John Bluford talks with TMC surgical technician Dionne Murphy at the weekly Health Harvest Produce Market. During warm months, the market is open for business every Wednesday outside the hospital.

INTERVIEW WITH JOHN W. BLUFORD III
CEO OF TRUMAN MEDICAL CENTERS, KANSAS CITY, MO.
CHAIRMAN OF AMERICAN HOSPITAL ASSOCIATION'S BOARD OF TRUSTEES

FOR URBAN HEALTH LEADER, CARE GOES BEYOND WALLS

As 2011 chairman of the American Hospital Association's Board of Trustees, John W. Bluford III called on hospital leaders to tackle their community's toughest ills. He asked that they learn from each other and recognize that hospital leaders will be judged not only by the care administered within the walls of the hospitals but also by the health status of the community they serve. Because of Bluford's long-standing commitment to urban health care, and his focus on health care in the context of community, *Health Progress* interviewed him for this issue.

HP: In January, you became chairman of the American Hospital Association. What have your goals been for your term?

BLUFORD: It's been good to reflect a little bit on that leading up to this interview, and you know, I see my role, as well as my goal, as educating the field and advocating to policymakers about the goals, the directions, the initiatives and the achievements of the field.

HP: The goals, the initiatives and the achievements?

BLUFORD: Of the field, yes. For example, the things that we're doing in HPOE — that's Hospitals in Pursuit of Excellence — are just phenomenal relative to improving quality and efficiencies, such as reducing acquired hospital infections, and talking about best practices and case studies and the top-of-the-box activities going on in the hospitals

today. The other sub-issues, as I see them, are reducing avoidable variations in the field, number one. And then we had this excellent call to action on creating a culture of health among hospital employees. I think that's just a great initiative. And the last thing that's kind of top-of-mind is a continuation of reducing disparities to zero, reducing racial and ethnic disparities to zero.

HP: Those are pretty lofty goals.

BLUFORD: Yes, all of them are. But we're in a lofty field.

HP: Talk a bit about racial and ethnic disparities. You must see a lot of that in Kansas City. Indirectly, that's what we're focusing on in this issue of *HP*, which has the theme of urban health care.

BLUFORD: Yes, there is certainly a lot of disparity in the urban markets, as well as disparity in the rural markets associated with access and so forth. But nonetheless, my orientation is in the urban environment, and reducing disparities to zero has been a major initiative of the AHA for the last four to five [years] now. And the more recent call to action by CHA and AAMC [Association of American Medical Colleges] and ACHE [American College of Health Care Executives] and NAPH [National Association of Public Hospitals] — we've got a significant call to action that all of our institutions begin documenting disparities [related to] racial and ethnic minorities so that we know what our numbers are. And then the other initiative we're trying to stress is that governance of our respective institutions should better reflect the markets that we serve. More diversity on our governance boards is also critical.

HP: Have you had any success in these areas?

BLUFORD: Well we definitely have had success. Several institutions across the country are leading the field. One of them is right here in our own community, Kansas City, at Children's Mercy Hospital. There are great case studies on the collection process, on how to document [disparities]. So yes, that is happening, no question about it. And then we've had about a two- to three-year experience in having one-day symposiums and seminars in various cities, inviting minorities across the country — an effort to attract prospective board members from ethnic and minority groups to come and learn and understand what good governance of hospitals represents, and what it means to be a good trustee in the field. And then we've created a database of all of participants so that hospitals in their respective communities can go to the profile in the database and hopefully solicit and attract some of those participants for their boards.

We've had a great deal of success in growing an audience for the symposiums. We haven't had as much success yet in actually placing those people on board — some, but not as much as we'd like to have.

HP: Talk a little bit about urban health in general. Apart from disparities, what do you see as the major problems?

BLUFORD: I've been in safety-net environments in the urban cores of Chicago, Minneapolis and now Kansas City, Mo., for the last 35 years, and what is clearly missing, in my mind, based on that experience, is the merging of [problems related to] social disparities with health disparities. And I don't think we're going to make the kind of successful engagement that we all want to make, unless we merge the two. You can't do one without the other. The health care status of many of the populations we serve in the urban core is contingent upon their housing circumstances, upon the employment rates in those respective communities, upon educational attainment of the people in those communities, and certainly race plays a role as well. We've got to deal with all of those social ills before we can successfully deal with the health disparity element. And then the last thing that I've been pretty adamant and vocal about is defining violence as a public health concern. There is some adherence with that — it's certainly not a policy of the AHA, but there is a sympathetic ear to better understanding how violence plays into the health care system, and what the health care system can and should do about it.

I think once the nation and the urban cities define violence as a public health concern and as an epidemic, then we'll make more gains in trying to get our hands around it.

HP: I know some Catholic hospitals have been engaged, are engaged, in efforts aimed at better housing, improving neighborhoods, and that sort of thing. There seems to be some question whether the IRS is going to allow those efforts to be defined as community benefits for tax-exemption purposes.

BLUFORD: I would certainly hope the IRS does so. But if they don't, it shouldn't discourage us from

doing the right thing, because I think we need to get involved in those things. The phrase I like to coin is "thinking outside the bed." That's because the success of our hospitals should be determined by the health care status of the community that we serve. And if we don't get involved in these kinds of social-oriented activities, we won't be successful.

HP: What have you accomplished at Truman?

