Episode 142

When a hospital becomes the patient: The challenge of receiving an “F” Grade during the pandemic, and the pathway to recovery involving Just Culture.

One of the recurring themes linked to healthcare in the United States is that where the need is greatest, there you are likely to find the fewest resources needed for resilience to challenges. This is particularly true during a disaster, be it pandemic, hurricane or economic downturn. A year into the COVID pandemic, the St. Bernard safety-net hospital in the South Side of Chicago received an “F” grade on its safety report. Already under disproportionate strain, the management team needed to implement a turnaround.

Deploying the Just Culture model and collaborative change principles, the team fostered adoption of improved practices and documentation, resulting in a “B” rating in 2022, and at the time of publishing this episode in May 2023, St. Bernard Hospital has now scored an “A” Grade. For this episode of the podcast, three members of the team that led those changes share their experiences with our host and Movement is Life Chair, Dr. Mary O’Connor.

Featuring Orthopedic surgeon Dr. Daria Terrell MD, Medical Director of Clinical Programming and Health Outcomes, and President of Medical Staff; Orthopedic surgeon Dr. Vietta L. Johnson, MD; and Michael Richardson, RN, Chief Clinical, Quality & Patient Safety Officer.

Excerpt: “Initially, the feelings were ones of disappointment. I would, I may even say a little bit of feelings of resentment and betrayal. From the standpoint of, at that point, you had people who had literally given their lives to take care of patients for a year. And in a smaller hospital that takes on a whole different meaning.”

Dr. Mary O’Connor: Hi, I'm Dr. Mary O'Connor, Chair of Movement Is Life, and the co-founder and Chief Medical Officer of Vori Health. In a previous life, I was professor of orthopedics at Mayo Clinic and Yale School of Medicine. Today we have an amazing story to share on our podcast, the story of St. Bernard's Hospital and Healthcare Center. This center is a 118-year-old hospital that is a rarity in Chicago, an independent community hospital. That means it doesn't have the same resources as hospitals that are part of larger systems. St. Bernard's is a safety net hospital in the Englewood neighborhood, just a few blocks off the expressway, next to an elevated train track. It's less than two and a half miles from the University of Chicago Medical Center, one of the city's largest and most prestigious hospitals in the region. Yet many people from the neighborhood choose St. Bernard's over the University of Chicago.

In 2020, about 94% of St. Bernard's patients were black, and the majority of its patients were on Medicaid, a state and federally funded health insurance program for people who have low incomes. Medicaid generally reimburses hospitals less for their services than private insurance, which can leave hospitals such as St. Bernard's struggling to stay financially solvent. In April of 2021, St. Bernard Hospital learned that it had earned an F, yes, an F grade for safety from

the Leapfrog Group, which is a well-recognized national patient safety organization. It was the only hospital in the entire state of Illinois to earn that distinction that spring. This was news that potentially imperiled the future of the hospital. St. Bernard leaders did not simply dismiss the F grade. They were determined to turn the situation around. Now, less than two years later, the hospital is celebrating the results. Its safety grade has risen from an F to a B, despite challenges that may have made other hospitals bulk. Those challenges include financial struggles, patients who have trouble accessing regular medical care or don't always have the resources to recover at home and an aging facility. Our guests today had front row seats in the turnaround at St. Bernard Hospital and Healthcare Center. So, I'm delighted to welcome our guest to the podcast. Dr. Daria Terrell MD is an orthopedic surgeon and medical director of clinical programming and health outcomes at St. Bernard Hospital in Chicago, where she has served for over 11 years. She earned her medical degree at Case Western University School of Medicine.

Dr. Daria Terrell: Hello everyone. Thank you again for the invitation. This is exciting and very honored and very glad to be a part of this discussion.

Dr. Mary O'Connor: Michael Richardson is a registered nurse with a master's degree in health science. He joined the executive team of St. Bernard Hospital in September of 2021 as Chief Quality and Patient Safety Officer. He leads the patient safety and quality team working to ensure that healthcare services are provided with an intense focus on zero harm, preventing errors, and enhancing the overall patient experience. Previously, Michael was Assistant Director of Risk Management at Memorial Healthcare System in Florida.

Michael Richardson: Hello, everybody. Thank you so much for the invite on this podcast. It's great to be here. I'm looking forward to sharing a story of St. Bernard.

Dr. Mary O'Connor: Dr. Vietta Johnson, MD, is also an orthopedic surgeon in Chicago and is affiliated with St. Bernard Hospital and Healthcare Center. She received her medical degree from Harvard Medical School and has been in practice for more than 20 years.

Dr. Vietta Johnson: Good afternoon, I'm happy to be here participating in this panel.

