigger picture. The best leaders go up

and down—they go from granular to big picture. The best leaders use what they learn on a granular level to improve things at the big picture.

Q. What is your biggest leadership challenge?

A. I think a common issue in a large bureaucracy is that you can articulate your vision to direct reports, but how does it move down the chain? So I am trying to figure out how to communicate with 18,000 employees stretched over 400 square miles who work seven days a week, three different shifts. How do I get the registration clerk to feel the sense of urgency as I do? We are doing a lot with our own YouTube network, electronic newsletters, personal visits, and an interactive web-based message board. I also respond to email. My goal is for everyone to have the same sense about our organization, despite our size.

Q. How did you create your vision for L.A. County?

A. Well I went into the job with a vision to focus on patients because I knew that's what needed to be done. But it has also evolved. I knew if I was going to change our organization, I had to change the culture of the organization. The organization didn't believe in itself, and if you don't believe you can make things better, then how can you succeed? I do believe that culture matters more than strategy. You have to focus on culture. I have energized a base of people who want the right thing to happen. Now I hope they see that it can happen.

Q. What are the "biggest" challenges facing healthcare today?

A. Expanding access and coming up with creative, innovative ways to decrease the cost of care per person. The goal needs to be that everyone can benefit from effective care without bankrupting the country. While the Affordable Care Act improves care in a number of ways, its costs saving provisions are not strong enough.

Q. How should healthcare think about developing its future leaders?

A. Success in the 21st century will require that people in healthcare be trained to work in teams and focus on collaboration rather than individual achievement. It's also critical that we think less about administration and more about the role of healthcare providers as healers, and what is needed to support the connection between healthcare providers and their patients. You need not be a clinician to do this. Administrators can equally well take the point of view of the patient as the focus of their work.

Q. You run a $3.6 billion organization, with 18,000 employees meeting the healthcare needs of 10 million people in Los Angeles County. What is the leadership challenge that keeps you up at night?

A. The most likely thing to worry me is something about my patients, not something about running the county health department. As an administrator I believe that honesty and hard work and the right values will generally pay off. If I make a mistake, I make a mistake. There is no right or wrong way to be an administrator. But I always worry about whether I missed something with a patient that I should have caught or that I am doing the wrong treatment.