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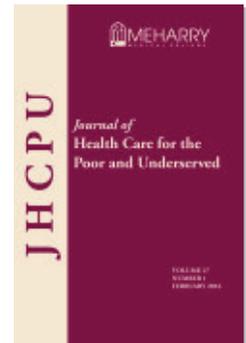
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Fostering a Commitment to Quality: Best Practices in Safety-net Hospitals

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Abstract: In 2007, the Martin Luther King, Jr.-Harbor Hospital (MLK-Harbor), which served a large safety-net population in South Los Angeles, closed due to quality challenges. Shortly thereafter, an agreement was made to establish a new hospital, Martin Luther King, Jr. Community Hospital (MLKCH), to serve the unmet needs of the community. To assist the newly appointed MLKCH Board of Directors in building a *culture of quality*, we conducted a series of interviews with five high-performing hospital systems. In this report,

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we describe our findings. The hospitals we interviewed achieved a culture of quality by: 1) developing guiding principles that foster quality; 2) hiring and retaining personnel who are stewards of quality; 3) promoting efficient resource utilization; 4) developing a well-organized quality improvement infrastructure; and 5) cultivating integrated, patient-centric care. The institutions highlighted in this report provide important lessons for MLKCH and other safety-net institutions.

Key words: Quality improvement, safety-net, community.

Following a series of high-profile quality challenges, the Martin Luther King, Jr.-Harbor (MLK-Harbor) hospital in South Los Angeles was closed in 2007.¹ Prior to its closure, MLK-Harbor was a publically operated hospital serving a large safety-net population in its community. As one of two major trauma centers in the area, the closure of MLK-Harbor had an immediate impact on the community and resulted in some community members seeking care at hospitals outside of their community.²

In 2009, the County of Los Angeles and the University of California worked together to open a new, private, non-profit hospital named the Martin Luther King, Jr. Community Hospital (MLKCH) to meet the medical needs of the community (in particular, need for access to specialty, hospital, and emergency care).³ The new hospital's leadership has put considerable thought into developing a robust infrastructure to ensure what it calls a *culture of quality*⁴, which has been defined "as an environment in which employees not only follow quality guidelines but also consistently see others taking quality-focused actions, hear others talking about quality, and feel quality all around them."^{5[24]}

To assist in this process, a team of Robert Wood Johnson Foundation Clinical Scholars worked with the MLKCH Board of Directors and conducted a series of interviews with high-performing hospital systems to identify best practices for creating and maintaining a culture of quality, including technical quality, interpersonal quality, and efficiency. A key focus of our interviews was on understanding how these institutions used resources efficiently to promote high quality, patient-centric care despite resource limitations⁶. In this report, we provide a summary of our findings, which have been presented to the MLKCH Board of Directors.

Methods

In order to identify best practices for enhancing quality and integration of care, we conducted site visits at five institutions. After reviewing the literature and surveying experts, we selected hospitals with: 1) an established history of processes and procedures that result in measurable, high-quality patient-centered care; 2) leadership and/or external pressures that drove new quality improvement efforts; and 3) a high volume of Medicaid and uninsured patients. The five hospitals selected included four safety-net systems (Denver Health, Grady Health, Harlem Hospital Center, and Mount Sinai Health System). We also visited a private hospital, Virginia Mason Medical Center, considered an exemplar for quality transformation. Important characteristics of the five selected hospitals are summarized in Table 1.

All site visits were conducted in 2011. They consisted of semi-structured interviews

Table 1.
HOSPITAL CHARACTERISTICS (2011)

Hospital	Ownership	Beds	% Medicare/ Medicaid/ Uninsured	Patient Demographics
Denver Health System (Denver, CO)	Public	477	16%, 34%, 32%	50% HS, 29%WH, 14% AA, 3% AS, 4% unknown
Grady Health System (Atlanta, GA)	Public, governed by non-profit Board	953	18%, 24%, 38%	80% AA, 15%WH, 5% HS
Harlem Hospital (New York, NY)	Public	286	23%, 51%, 18%	48% AA, 35%HS, 10% WH, 3% AS, 4% other
Mt. Sinai Hospital (Chicago, IL)	Private, non-profit	319	21%, 52%, 17%	Not available
Virginia Mason Medical Center ^a (Seattle, WA)	Private, non-profit	336	Not available	Not available

