Viewpoint

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Talk about baptism of fire. Within a month of Barclay Berdan becoming CEO of Texas Health Resources in September 2014, the Arlington-based health system was rocked by the Ebola situation, taking center stage in what became minute-to-minute on-the-job-training in how a world-class health system should deal with one of the world's most virulent pathogens. Almost exactly a year later, having navigated the ship through those treacherous waters, Berdan, 62, is as steady as ever at the helm of Texas Health, the largest faith-based, nonprofit health system in North Texas, with 25 hospitals, 16 behavioral health centers, 21 outpatient centers and Texas Health Physicians Group with more than 200 access points. He was well prepared: prior to becoming CEO, Berdan served as senior EVP and COO of Texas Health for two years; he also has more than 30 years' experience as a healthcare leader, joining Texas Health in 1986 as VP and administrator of Harris Methodist Southwest, which he oversaw from the ground up. He served as COO of Texas Health Harris Methodist Fort Worth Hospital from 1999 to 2007, also serving as EVP for Texas Health from 2005 to 2007 and senior EVP for system alignment and performance from 2007 to 2012. Berdan earned an undergraduate degree in biology from Texas Christian University and an MBA from the University of Chicago.

As the first U.S. health system to diagnose and care for an Ebola patient, Texas Health was the center of international attention in 2014. What are the lessons learned both for Texas Health and U.S. health?

BARCLAY BERDAN, CEO, TEXAS HEALTH RESOURCES

[Editor's note: As this article was going to print, Texas Health released "The Expert Panel Report to Texas Health Resources Leadership on the 2014 Ebola Events," available on www.TexasHealth.org.] We have shared lessons learned widely over the course of the past 12 months. It really involves thinking about how you might anticipate treating an undiagnosed patient who walks into the ED. That is different than treating a patient you have diagnosed ahead of time. In this case the patient came to our ED because our hospital is the nearest to the neighborhood where he was staying. One of the lessons we learned is that we've all become dependent on EMRs in the past 10 years, and that electronic records are not a complete replacement for face-to-face dialogue, which is often the best way for communicating and getting timely and accurate information.

Especially with ED processes, we need rapid, effective screening in addition to rapid treatments. We discovered, interestingly enough, that ED processes were designed to maximize patient satisfaction. So, we had to redesign those intake processes based on new questions, including, 'As people walk through the door how do you rapidly assess folks?' We developed a whole new set of questions and processes that separate clinical triage from the questions you ask in a more private, less public environment. The registration person, for example, asks patients at the front door, 'Have you been to West Africa recently?' We now require additional training, simulation and reinforcement of new skill sets and processes, repeating them over time.

One of the big lessons learned was that collaboration and coordination with public entities—city, county, state—is critical. This was a novel situation. In a place like Dallas-Fort Worth each county has its own health department and we found that formal communication links among all jurisdictions were not as well developed as they should be. We learned a lot about how to relate to the Centers for Disease Control. The overall lesson: Work on these relationships in advance. If you're like Dallas-Fort Worth, there's no single government in the metro area, and political lines are not recognized by an infectious bug.

What is Texas Health doing to recognize and leverage potential disruptors of the healthcare industry?

The word disruptor likely carries a negative connotation, but I think it's largely about innovation and an opportunity to change processes and be more receptive to customer requirements. The big discussion in healthcare moving from volume to value is about disruption, which is a big opportunity to change things for the better.

Texas is a hotbed for physician-owned hospitals and surgicenters and we don't see that as a barrier or bad thing. We started years ago creating partnerships and have several acute-care and ambulatory partnerships. We've also joint-ventured a number of ambulatory surgicenters with Surgical Care Affiliates, and now have 14 such centers from just a handful a few years ago.

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Another interesting relationship is with CVS Caremark, which has 31 retail-clinic sites in the Dallas-Fort Worth area. Our employed physicians group supervises the nurse practitioners and shares the same EMR. So we can move that EMR information among our hospitals, physician offices and CVS Caremark MinuteClinics securely and seamlessly. Many of the people who utilize MinuteClinics lack a primary care physician. A recent Gallup-Healthways survey found that Texas leads the nation with one-in-five people uninsured. Still, we've made progress, dropping from 27 percent of the population to 20 percent. Some people might see CVS as a competitor. We see it as an opportunity to connect people.

> *"We've all become dependent on EMRs in the past 10 years and electronic records cannot completely replace face-to-face dialogue."*

Despite the challenges, we're seeing tremendous growth and lots of opportunity in healthcare in our North Texas marketplace. Lots of people are moving here. Many primary care physicians do not take Medicare patients, and consequently some seniors have difficulty finding doctors. So, Texas Health Physicians Group created and supervises nurse-practitioner-staffed clinics designed to be access points for these seniors. We're trying to fill a gap.

How is Texas Health dealing with the emergence of consumerism in healthcare?

I don't think healthcare generally has been very consumer centric. It's been provider-centric for a variety of reasons. Today, however, consumers are anxious to become more active in healthcare as they begin to grasp what services offer value. We can learn a lot from companies selling to consumers, including how to segment patient populations based on their different requirements. Texas Health listens to patients through face-to-face techniques like focus groups as well as through formal surveys. It becomes obvious that a single millennial male has a different set of needs than a 55-year-old married guy with emerging chronic conditions.

Ease of use and cost are topmost consumer themes. They want providers who are affordable, innovative and reliable.

What impact has the organization's culture had on Texas Health's clinical and operational performance?

We believe culture is the key to everything. You can adopt a great strategy, but it will fail if your organizational culture is not ready to encourage that strategy. Culture trumps strategy every day. We've found that one of the key elements of culture is mission, which has great meaning to Texas Health people. We've also developed "The THR Promise: Individuals Caring for Individuals,Together," which resonates with everyone from our staff up to the executive team. We all have the same set of values of respect, integrity, compassion and excellence. We've deployed a set of tools that enables us on a monthly basis to disseminate a set of promise—behaviors that are discussed at every level in the company. This is not just sloganeering. Texas Health is in the top decile of Press Ganey's employee engagement scores. Also, Texas Health is ranked in Fortune Magazine's 2015 100 Best Companies to Work For and 2015 100 Best Workplaces for Millennials. Fortune also ranked Texas Health the nation's number one best place to work in healthcare.

What are the toughest challenges a health system faces in navigating the shift from volume to value?

Timing. All the pieces of the system—health systems, physicians, post-acute care providers—have to coordinate and collaborate under a value-based model. We have to work hand-in-hand with those who pay for care. In North Texas, 70 percent of employers, including Texas Health, are self-insured and use a payer for day-to-day administration. Health systems are very capital-intensive and the shift to value has to be timed and coordinated by all of the players who are delivering, regulating and paying for care. Otherwise the shift could challenge the financial sustainability of one or more of the interlocking parts of the system.

How does a large health system with a mix of employed and independent physicians engage physicians in meaningful leadership roles?

Five years ago Texas Health's senior leadership asked, 'Do we have the right roadmap up Transformation Mountain?' That's when we decided to become a great health company, expanding from our history as a great acute care hospital company—and that requires engaged physician leadership. Our Chief Clinical Officer and COO are both physicians. We use a triad leadership model in our hospitals consisting of the CMO, CNO and president. We've also invested heavily in leadership training for physicians. Some are natural leaders but don't quite know how to apply those gifts in the workplace. We recently kicked off a year-long leadership class and I was amazed at the number of folks who are giving their weekends to attend.

~ *Chuck Appleby*
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