Dr. Mary O'Connor: Dr. Johnson and Dr. Terrell, please set the scene for us. As you and your colleagues absorbed the news that St. Bernard Hospital had received an F grade. It's the spring of '21. It's far from a normal year after the pandemic has passed its first anniversary around that time and we're in the early stages of rolling out COVID vaccines. Presumably the hospital has been under immense strain. And for orthopedic surgeons, this must have been a very challenging period. What was the collective attitude of the staff?

Dr. Daria Terrell: Initially, the feelings were ones of disappointment. I would, I may even say a little bit of feelings of resentment and betrayal from the standpoint of, at that point, you had people who had literally given their lives to take care of patients for a year. And in a smaller hospital, that takes on a whole different meaning. So, the smallest challenges can become almost insurmountable when you don't have as many resources. Just to give you an example, in a smaller

community hospital, your staffing is different. So, we don't have 15 different cardiologists. You may only have a couple cardiologists, and so when one of them gets COVID or one of them is overburdened, that puts a different spin on what the others have to do. In a similar vein, you know, keeping up with challenges with our staffing nursing and other allied health services was also very challenging. So, having come through all of those things and feeling like you're just starting to figure out how to put your feet forward, and then you find out you have an F. I think for Dr. Johnson and myself, what COVID meant for us was having to really speak up for our patients because in the field of orthopedics, which is not considered life and death in most circumstances, we had to really prioritize what cases that we did because in the early part of covid, we had to think about what resources could be utilized. So, not every orthopedic case was deemed something that needed to be done urgently. But on the flipside, we had to think about if we waited until, you know, it might be safer or it might be a more opportune time to do these cases, what would that mean for our patients? So, if you had a broken leg and we said, oh, no, well, that's considered an elective procedure. We're not going to fix your leg. Or for the, you know, 20-year-old that I had with a broken arm, if we said, no, we're not going to fix your arm right now. We want you to live with this broken arm and just let it heal however it's going to heal. So, you know, there were those things that we had to get past. There were the challenges from the standpoint of our internists who had to at one point fill out nine pages of paperwork to get remdesivir in our small community hospital versus the larger hospitals who have that drug more readily available. And we're arguing, well, our patients are sick too. Why can't we have those drugs? And why do we have to fill out nine pages and which part of our already stretched staff are we going to have help us with these kinds of things. So, when you look at all of those challenges and see where we came through, I think, you know, finding that there was an F grade was a little disconcerting,

Dr. Vietta Johnson: I would say, it was a feeling of shock and awe. Kick you while you're down and keep kicking. So, as Dr. Terrell so eloquently explained, you have a small community hospital overburdened, few resources, more patients than there are staff. And then, you get an F and you get an F from an entity that you don't know anything about. It's like, who is a Leapfrog? You know, what's a Leapfrog? What does that mean? But one thing everybody knows is an F is an F on an A to F scale, and that's not a good thing. And when you're working at capacity and beyond, you're, everyone here on staff was working at full throttle. And then to find out you get an F, it's hard to reach back and say, and what else can I do? And so, we were, it was an uphill battle from the fact that everyone thought that they were working full throttle. Now we have an F. We're trying to save lives, and we have an F from this Leapfrog. So, a very shall I say, confusing time. But as we will go on to find out, we met the challenge.

Dr. Mary O'Connor: Michael, what would've happened to St. Bernard Hospital if the F quality rating continued would the hospital be at risk of closure by the Joint Commission?

Michael Richardson: The Joint Commission has a different pathway of evaluating hospitals through its accreditation process. So, essentially having the F grade would've not impacted that survey, you know, Joint Commission does onsite surveys or unannounced. They come into the hospital, they bring a whole team. They look

at different components of the hospital, the building safety regulations, and then also the patient quality and patient safety regulations. So, they, they, they tend to look at records and trace the patient. Leapfrog is a different process of gathering information. So, the Joint Commission wouldn't necessarily close the hospital down based on poor ratings. It may be on their radar, I don't know, but certainly it's a, it's a different pathway. So, we weren't at risk from them. But the whole F grade potentially had a, you know, a long, a bigger impact when it comes to the perception of how safe we are.

Dr. Mary O'Connor: Dr. Johnson, how widespread was this rating in terms of community awareness? Were patients coming in understanding that St. Bernard had just been graded F?

Dr. Vietta Johnson: Since I spent most of my time in the clinic, I would say they did not, but on the hospital side, the information moves swifter than we would've liked it, I would say. And when they ask you and then someone asks you, what does that mean? What does an F mean, and I am your patient in the hospital. That is sobering. And then, like I said, the learning curve, then we had to learn, then we have to teach the patient. So, it brought patients some hesitation, but they stuck with us.