HS=Hispanic, WH=White/Caucasian/Non-Hispanic, AA=African-American, AS =Asian
^aNon-safety-net institution

of hospital leadership, including, when possible, the executive team (Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Chief Financial Officer), Quality Directors, and Community Health Directors. Our protocol was collaboratively developed to investigate the innovative philosophies and practices employed by the selected health care systems to achieve high quality care. Interview questions were developed from a literature search of health care quality improvement “best practices” at hospitals and consultation with an advisory team of current and former Chief Executive Officers of health care systems. The interview protocol had 10 domains for Quality of Care: 1) Institutional Values and Cultural Transformation; 2) Organizational Structure and Quality Improvement Infrastructure; 3) Financial Resources; 4) Policies to Promote Quality and Efficiency; 5) Physician Hiring and Credentialing; 6) Nursing Competencies; 7) Information Technology; 8) Monitoring and Data Collection; 9) Employee Motivation, Incentives, and Rewards; 10) Community Engagement. (See Appendix A for a copy of the interview protocol.)

Analysis. All interviews were digitally recorded. The audio files and field notes were analyzed and coded using an inductive approach based on qualitative thematic analysis.⁷ Members of the study team identified themes that represented major perspectives and ideas of the leaders interviewed by comparing and contrasting and looking for repetition in what leaders said.⁸ The initial coding was then further categorized into overall content themes and related sub-themes with recommendations and specific quotes. Tallies of each of the emerging types of answers to the various questions were created. Salient themes and recommendations were selected based on their occurrence frequency and importance across the five sites.

Results

Five organizational components emerged from the interview data as essential to the establishment and maintenance of a high-quality health care system: Institutional Guiding Principles, Personnel Quality Practices, Finances, Quality Monitoring, and Seamless Integrated Care Processes. These fundamental components provide a general quality of care framework for a successful safety-net hospital and health system.

Institutional guiding principles. Establishing an explicit shared vision, mission, and set of institutional values was regarded by all of the institutions as the cornerstone for building a culture dedicated to high-quality, patient-centered care. The vision statements at each institution serve as clear and inspiring guides for choosing current and future actions. The mission statements further function to highlight core values, emphasize the patient populations they will serve, and specify how the hospital will serve them. The institutional values consist of the shared philosophies or principles that guide the organization's internal conduct and relationship with its patients and partners. Identifiable phrases, such as Harlem Hospital's "(Joint Commission) survey-ready everyday" and Virginia Mason's "the patient is first" and "just culture" help to rally staff in a common pursuit. Each of the five institutions emphasize respect, an empowered front-line staff, and data-driven processes to affect change and achieve desirable outcomes.

Lean improvement methodology was employed at all five institutions examined in this study. Lean is a set of management principles that emphasizes rigorous problem solving, standardization of work, aiming for zero defects and eliminating waste.⁹ Waste is defined as anything that does not add value or serve patient needs. Lean delineates a

Box 1.

HOSPITAL VIGNETTE: "GETTING IT RIGHT: PERFECTING THE PATIENT EXPERIENCE"

To achieve its mission to "provide access to the highest quality health care," Denver Health created a comprehensive framework to drive the transformation of care delivery processes. The Chief Executive Officer organized 60 employee and patient focus groups to identify barriers to efficiency, processes that were harming patients and to clarify patient and employee needs. Based on these focus groups and an external advisory board with innovation experts, Denver Health launched a comprehensive transformation initiative called "Getting It Right: Perfecting the Patient Experience." This initiative was comprised of five linked components: the right environment to provide safe, efficient, and high-quality care; the right people selected based on personal characteristics reflective of high performers; the right structured communication between providers especially when patients require an escalation of care; the right financial rewards for teams that successfully address quality issues and the right process. Denver Health achieved the right process by disseminating Lean across the system, training over 250 employees as "Lean black-belts" who led over 400 rapid improvement events to transform care processes over eight years.

set of specific tools used to plan and achieve the main goal of maximizing value at every step of the patient experience. At each institution, Lean principles have been adapted to fit the specific needs of that system and are implemented to varying degrees. Three of the five systems have several years of Lean experience. The other two have recently begun to train their staff and launch interventions.