BLUFORD: I think we've done some extremely creative things. One of the things that I'm most proud of is the establishment of a corporate academy on our premises, and we started that in 2001. Since then, we've had over 8,000 registrations in courses, everything from GED preparation classes to M.B.A. degree courses. We've had many of our employees and their families graduate from high school, from college and get masters' degrees. And I think that's a major statement in educating the community as a whole, and as a benefit to a community, that's a big step.

The other things more recently have been some significant chronic disease management programs, one of which we call Passport to Wellness. It deals with diabetes, hypertension, sickle-cell anemia and reducing emergency room visits. Over the last 18 months, we had some tremendous successes relative to reducing readmissions, reducing ER visits, reducing the length of stay when those patients are admitted, and in general, improving the quality of life of many of our patients.

HP: Do you expect health care reform — the Affordable Care Act — to be a help in addressing any of these problems?

BLUFORD: Well yes, because I think health reform really draws attention to the issues, and it also incentivizes population-based management and continuum of care. All of that is incentivized by the new payment structures that are being put in place, like bundled payments and accountable care organizations. Primary care focus would be another outcome of health care reform, and I think that's good. Enhanced technology, that's a part of health reform, and I think that's good. And the last thing that shouldn't be underestimated is that it has created the conversation around health. But can I go back to Truman Medical Center for a second? Because there were two things I wanted to highlight that we have been very successful in.

One is that we've got a great partnership with U.S. Bank whereby they've got a branch office in our building, in our hospital. That's been a tremendous asset in terms of increasing financial literacy among our population. I can go on and on about that, but it's been a real asset in terms of many of our patients and employees not having to use cash stores [non-banking companies that offer check cashing, cash advances, loans and other financial services] to do their business transactions. The number of loans that have been made to our employees and our patients has just been very rewarding and successful.

Then the last thing, which is kind of novel, but I can see it having systemic impact and an effect on our patient population, and that's the concept of a hospital and an art gallery. We're literally gallery-izing all of our corridors with museum-quality art. The significance of that is the *esprit de corps* that it creates, and the sense of pride it creates for both our employee groups and our patient groups. It

JOHN W. BLUFORD III

John W. Bluford III has been chief executive officer and executive director of Truman Medical Centers (TMC), a non-profit system based in Kansas City, Mo., since 1999 — a part of his long experience with and deep commitment to health care in the nation's urban core. He assumed chairmanship of the American Hospital Association, the highest elected position of that organization, in January, 2011.

Bluford holds a master's degree in business administration from Northwestern University in Chicago and attended Harvard University's executive program in health system management. He is a former chairman of the National Association of Public Hospitals, of the Missouri Hospital Association and of the Greater Kansas City Chamber of Commerce.

Bluford has served five years on the AHA board and three years on its executive committee. *Modern Healthcare* has named him one of the most powerful people in U.S. health care.

Truman Medical Centers is a non-profit system composed of two acute care hospitals, a behavioral health facility and the Jackson County Health Department, as well as a number of primary care practices in Jackson County, Mo.

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shows that we care, and it really makes a difference. So environment does matter — that's the punch line to that.

HP: I have a question about that bank. Some cynic could look at your statement and say, "Well, gee, they're just getting people loans so that they can pay their hospital bills." Is that what that's about?

BLUFORD: No, it's about having, one, the intelligence to manage money, and then, two, access to the necessary services that many people have, that people in the urban core don't. It's hard to find a bank in the urban core, and we're providing that. And people typically use those cash stores as their bank, and that is not a moneymaking proposition. I'll tell you what the bank has done for us. First of all, we've gone to direct deposit for all of our payroll, and in order to do that, you got to have a banking account, a checking account. Many of our employees did not have checking accounts prior to this policy. Now, out of 4,000 employees, I think we have about three dozen that don't have checking accounts. So we're able to direct deposit all of our payroll. And that enables or allows many of our employees not to have to use cash stores. If you do a little homework on that, you'd find that some of our employees were paying as much as $1,500 to $2,000 a year just to cash their checks and pay their bills. That's criminal. The bank has allowed those employees to avoid that cost. And then the other thing: Our bank has made over a half-million dollars in loans, not including mortgage loans, to our employees, for small business loans, car loans and the like. I think that's just a great asset.

HP: You've spoken about the benefits of health reform. In terms of urban health care, do you see any tweaking that needs to be done?

BLUFORD: No ... well, the thing we're a little bit concerned about is that urban core and safety-net environments may be penalized by some of the readmission policies that might be put in place. Because oftentimes we have adverse selection in terms of co-morbidities and more serious illnesses, we don't want some of the new payment methodologies to penalize us. We're concerned about not being paid for unavoidable readmissions.

HP: Which will impact people who have ongoing, chronic poor health issues.

BLUFORD: Exactly. We want to make sure that adverse patient populations are not avoided, because of potential penalties they might create with the payment system.

HP: Right. One of our last questions relates to your knowledge of Catholic health care. Are there any ways that Catholic health care might strengthen its contribution, particularly in terms of urban health?

BLUFORD: Well I would just hope that Catholic Health Association and its membership continue to be a strong voice on behalf of vulnerable patient populations. People like Sister Carol [Sr. Carol Keehan, DC] and Sister Roch [Sr. Mary Roch Rocklage, RSM] whom I've known for a long time have been very strong voices for the underserved. So your major systems like CHI and Catholic Health West and SSM, all of them have both an urban and strong rural presence. It's much needed and well respected.

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