Dr. Mary O'Connor: And Dr. Terrell, how did St. Bernard earn the F? Can you share with us some of the factors that resulted in that grade?

Dr. Daria Terrell: Well, I'll go back a little bit. Previous to that determination in 2021, St. Bernard Hospital did not participate in the Leapfrog survey. Up until that point, it was essentially a voluntary choice to participate. And so, having not participated in the past, there were certain measures and data that we did not have in the form that was ideal for the collection period. So that when we did participate in the survey, there were certain standards that we were not able to make. So, for example, you know, a lot of our efforts around where physicians are actually putting their orders in the computer, small things like that, we didn't have the data to support that we were doing these things. We had older, our computer system itself takes a little bit more work to generate the information that's needed to substantiate and show the efforts that we're making. You know, another example, which we'll probably talk about a little bit more is just, you know, hand hygiene. So, things like that, not being able to readily show how we were participating, you know, in these measures hurt us. I mean, there are, you know, there definitely were some areas that we know we had room for improvement, but a lot of it had to do with our ability, I should say, to present what we do and how we, and what measures we take to try to maintain safety standards.

Dr. Mary O'Connor: Yes, totally understand that. You have to have the data and it has to be in the format that they are asking for. So, Michael, you were hired as a risk management expert to address safety issues. Tell us about some of the key points from your initial situation analysis and were you optimistic the problems could be resolved with the available resources?

Michael Richardson: So, let me take you back on my journey with St. Bernard, because I was kind of watching this from the distance. I was living in Florida. I made a decision to move to Chicago and I actually applied for, you know, a number of jobs in Chicago and actually, you know, was given a position at a larger system. And

then this job popped up for St. Bernard Hospital. And I read the job description and I was like, this is my ideal job. This is my end of career kind of job. That, and then I kind of did some research. I started looking online and read some research, and I went to their website and I read the passionate letter that, you know, the CEO had written about you know, the F grade that they'd received. And then I started looking at reviews, Google reviews, Facebook reviews, TikTok reviews, and I just thought, boy, this hospital is just getting so beaten, but looking at its history, 118 years, community hospital, safety net hospital serving you know, an underserved population. I just thought it was, so, I just thought it was unfair. So, I made the decision that this is the job I wanted. So, I really pushed for it. I met, you know, the CEO and then, I, you know, got the job and came up here. So, my goal was obviously, and it was a bit of, you could sense it was a, a bitter pill to swallow, if you like. It was a kind of the badge of shame being the only hospital in Illinois that had the F grade. And it was reported in all the newspapers and, you know, the Chicago Tribune, Crains. And it was, you know, St. Bernard Flunks, you know? It was just really demoralizing, not just for the staff, but I'm sure adding to the perception of the patients that their community hospital wasn't the safest place to go. So there, we needed to do something and we, you know, it was long discussions with leadership of how we were going to attack this. And for me, looking at the survey, looking at what was already submitted, because St. Bernard did the right thing. They decided they were going to face this head on and not just, you know, argue with the, you know, the bad press and put out more statements. They were just going to attack it head on. And that's what they'd stated in their response. So, it was kind of looking at the, what was going on, what was the current state, what was in the survey that they already put together probably in, you know, in a little bit of a rush to get it in there in time after the F grade. So, we looked, I looked, at the survey and started looking at the low-lying fruit if you like. What could we fix in the immediate that would maybe make a difference? So, we looked, started looking at data, and to Dr. Terrell's point, and Dr. Johnson's point, the data was challenging to get. So, once I got, you know, tapped into some of the experts here, because we got some really smart people who work here, they would be able to say, well, what do you need and when do you need it by? And I said, I need it now and I need it now. So, they worked really hard and got me the data and I was able to look at the data and say, okay, what's the problem then? If we are supposed to be at a certain level, and I'll give you an example, when medication is scanned by, sorry, the patient wears a bracelet. When a medication is being administered, the nurse scans that bracelet and scans the medication. And we were low on those numbers. We weren't where the Leapfrog benchmark was asking us to be. So, we formed a committee and we sat around a table with all the experts, nursing, pharmacy, respiratory, IT, and said, what are the barriers that are preventing us from driving this measure? And we found out that, you know, when we surveyed the nursing staff and asked the nursing staff and the people and the respiratory staff, those people use them scanning, they said some of the equipment was broken, some of the Wi-Fi that it needs to connect to the medical records doesn't connect in certain rooms. Some of the barcodes on certain medications don’t scan. So, as a team, we work together to fix those barriers, those physical barriers that our system barriers if you like. And then anything after that we knew was potentially behavioral. So, we fixed all the barriers so nobody could say, well, it doesn't work anymore. So now it was saying, okay, everything's fixed, do what you need to do, do the right thing that's safe. And they did, they really