Personnel quality practices. All five institutions emphasized that the personnel, consisting of the executive leadership, physicians, nurses, and other patient-facing staff are the stewards of quality health care.

Executive leadership. There were several commonalities that were observed among the executive leadership of the institutions: 1) All of the leaders are intensively trained in a common quality management and culture transformation method. 2) Each of the executive leadership teams expressed a “top-down” commitment to improving patient-centered, quality care by personally engaging frontline providers, ensuring “visibility and touchability.” This engagement included weekly executive walk rounds and patient or staff focus groups conducted by the Chief Executive Officer. 3) Executive leaders are also held accountable for reaching patient safety and quality of care goals. Four of the five institutions offer modest individual or team-based financial incentives for successful attainment of hospital or department-level quality goals. The remaining hospital offers non-financial incentives such as special recognition at hospital-wide and/or public events.

Physicians. Two of the five institutions formally train the majority of their physicians in an institutional quality improvement and assurance methodology and two are working toward this goal. Physicians are expected to embrace quality improvement practices. They are not promoted unless they demonstrate a clear commitment to the institutional quality improvement methodology. Virginia Mason enforces a “physician compact” that explicitly outlines the hospital’s expectation that all physicians are com-

Box 2.

HOSPITAL VIGNETTE: EXECUTIVE LEADERSHIP CONTRACTS WITH PERFORMANCE IMPROVEMENT GOALS

To increase accountability for high-quality care throughout all levels of the organization, Grady Memorial Hospital bases part of their executive leaders’ compensation on meeting specific performance improvement goals. Contracts for executive leaders and department chairs include specific quality measures and patient satisfaction goals relevant to the entire hospital and the departments under their supervision. For example, the Chief Nursing Officer’s compensation is partially based on decreasing rates of hospital-acquired pressure ulcers, reducing inpatient falls, and improving patient satisfaction scores for nurses. The executive leaders have quarterly meetings with the Chief Executive Officer to review their progress toward meeting these goals. If they do not meet their quality goals, they lose part of their compensation and are required to develop performance improvement plans.

mitted to providing patient-centered care that is high quality, safe, and respectful. All five of the institutions require department/unit physician leaders to take ownership of performance improvement and quality initiatives. Department Chairs and unit physician leaders report the performance of their department or unit on quality metrics directly to quality committees headed by either the Chief Quality Officer or the Chief Medical Officer.

Nursing. Nursing staff play a critical role in quality improvement initiatives at each of the five institutions. Nurses are engaged in quality improvement processes and empowered to create and implement solutions to patient safety or quality challenges. Nursing representation is included in all unit, departmental, and hospital-wide quality efforts. Nursing self-governance is established through continuous core competency education and professional practices.

Finances. Value-based health care is based on the numerator of quality divided by the denominator of cost. An institution must closely monitor and evaluate its financial model in order to remain financially viable and deliver the most efficient health care possible. All five institutions offer a full range of inpatient and specialty health services. The safety-net institutions all significantly invest in health service lines that receive higher Medicaid reimbursement such as obstetrics and neonatal intensive care.

In addressing the cost aspect of delivering value-based care, all of the institutions emphasize the return on investment they obtain from improving efficiency. Each institution made significant financial investments to implement Lean. Denver Health saved \$160 million over six years as a result of using Lean, while Virginia Mason saved \$50 million in four years.

All of the institutions also emphasize the importance of appropriately collecting patient care revenue. They devote considerable personnel and information technology resources to aggressively identify and enroll all eligible patients into Medicaid or other insurance plans to ensure appropriate billing for clinical services rendered. All of the safety-net institutions offer comprehensive financial counseling and assistance with Medicaid enrollment to uninsured patients during and after admission.

Grant funding is used by each of the hospitals to maximize efficient care and fund innovative programs. Several of them have fully functioning institutes that support research, quality improvement, and/or community aspects of care.

