

September 6, 2012

Dear Friends and Colleagues,

Our nation's healthcare crisis has reached a turning point. Consider these two chilling commentaries.

- Federal healthcare costs are expected to reach \$950 billion this year—nearly \$1 trillion!—and become the largest contributor to the skyrocketing national debt. In Florida, Medicaid costs our state 30% (\$21 billion) of its \$70 billion budget. Slightly more than half of Florida's Medicaid funding comes from the Federal Government (<http://healthystate.org/2012/03/the-financial-state-of-floridas-medicaid/>).
- Meanwhile, America's quality of care delivered falls short of other developed countries in terms of life expectancy, preterm births, and other measures of population health—even though we spend about twice as much as other nations on per person healthcare costs. Florida stands in the 3rd quartile for our nation (<http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/State-Scorecard.aspx>)—although Collier County has ranked first healthiest for two of the past three years and most recently as 4th healthiest of the 67 counties in our state.

Our goal at NCH is to provide high-value healthcare to our community. What does that mean exactly? Recently the Institute of Medicine offered a 10-point checklist on high value healthcare. Here's how NCH stacks up on the first four measures of this list:

Foundational Elements

- Culture of continuous improvement and leadership, e.g., NCH's selection of the most posters on best practices at last year's Institute of Healthcare Improvement; Board of Trustees and management leadership team, e.g., Board Quality Committee, Physicians' Excellence Committee, Physicians' Improvement Committee, etc.

Fundamental Infrastructure

- Information technology (IT) best practices—automated, reliable information to and from the point of care, e.g., recent designation of “Most Wired” award, plans for a Health Information Exchange (HIE), etc.
- Evidence-based medicine—effective, efficient, and consistent care, e.g., protocols leading to no central line infections from 16 to 31 months depending on the unit.
- Resource utilization—optimized use of personnel, physical space, and other resources, e.g., markedly improved door-to-doctor time in the ER, averaging 30 minutes out of season and 60 minutes in season.

Care Delivery Priorities

- Integrated care/Shared decision-making—right care, right place, right team/patient-clinician collaboration, e.g., cardiac surgeons, interventional cardiologists and patients understanding therapeutic options and accomplishing optimal outcomes.
- Targeted services—tailored community and clinic resources for resource-intensive patients, e.g., Community Health Partners working with very ill, complex patients to maximize their health.

Reliability and Feedback

- Internal transparency/Embedded safeguards—supports and prompts to reduce injury and infection, sharing information with community leaders through NCH Board and the medical staff.

I'll update you on our progress in meeting the other elements on the Institute's list in a future *Straight Talk*. The point is that while our nation's healthcare course remains uncertain—at NCH, we're not waiting. We're acting.

Respectfully,



Allen S. Weiss, M.D., President and CEO

P.S. Feel free to share *Straight Talk* and ask anyone to email me at allen.weiss@nchmd.org to be added.