jumped on and we saw an immediate, and I mean, it was surprisingly shockingly surprising that we went to a certain level so quickly and consistently we've been, once we built it up, we've been almost 12 months now where we've been way above the benchmarks that that's required from Leapfrog on that one, medication scanning. So that was kind of an easy fix. We could fix that in the immediate. The other things that we couldn't fix necessarily was the data that's in CMS. So, Leapfrog pulls the data that we submit into CMSs patient quality portals, et cetera, NHSN, all this information. Leapfrog pulls that data as well, and they use that data. And some of that data is old. When I was talking to the nursing staff and then, and physicians and the infection preventionists, we'd already improved on some of those measures. It was just a matter of time before Leapfrog or CMS caught up. So, when Leapfrog pulled the data, it would be more current. So, we saw an immediate jump. That's why we went from the F to the C because CMS essentially caught up to where all the good work that St. Bernard had already been doing. And then another thing was, would it, the biggest thing I think in any organization is the culture surrounding patient safety. How are you going to adjust that culture to make sure that when everybody walks through the door in the mornings or in the evenings, that they're all aligned with the culture that we're trying to change. So, in other words, how are we all going to be safe? How are we going to make patient care safer? So, if everybody buys into that culture change, and then things can start to shift in the right direction. And I'm sorry, that was a very long answer.

Dr. Mary O'Connor: That was a great answer. I'm going to ask Dr. Terrell if she has some other comments to add.

Dr. Daria Terrell: Well, I would say just kind of piggybacking off of Mr. Richardson's comments, a lot of this I would say started from the top with leadership. Actually, before that grade was announced, I had conversations, you know, with our administrative team about how do we want to start to move out of this pandemic? And one of the suggestions that I made was to put a focus on patient safety and take a top-down approach and want and all, like literally from the top. So, including our board of trustees, just really having a complete engagement in the campaign to bring about awareness and improve all of our efforts around patient safety. And I must say, you know, for something like this to be successful, you have to have the full commitment of your leadership team. And so, by our leadership team, you know, embracing that following through with the hiring of Mr. Richardson, you know, we do now involve our board. Mr. Richardson actually just made a presentation to our board this week. Just, you know, in updates about patient safety. We've also done things to include community engagement around those safety measures. So, we have our Patient Family Advisory Committee and one of the members of that committee actually sits on our quality and safety committee. And that's to ensure and gather some authenticity with the efforts that we make as, when we say we want to do things to better the community and to engage the community and meet their needs, we want to make sure that there's somebody who's really there talking about the needs of the community. So, I think this, you know, total approach to looking at patient safety on a number of levels at every entry point within our system has really spoken to the success of our efforts. And, you know, I think some of us looked at the F as, you know, an opportunity for growth like this kind of wakes everybody up and says, yep, there are things that we can do better. You know, obviously

everybody that's in this system knows that we're better than an F but I think it really provided a driving force to really do everything possible to make us be better at reflecting what we think that we are truly able to bring.

Dr. Mary O'Connor: So, Dr. Johnson, we all know that surgeons as a group tend to not want to change anything that they do. So, I'm interested in your perspective on how you and Dr. Johnson got the surgeons there to do better. And I'm sure Mr. Richardson was influential too, but in general, surgeons are going to listen to surgeons. So how did, how did you get the surgeons on board?

Dr. Vietta Johnson: When you look at things from the team approach, and this is, this was the entire approach for this effort. Surgeons do not like to be not included on the team. So, when you have to be a team member, not only do we want to be on the team, we want to be notable team members. And so, we had to keep pace and especially, well, we had a little bit of wiggle room because especially for the hand hygiene system that we now have parts of the OR are not included, but that did not absolve us from doing what we needed to do on the floor. And I will say that our hand hygiene system with the big hand, literally green, red or white that everyone wears when they go into a patient room, when you see everyone doing that, then you want to make sure that you are not out of the bell curve. And so, I think because it was brought to the entire organization as a team effort, that everyone would be involved, including administrators wearing the hand as I called it, the hand, the clean hand, then the surgeons, there was no, we didn't need to be cajoled because we needed to hold up our part of our patient safety. And we especially know patient safety and sterilization and things like that as surgeons. So, if it comes down to handwashing and going into seeing your patient, then you just need to document that. And we, we are well versed in that as well.

Dr. Mary O'Connor: So, can you just tell our listeners a little more about the hand? Did you like flip it to green if you had done, you know, handwashing before you went into the patient room? Or how did the hand work?