Quality monitoring. Leadership from all five systems emphasized that effective real-time monitoring of care processes and outcomes is essential to build a system-wide quality infrastructure. The fundamental components were the implementation of an electronic health record and an established quality improvement infrastructure.

Electronic health record. Investment in a high-quality electronic health record system that has “front end” and “back end” capability to ensure standardized clinical care, patient safety, data warehousing, and effortless monitoring of quality and efficiency was deemed important by all institutions in this study. Front-end capability allows for electronic order entry and built-in order sets to drive clinicians down standardized clinical care pathways. Back-end capability allows for easy data extraction and enables reports to be built around a broad set of quality outcomes. All sites emphasized that the electronic records must be easily modifiable to fit the changing needs of the orga-

Box 3.**HOSPITAL VIGNETTE: COLLECTION OF PATIENT CARE REVENUE WITH AGGRESSIVE MEDICAID ENROLLMENT**

Denver Health focuses on ensuring diverse revenue streams, which include Medicaid, county funding, grants, private insurance through the Denver Health plan, and Disproportionate Share Hospital funds. Due to its significant Medicaid population, Denver Health devotes considerable resources to identify and enroll all eligible patients into Medicaid. The health system relies on multiple electronic systems to check the eligibility of hospitalized patients, and employs a 65-person Medicaid enrollment team. All uninsured patients receive financial counseling during and after hospitalization to assist with Medicaid enrollment because the hospital can receive retroactive payments. Case-workers visit eligible patients every day that they are hospitalized and follow-up after discharge to assist with Medicaid enrollment.

nization. Hospital-based information technology employees allow rapid implementation of changes to the electronic medical record and result in lower associated costs than relying on an outside vendor. Each site expressed the importance of having a shared record with outpatient providers, either through a shared electronic health record (as was the case at some of the hospitals) or through an effective electronic health information exchange (which was present or in development at all hospitals).

Quality improvement infrastructure. Four components were utilized by all five institutions implemented to create and evaluate quality improvement efforts: 1) a dedicated quality improvement department that oversees the monitoring and reporting of quality improvement goals; 2) a Chief Quality Officer who reports directly to the hospital executive leadership and leads all quality improvement departments; 3) a dedicated quality improvement infrastructure, ranging in size from six to 20 full-time employees, with diverse clinical, research, and administrative backgrounds; 4) implementation of rigorous data collection and monitoring systems to evaluate performance on all national quality measures and internal hospital initiatives.

Exceeding the Joint Commission and Centers for Medicare and Medicaid Core quality and patient safety measures is a strategic priority for all five institutions. Two of the five hospitals use additional metrics to exceed standard expectations such as Leap Frog Quality, National Quality Forum, and the National Database of Nursing Quality Indicators.¹⁰ (See above.) Progress of quality initiatives is reported on a hospital-wide, departmental, and individual provider level. Reports with performance on the hospital-wide and departmental core quality measures are distributed on a continuous or monthly basis depending on the measures. All leaders are held accountable for continuously examining the quality of care processes and rapidly correcting areas in which errors or “near misses” occur. Confidential reporting systems are used to continuously monitor for errors, patient safety concerns, and “near-misses.” Employees who report

errors experience few or no consequences, which reinforces a culture that rewards full transparency. Rapid problem resolution is expected of all providers, department/unit leaders, and executive leaders.

Dashboards are universally utilized to visually report quality performance on a hospital and departmental/unit level throughout the hospital.

Integrated Care Processes. While all of the hospitals are moving toward patient-centered care, only two have transformed their care delivery models. The two highest performing hospitals, Denver Health and Virginia Mason, built new models that revolutionized how they deliver care. They redesigned all of their care processes to be integrated both vertically and horizontally and oriented around the patient. From the

Box 4.

HOSPITAL VIGNETTE: QUALITY IMPROVEMENT OVERSIGHT JOINT COMMISSION AUDITS BY INTERNATIONAL MEDICAL GRADUATES

Harlem Hospital has implemented an innovative Quality Improvement department and strategy to ensure compliance with Joint Commission inspections. Nine International Medical Graduates staff the Quality Improvement department and conduct daily audits of sample inpatient charts using the Joint Commission criteria. International medical graduates are effective in this role due to their extensive clinical background, which allows them to understand the processes and procedures involved in each patient case. Management errors or patient safety issues identified during the chart reviews are immediately reported to the involved staff and the unit/department chair or manager. All chart review alerts are reviewed and acted upon quickly to prevent further lapses in patient safety or quality of care.

Box 5.

HOSPITAL VIGNETTE: MOUNT SINAI QUALITY IMPROVEMENT DASHBOARD

Mount Sinai identifies its “Go Green” Dashboard as the most important tool for improving quality because it serves as a visible rallying point for individuals, services, and the hospital as a whole in the drive towards excellence. Each department or service has its own specific set of measures. For example, the Department of Medicine Dashboard is broken up into 5 categories with 77 measures for: 1) Excellence in care and operations 2) Keeping our patients safe 3) Core measures compliance 4) Improve patient experience, and 5) Financial viability. Each measure is listed with its corresponding goal and is colored in green, for goal achieved yellow for goal not met but within 20%, or red for performance below 20% of goal. Goals are set so that performance is within the top decile nationwide. The dashboard is updated weekly and is widely displayed and distributed, including to the Board on a monthly basis.

Box 6.**HOSPITAL VIGNETTE: VIRGINIA MASON INTEGRATED CARE PROCESSES**

Virginia Mason's patient-centered redesign of its outpatient oncology center epitomizes how the organization developed integrated care processes that prioritize the patient and maximize value at every step. Under the old model, frail cancer patients were required to walk hundreds of feet between different levels of the medical center housing radiology, laboratory, the infusion center, and the clinic to receive outpatient chemotherapy. An interdisciplinary team used Lean methods to design a new Cancer Center where the entire experience of care revolves around the patient. Doctors, social workers, and nurses all come to the patient. The patient remains in a private room where the nurse draws their blood and delivers the medications prepared by a satellite pharmacy. The new system reduced the amount of time spent by a patient by nearly 50% from 11 hours and 25 minutes to 7 hours and 45 minutes and the distance walked from 745 feet to 181 feet. The level of patient satisfaction increased from approximately 70 percent to over 90 percent. Virginia Mason consistently applies this patient-centered approach to streamline care processes and optimize the patient experience.

moment a patient enters the emergency room, every step of their care is standardized along an integrated pathway, so that it delivers value to the patient and eliminates waste while ensuring communication among different care providers. For example, a patient with symptoms of a heart attack receives integrated care focused on confirming the diagnosis and getting the patient to the catheterization lab as quickly as possible because every minute saved improves outcomes. Patients receive the highest level of care, delivered in seamless, integrated-care processes that provide the right care at the right time and achieve the best outcomes.

Discussion

We found that the high-performing institutions we interviewed had developed effective strategies for promoting high quality care, patient-centric care with a modest investment of resources.¹¹ Specifically, these systems were able to: 1) develop guiding principles that foster a culture of quality; 2) hire and train personnel who are stewards of quality; 3) promote efficient resource utilization; 4) develop a well-organized quality improvement infrastructure, including high-performing EHR systems; and 5) cultivate integrated, patient-centric care.

Based on our interviews, we believe that safety-net hospitals such as MLKCH can provide high quality, patient-centric care with limited resources. However, doing so effectively requires a thoughtful approach and upfront investment. For example, the systems we interviewed invested heavily in staff development, creating loyalty and providing their staff with the tools to deliver high quality, patient-centric care. They also were strategic in developing a quality improvement infrastructure that fostered

high-value care. These findings may provide important lessons for safety net hospitals such as MLKCH working to replicate the successes of these model systems.

Our findings also have policy implications. As an increasing number of safety-net patients receive health coverage as a result of the Affordable Care Act,¹² safety-net patients will have greater choice regarding where they receive care. As has happened in the past following coverage expansion, newly insured patients may leave safety-net providers that fail to deliver high quality, patient-centric care.¹³ This will result in lost revenue from these newly insured patients. At the same time, special payments to providers who serve a safety-net population, such as disproportionate share hospital (DSH) payments, are likely to be reduced (since these payments serve in large part to support care for the uninsured).¹⁴ Value-based incentives promoted by the Affordable Care Act will reward institutions that provide high-value care.¹⁵ Safety-net providers, who have less experience with value-based reimbursement, may lose these incentive dollars or even face financial penalties if they cannot quickly adapt to the new incentive structures.