Michael Richardson: Dr. Johnson, do you want me to take this one?

Dr. Vietta Johnson: Yes, but I will mention, I do know the name of it. It's bio vigil. I don't want you to think, I just call it the hand. It's huge system that is throughout the hospital and I will let Mr. Richardson take it from there.

Michael Richardson: So, this was when Dr. Terrell talked about leadership support. This is one of the things that we talked about to the board because one of the Leapfrog requirements is you have to do these hand hygiene observations. So, in other words, you have to have a secret shopper watching somebody going in and out of the room with a clipboard and monitoring their hand hygiene. It's very burdensome and cumbersome. So, I, we, myself and the infection preventionist looked at three different systems where we could do it electronically. So, we don't have to do all the observations. We still do some, but not all of the, you know, the large number that Leapfrog required. So, we invested in a system called Bio Vigil. It's a badge wearing system. I'm wearing one right now, but it's a little badge you wear on your lapel or your jacket or your scrub. And then, once you've entered a patient's room, the badge recognizes that you've walked into a patient

room. So, it requires you to then sanitize your hand. And then, if you don't, it will start to warn you, it will start flashing yellow. If you don't sanitize within that one minute, it's going to turn red and that's going to be a ding against us. So, the idea is when you walk in, you sanitize, and you cover the badge with your hand and it gives you a credit and it turns green. And then the patients can see this badge and it, we can explain to the patient, this is our hand hygiene monitoring. If you see my badge is green, then that means my hands are clean. If you see it red or yellow and flashing, please remind me and I'll sanitize my hands. So, we wanted to make it patient facing. We wanted to make it family facing. We have posters on the wall explaining the same thing. So, we've had the system in about a year now. And so far, we've gathered just for a small organization, we've almost up reaching our first million episodes of hand hygiene monitoring using this system. So, in other words, a million times that somebody's walked in and out of a room and it's registered that we, somebody has to do the hand hygiene. Now, currently we're around 90% compliant. So, there is opportunity still, and we're working on those, we're actually having a reboot of the, of the whole process. And this just affirms our commitment to prevent patients from getting hospital acquired infections because most hospital acquired infections come from patients' hands, I mean from staff hands. So, we're encouraging them to do the right thing and then get credit for it. And now, we have this award system. So, we're actually recognizing departments that got the best. We have this little Bio Vigil award that goes out every month and each department now is buying for that little award, even though it's very tiny. But it's set up some competition. And I think it's really, a really good system. But we wouldn't have gotten that without the support of the board and the commitment and the financial commitment, which as we talk about resources is, you know, one of the things that we have to balance, you know, is it worth the cost? Well, absolutely, if it saves a patient's life and it saves thousands of dollars of, you know, extended length of stay in the hospital because a patient develops a hospital acquired infection, it's worth every dime that we spend.

Dr. Mary O'Connor: Dr. Terrell, your comment on the hand.

Dr. Daria Terrell: I think the hand is a part of how cultural changes are instrumental in, in changing the whole scope of how we practice. One of the things I was thinking as you were talking about how this affected surgery Dr. Johnson is vice chair of the department and I'm chair of the department. So, we saw a lot firsthand particularly how our surgical department changed. We lost a lot of nursing staff throughout the pandemic. And there was a, a high turnover at one point. And while that initially was a little disruptive to the system that we had been used to, I think part of welcoming change and part of embracing a new culture and this, this thought of everything we do is about patient safety led us to take some of the, the perspective and the eyes and ears of those new people coming in, whether they be, you know, agency or from other places.

And I think it, it helped to foster a, a system where people felt like, okay, well you know what? Let's, let's look at this. We did it this way. Do, should we start thinking of trying to make some changes in how we do things? And I think that to your point, surgeons don't always like change, but I think when you couch it within the framework of, you know, this is a culture shift to bring about safety, we have been able, I think, to make some strides in our surgery department that all go towards making things more efficient. And also, you know, this overall

continuing message of everything's have got to be for the patient's safety. And also we've actually implemented some things to help our staff just to support and secure their safety. Cuz that's, you know that's one of the things that we've learned during the pandemic. You got to take care of the people who take we, you have got to take care of the caretakers. If we don't take care of our staff the same the same priorities we want to have in terms of taking care of our patients, we want to also think about our staff because if we're as an institution protecting them, that's going to help them to take care of our patients better.

Dr. Mary O'Connor: So I want to touch on a theme that I'm hearing, but I'm not sure we've kind of explicitly called out here. You are an independent community hospital, 118 years old, limited resources, but you turned it around. And that to me speaks to culture because in my mind it's always all about culture, and culture is the hardest thing to change and the most important thing to advance. So, so just tell me a little bit more about how you saw the culture, how did it change as you went through this journey?