The loss of insurance revenue from newly insured patients, coupled with the reduction of special safety-net payment mechanisms and the potential loss of value-based incentive dollars, could present a financial strain to already financially strapped safety-net institutions.¹⁶ This financial strain could force some institutions to reduce investment in the people, processes, and systems that are necessary for providing high-value care. For example, these hospitals may be forced to scale back staff development efforts or EHR upgrades. This could create a negative feedback cycle within safety-net hospitals that may be currently performing poorly. Ultimately, some low-performing safety-net institutions may be forced to close,¹⁷ which could adversely affect patients who rely on them for care.¹⁸

For this reason, policymakers should provide guidance and support (including, in some cases, financial resources), to help safety-net institutions develop the systems and processes to deliver high-value care and become a “provider of choice”¹⁹ in their communities. Our interviews highlight some of the key systems and processes that will enable these institutions to succeed; however, developing these systems and processes will require effort and time. To assist essential safety-net institutions in making these changes, policy-makers might support or facilitate direct guidance to these institutions from high-performing hospitals such as the ones we studied.²⁰ Additionally, policymakers might create short-term exemptions for certain safety-net institutions from some of the financial penalties outlined by the Affordable Care Act for historically low-performing systems.^{21,22} Eventually, however, such incentive systems may have a role in promoting high-value care in the safety-net.²³

Safety-net institutions that serve low income populations represent a critical piece of our health care delivery system and will continue to do so even after the Affordable Care Act is fully implemented.²⁴ The closure of MLK-Harbor underscores the dire consequences when these institutions fail. Our interviews demonstrate that through thoughtful planning and persistence, safety-net institutions can deliver high quality, patient-centric care in a cost efficient manner. The successful institutions we interviewed provide important lessons for on how to accomplish this goal.

Conclusion. Our interviews with personnel at high-performing hospital systems, most of which serve a safety-net population, highlight key systems and processes that promote and enable high-value care. These model systems provide important lessons for other established safety-net hospitals and new hospitals such as MLKCH striving to deliver high-value care and to become a “provider of choice” in their communities. Implementing effective systems and processes like those exhibited by the hospitals we interviewed will be challenging. The stakes are high as a result of changes from the Affordable Care Act. Safety-net health systems may face competition for newly insured patients, experience cutbacks in subsidy payments like DSH funds, and face potential financial penalties if they have low performance on value-based metrics. Policymakers should consider ways to support safety-net institutions, which are vital to their communities, in making the necessary reforms to become high-value health systems.

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Appendix A. Interview Guide

Introduction: Thank you for taking time out of your busy schedule for this interview. The goal of our site visit to your hospital is to understand your best practices and lessons learned so we can apply them to MLK. This interview will help inform a strategic plan we are developing with the Board of Directors to deliver high quality, integrated care at the new MLK Hospital. The old public MLK Hospital closed in 2007 after losing its Joint Commission accreditation and failing a CMS inspection due to major deficiencies in quality and safety. The new MLK Hospital will open as a 120-bed non-profit hospital in January 2014. We would like your advice on how to promote quality at the new MLK hospital.

We understand that not everything, even in a high quality health system such as yours, works perfectly all the time. To assist the Board of MLK Hospital in opening a high quality hospital, we would like to learn about both what has worked well and what hasn't worked well at your hospital. The information you provide will be completely confidential. We will not identify your hospital or directly quote anyone we interview in our final report to the Board. If the Board is particularly interested in an innovative program from your hospital, we will contact you to ask your permission before identifying you.

Opening Questions: What role have you played in the development of your hospital? What is your expertise?

Quality of Care:

1. **Institutional Values and Cultural Transformation:** How did your organization embed quality as one of its core values? How did you create a culture of quality at your hospital?
2. **Nursing Competencies:** How do you select and hire nurses? How do you train them? How do you determine and verify their core competencies? Do you have standardized guidelines? Do you have regular bedside assessments of these competencies?
3. **Physician Hiring and Licensing:** How do you select and hire physicians? How do you manage credentialing and privileging? Do you have a closed staff or community doctors with admitting privileges?
4. **Resources:** What are the most important resources? How much money do you invest in quality? What is your Quality Officer's salary? Do you have committees or other organizations that support quality initiatives in your hospital?
5. **Technology:** Do you have an electronic medical record? How does your IT support your staff in delivering high quality care?
6. **Policies:** How do you promote safety, transparency, and openness? Where is your quality and safety data available (only in your annual report or on your website)?
7. **Organizational Structure:** How many FTEs do you have in your QI Department? How much authority and hiring authority does your Quality Officer have?
8. **Monitoring:** What outcomes do you measure? How did you choose which measures to track? What type of data is collected? What outcomes should MLK measure to ensure that it is delivering high quality care? Who is the data reported to and how frequently? Do you use your quality data in feedback to physicians, nurses, and other health care providers?
9. **Motivation and Rewards:** How do you motivate your staff to deliver high quality care? How do you reward excellence? Do you use pay for performance?
10. **Community Engagement:** What connections do you have to the community (i.e. community advisory board)? How has the community influenced your hospital and the quality of the care that you deliver? Are patients or community members involved in any quality initiatives or committees at your hospital? If so, what has worked well to engage these individuals? How can MLK demonstrate to the South LA community that it is delivering high quality care?
11. If you were opening a new hospital, what would you worry about and what would you warn the leaders about that might prevent the hospital from delivering high quality care?
12. How do you prioritize your most important goals for quality? What should the Board and MLK leaders prioritize when they first open the new hospital?
13. Is there anything else that we should have asked you? What are we missing?

Integration of Care:

Preamble: The new MLK hospital will not have its own primary care clinics. It will need to coordinate care with FQHCs, a large county ambulatory care clinic with primary care providers and specialists, and private primary care offices in the South Los Angeles community. We would like advice on how MLK can lead and promote integrated care for its patients without formal authority over its partners.

1. **FQHCs:** Do you have any formal contracts with FQHCs in your community? Do you have any clinical, legal, and/or financial relationships?
2. **County or city:** Do you have any formal contracts with the county or city? Do you coordinate joint credentialing or shared privileges for your medical staff? Do you have county or city employees working at your hospital? If so, how do you interact with unions?
3. **Financing:** How is your hospital funded (Medicaid FFS or Medicaid Managed Care payments, federal supplemental payments such as Medicaid UPL and Medicaid DSH, payer partnerships, state funds, county funds, bundled payments, per case or per diem payments, etc.?) How are your physicians paid (salaried, fee-for-service, productivity or pay for performance bonuses, etc.)?
4. **Organization:** How do you determine which services will be offered by your hospital and which will be offered by FQHCs, county clinics, or other community providers?
5. **Technology:** How do you share data (shared EMR or health information exchange)? Do you use telemedicine? Do you use technology in other innovative ways to promote integrated care?
6. **Cohesiveness:** How do you promote communication between different providers? Do you hold regular meetings? If so, how do you get all the stakeholders at the table for a discussion?
7. **Monitoring:** How do you measure how well your system is integrating care? Do you collect data to measure outpatient quality of care? Do you have patient registries for specific diseases? What data should MLK collect and what data should it share with FQHCs and community providers?
8. If you were opening a new hospital, what would you worry about and what would you warn the leaders about that might prevent the hospital from integrating care with community providers?
9. How do you prioritize your most important goals for care integration? What should the Board and MLK leaders prioritize when they open the new hospital?
10. How should MLK convince community providers to refer patients to the hospital and promote satisfaction among the community doctors who control referrals?
11. How does your hospital care for your highest utilizers (chronic care management, care transitions programs, patient registries)? How do you pay for these programs (grants, bundled payments)?
12. Is there anything else that we should have asked you? What are we missing?

Medical Education and Quality (Optional at Teaching Hospitals if Time Permits):

1. *How do you engage your residents/housestaff in quality and patient safety initiatives?*

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