Michael Richardson: So, culture is a really challenging thing because, you know, how do you align people's different values, beliefs, experiences, how do you align them? But when they walk into the hospital, they're all going to kind of feel the same, same way. So one of the first things that I wanted to do when I got here was, you know, there's a, there's a, a method out there or a process called just culture, and I'm sure everybody's familiar with, but it's becoming more common in, in healthcare, it's used in other industries. High reliability organizations use a just culture model where there's, you remove the fear of reporting because it's not punitive. You know, you try and deal with employees who make mistakes, trips and slips in a fair and just manner, rather than just going straight down to the, the punishment line or the punitive line, if you like.

Dr. Mary O'Connor: So, looking at how people make mistakes and looking at the systems that may have driven that person to make the mistake rather than just the person alone. And then looking at the choices that people make. If you use the, if I use the example of scanning patient medications and medications before administering you know, that's an expectation. It's not an aspiration, it's something we require you to do. So what are the choices that I'm making drives somebody to not do that. So is that just a poor choice? So looking at that protecting the, the, the employees from, you know, punitive actions when it's not necessary, and only dealing with poor choices that potentially become risky and reckless. So changing the culture of how we look at medical errors, if you like. And then, you know, looking at recognitions as well, we just, we introduced this new recognition process where if somebody had sees a good catch, how are we going to recognize that person?

Michael Richardson: I'm going to say thank you for bringing that to our attention because that was a potential error that could have reached a patient. Or, you know, if somebody provides good customer service, if somebody steps up and goes out the way to make that patient's experience different, how are we going to recognize those staff? So now we bring these, you know, the employees into the big leadership meetings that we have. We present them with an award, take some pictures, and then we share those pictures with the organization. So, it's recognizing those, those employees and, you know, there's no dollar amount

attached to it. We're not going to say, Hey, great job, here's an extra $5 an hour. It's just a thank you. And, you know, sometimes the thank you goes a long way. And it, and it sends a message that we appreciate what the, the employees are doing.

So that was my focus on changing the culture around safety. But it's an ongoing journey. Changing culture is not a light switch. It's not going to just happen. You know, change is something that we have to bring in and we, we have to bring it in so people can understand it. So sometimes it forces out of out of it forces change, forces us outta tired habits to try and impose better ones upon us. But it can also be stressful and sometimes it can be a little costly and even destructive. So culture change is, is an ongoing process. And so we have to be mindful that journey is, is definitely ongoing.

Dr. Johnson: Okay. I think it's also important to know that even though we're a small community and hospital, we want to be winners like everyone else. No one wants to get an F. And if it takes, if what it takes to be a winner, or at least perceived as a winner, is to change the mindset, especially of punitive actions. That was huge when someone could honestly say, well, we could do this better and it would be safer. Now people had a reason to not be punitive, and I think that's huge in any organization, but let's be clear, we don't want to be last <laugh>. And especially when you're working and you feel that you, you don't deserve to be less because you're doing what you know, other people are doing, but it doesn't appear that way. And so now we have things that hold us accountable. And the most important change in the culture is the lack of focus on being punitive versus being safe. That's huge.

Dr. O'Connor: That, that is huge. Dr. Terrell, how has the community responded to this fabulous B rating, this incredible improvement that you've all achieved?

Dr. Terrell: We've actually seen very positive feedback on our social media pages. You know, that's, that's how people speak. And I, I think while that kind of acknowledgement is important, we've also, you know, gotten kudos from other entities. But I think for us as an institution, what really made all of this matter is we're in a community where we want our patients to take better care of themselves. So we want them to be involved in preventive medicine. We want them to utilize the ambulatory care center that we built about six years ago because we wanted people to have the care that they needed in their own community without having to leave the community for all of their services. So if, if your community hospital gets an F and you're coming out of Covid and you're already a little skittish about, do I want to go into a medical institution and am I going to catch something?

If I'm in there and they've got an F, Oh no, I'm going to stay at home. I don't need a colonoscopy, please don't check my blood pressure, I don't need any of that, I'm fine. But now that you start seeing, you know, the newspapers are talking about it, the TB stations are talking about it, my neighbor told me, Hey, yeah, you know, I saw, I heard that, you know, they, they got a B So now the patient starts to say, well, hey, maybe it is safe for me to come back. Maybe I haven't been to the doctor for a while. Maybe it is now's a good time. Where I was a little skeptical before about going there. They are doing some things to change the

perception in the community. So I think that part has also been very important to us, especially coming out of the pandemic because we want people to return to healthy healthy medical habits, healthy health habits. So we want people to, to get those prevent preventive screenings, to do all those things that we are very proud that we are able to offer. And I think this help people feel a little bit more comfortable coming to us to do those things.

Dr. O'Connor: Mr. Richardson, let me ask, so so you received the B rating. Did you get some good local press? Did people celebrate the achievement?

Michael Richardson: Well, on December 26th, we actually got a front page article in the Chicago Tribune. It was above the fold. It was a great article. The actual reporter came in and she stayed a lot longer than we thought that myself, Dr. L, Dr. Johnson, she was actually here three hours. And she did talk to the, the patients and the patient in private. We, there was no prompting from us. She pulled pa you know, patients got permission and had a conversation and they gave us a glowing report. So yeah, it was a great, and then the Chicago Tribune jumped on and did an editorial because when we met, we talked about the hand hygiene system. The, apparently many years ago, I wasn't here at the time, but many years ago, Chicago, the Chicago Tribune had championed or were pushing for, you know, better quality and hand hygiene at that time.

And they wrote an editorial on what we were doing. Now, I think, yeah, I don't know, maybe it was 20 years ago that they were pushing for this. But they said, do what St. Bernard is doing. You know what they're doing. If they can do it, you can do it. So that was great. And then, you know, this is, you know, podcasts like this. And I've had calls from other hospitals, you know, who, who maybe in the same situation as we were bigger hospitals that don't need any, any advice, but they were calling saying, no, tell us, tell us your story. How, how is this, how is this working out for you? And to Dr. Terrell's point, you know, we can look at the leapfrog, we can look at the score, but it's the, it's giving the public that perception that we're doing this for them.

We're not doing it for the, for the, essentially the grade. The grade just tells the story. It, you know, they, they can see that we're making changes at St. Bernard. We are trying to be safe, and we are trying to, we are going to maintain that safety. So they want to come back to this hospital. It is theirs; St. Bernard is their hospital. We're here for them. We're not here for us or for, to keep this hospital going and, and make millions of dollars. We're, we're an underserved safety net hospital. That's never going to happen. But we want to provide that, that community hospital, so patients who've got somewhere close that they can come to and not have to disperse all around the city trying to get care.

Dr. O'Connor: That's wonderful. And I'm just so pleased that, that they reported that above the fold because Well, no, kudos, kudos, kudos to the reporter and the paper for doing that because it's very easy of course for people to write the bad stories. And they don't always necessarily write the good stories. And, and the story of, of the incredible turnaround that you all, that you, you and your teams achieved is newsworthy. Absolutely newsworthy. So let's, let's follow this thread of safety net hospitals across the country, because we know that they're constantly under threat of closure. And, you know, we at movement is life. We're of course very

strong advocates to finding ways to help them stay open because they really serve their communities, and they are always in underserved communities. So, so tell us about the prognosis for St. Bernard. Now, Dr. Terrell, we're going to let you start with that one. <Laugh>, she's the medical, she's the medical staff president. So, she has her finger on the pulse. I'm also on med exec. But we are going to let her feel that one first.

Dr. Terrell: Well, I think we are at a point where we're committed to doing what we've done for 118 years, so we kind of figure there's no point in stopping now. It's just more challenging to do that. So our plan is still to be a beacon for the community in terms of providing quality safe healthcare. So what does that mean? We're hoping to galvanize around these efforts. And I think we, we really do believe that doing what we know that we can do and doing that well should translate to being successful in delivering healthcare. Now, the nuances of how to do that so we're, we're having to make different partnerships. We're reaching out to different community organizations. We have a very strong, we call it faith-based support group. So our allegiance of churches and other community partners that we rely on both to help us know what we need to do, but also making sure that, you know, these partners know how we can help the community.

We have, we're engaged in things around, you know, food equity and food distribution. So all of these small things the hospital is doing of course, we're, we're focusing on the things that our community needs assessment which we do on a routine basis. So when our community needs assessment is completed, and the, it comes back and says, okay, the, the needs of the and the concerns of the community are centered around hypertension, diabetes, maternal morbidity behavioral health, you know, these are the things that then we try to reshape our, our programs around. And just to give you an example of sort of kind of the, the little niche work that has to happen in a safety net hospital, we may not be able to recruit or retain and hire a diabetes nurse, but one thing we've done around diabetes is partner with AmeriCorps to have an AmeriCorps fellow come and be our diabetes educator. And that AmeriCorps fellow runs a diabetes prevention program for us. So that is, you know, all these little things are ways that we, you know, try to keep things moving towards providing quality care.

And it, it's also important to note that we know our limitations. We are not the university. We are, we are not trying to be the university. We actually are, we're focused on the community. And when I say that we, in focusing on the community in which you serve and being here close in and caring about them, we are delivering within our scope what we do, and we do it best. And I think that's our greatest message. We're going to provide safety, protect the patient and care about you to the best of our ability, given the hand that we're dealt being a community hospital. Because patients know we're not the university <laugh>, and we, and, and, and, and we don't want them to think that we're trying to be the university we have. We all of all of the health and healthcare institutions would hopefully care for patients and do that to the best of their ability. But we do it at a very focused level on a focus population. And I think that that's what makes us, you know, stand out.

Dr. O'Connor: Absolutely. All right. I'm going to ask you one more question. I'd like each of you to respond. What are the lessons you want to share with others who may be on a similar journey? Mr. Richardson, we'll start with you.

Michael Richardson: Okay. I'll try and keep this brief. Just don't give up. You know, when you're in this a situation, sometimes when you, when we, when when we were where we were, we only had one place to go and that was open. So just focus on that and take, you know, you know, our journey was, seems reasonably quick, but just, it's going to take time. So just let time be what it is and just move along with it. And then when you get where you want to be, and this is where we are now, is test your resilience. How are we going to maintain what we've done so far? And that's the challenge now. Cause once we come from the air and we get up there, now we can go both ways. We can either go one more to the A or we could come down. So it's testing that resilience, making sure that the systems we put in place stays safe, that we don't get any infections, that we don't fail on some of the things that we've already succeeded on. And that's my goal, is to make sure that we maintain this. And it takes a team. And I know Dr. Terrell and Dr. Johnson are both extremely committed in this. They've been really supportive of me coming here. Sometimes when you get strangers coming into the hospital, it's, you know, you're not always welcome. But this hospital has been extremely committed and welcoming. So tap into the resources that you've got. We don't always have all the resources like the big hospitals have. So look at what skillsets you've got in the hospital and use those. You'll, you'll be surprised what's experts you have right under your nose. So picking on the low lying fruit first, and that will help Dr. Terrell.

Dr. Terrell: Well, I'll start with the surgical analogy. You know, when you're doing surgery, you want to stay in the planes that you're supposed to be in. So in this instance, you, you, if you stay in the lane of patient safety and you stay in the lane of doing what's best for the patients, you can't go wrong. You don't harm if you keep that as your goal and to Mr. Richardson's point you know, you, you can't give up. Like we could've just kind of said, we, this is an f and just been mad and left it there. But it's, it's what you do with that and how do you keep moving to, to be the best that you can be. And I also think, you know, once you put in the work, the work should speak for itself. So, when we go to the legislator and say, you know, we need more funding, we need more support. We continually will have proof of why we need your we, why we need support. We continue to be what we are striving to be for our for our neighbors. And so you just have to be persistent in doing what you need to do and hope that, you know, those things will be recognized and most importantly, they'll be appreciated and valued by the patients that you try to serve.

Dr. Johnson: I'm going to start out with the famous statement from Maya, Angela, when you know better, you do better. So now that we've learned better, we are doing better and we are on the continual curve to improve. We want to continue to know better so we can continue to do better. And that would be my advice to anyone. Don't quit. Whatever you do, don't quit <laugh>. Whatever you do, you have to stay in, you have to change the learning curve. You have to learn and you have to do better because what's the choice of not doing better, doing worse? And like Mr. Richardson said, we might not, if we go to a C it, we'll go down fighting <laugh>. But our goal is to absolutely be an A and stay at an A, because now

we've learned, and we're learning, as Dr. Terrell said, we weren't a, a participant in Leapfrog until 2021. We, we, we did not participate. So now it's only 2023, and we've gone from an F to A to a B. And so, we have now as Maya Angelou would say, when you know better, you do better. And that's what we're doing.

Dr. O'Connor: Well, I just want to congratulate all of you for your leadership. St. Bernard Hospital and Healthcare Center is blessed to have each of you. And it's a, a remarkable story, but actually not remarkable because I personally know two of you and I, you're remarkable women and leaders. And so I would've expected nothing less than this turnaround. And Mr. Richardson, I'm so glad that they warmly welcomed you to Chicago. I know your accent fit right in. So, I just want to thank each of you for being on the Health Disparity podcast. I really enjoyed this session. And look forward to learning about your journey from B to a. I have total confidence that you can achieve that. And your patients are just, you know, so fortunate to have all of you and thank you for all the outstanding work that you're doing. So, to our listeners, thank you for joining this episode of the Health Disparities Podcast, and we'll see you next time. Thank you.

Thank you for inviting us. Thank you. Be well.