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20 People Who Make Healthcare Better—2011

HealthLeaders Media Staff, December 13, 2011

Some people lament the need for a better way. Others seek it out. The inventors, innovators, and iconoclasts see the future and strive to get us there. Determination and a willingness to take a chance are among the qualities we see in our annual HealthLeaders 20 as they set about dedicating their professional lives to making a difference for good in healthcare. Here, we offer profiles of those selected for our 2011 list.

[>>See extended versions of these profiles.<<](#)

Getting Better All the Time

Wright L. Lassiter III

In September, Alameda County Medical Center was recognized as a Top Performer in Key Quality Measures by The Joint Commission, which placed the safety-net health system among the top 14% of 3,099 accredited hospitals in the United States.

That distinction marked the latest affirmation of a remarkable turnaround for the Oakland, CA–based, six-facility public system, which only six years earlier had been near collapse. That turnaround trajectory started in 2005 with the arrival of Wright L. Lassiter III as CEO.

Rather than wielding a budget cleaver and chopping staff, Lassiter hired a like-minded C-suite team that engaged staff to find savings across the organization, which would result in fewer job eliminations.

“We used a team approach to garner revenues, enhance cost savings, and find contract savings,” he says. “We also had a [Centers for Medicare & Medicaid Services] survey of our psychiatric facility that happened six days on the job that wasn’t particularly flattering. It was the first time in my career that I had had a survey go that badly. I used that as a rallying cry for the organization, and I challenged the organization. Do we believe we should go from survey to survey riding correction plans, or are we going to focus on creating discipline to demonstrate that we are better all the time?”

Today, the system, which had been losing money, looks to generate between \$3 million and \$5 million in net income each year; it has whittled down its debt to the county to about \$140 million from about \$200 million, and plans to repay the debt by 2018.

The son of an ordained minister, Lassiter says he gains spiritual fulfillment from the success of ACMC. “You get great satisfaction creating a high-reliability, high-quality, high-patient-experience organization and one that treats the people who don’t have lots of options,” he says. “So, to take care of this population is one of those things that gets me up in the morning.”

—John Commins

Caring for the Impoverished

Anne Brooks, DO

Anne Brooks, DO, is a doctor, not an artist—but then again, maybe a bit of both. She says too many of her patients at the small Tutwiler (MS) Clinic smoke too much—their skin wrinkled by years of tobacco intake, their lungs brittle. She tells each of them they are having too many cigarettes, and then she takes pen to paper. She sketches their heart and lungs, and writes down how “tar,” that toxic material, ravages both.

“I draw pictures of the lungs and put tar on the alveoli, where the air goes in, and tell them, ‘If you put tar through the air sacs, how can you breathe?’” Brooks says. “They look at me, and we discuss what it means. It dawns on them what is happening to their lungs.”

For 28 years, Brooks, a Roman Catholic nun, has practiced in one of the poorest areas of the country; that’s why she went to Tutwiler in the first place. She spends morning and night working for her patients, and in the process has become a spokesperson for the country’s needy and has been lionized by various groups for her efforts in helping the poor and improving the healthcare needs of diverse populations.

“I set for myself a little higher standard, and that is what I expect my patients to do,” Brooks says. “I try harder, and they try harder. I yell at them louder, and they laugh at me louder.

“Sometimes I get a little dramatic with them, and say, ‘What are you doing to me?’ They get the point.”

—Joe Cantlupe

Understanding the Patient’s Need for Understanding

Alex Blau, MD, and Brad Cohn, MD

While working the overnight shift at San Francisco General Hospital, Alex Blau, MD, and Brad Cohn, MD, found themselves at the corner of

necessity and invention. The two young physicians in training were in their third year of medical school at the University of California, San Francisco, in 2008, and they were frustrated by their inability to communicate with patients from the Bay Area's diverse racial and ethnic communities.

"In healthcare, your greatest diagnostic tool is your ability to communicate, to obtain a decent history and a physical exam from your patients. This is difficult to do with patients you can't easily communicate with," says Cohn, 29, now a resident in anesthesiology at UCSF and San Francisco General Hospital.

So the pair came up with the idea for MediBabble and formed NiteFloat Inc. to produce an iPhone/iPad app that allows clinicians to better communicate with non-English-speaking patients during the initial exam and history taking.

"This was just something we needed, and we were surprised that it didn't exist," says Blau, 35, an emergency physician who has since left medicine to develop MediBabble. He is also medical director at Doximity Inc. in San Mateo, CA. "We both had iPhones, and we thought, 'Why isn't there an app that helps us?' ... Then we realized that we were perfectly situated to do it ourselves."

MediBabble—which is free and does not require Internet access once it is downloaded—focuses on the history-taking process during the initial patient interview. Since it was launched in February 2011, more than 15,000 clinicians have downloaded it.

While it's not charging a fee for MediBabble, NiteFloat asks users to donate money. "We are technically not a nonprofit, but we are also technically not profitable," Cohn says.

—*John Commins*

Seeing a Better Way

George Berci, MD

In the late 1950s, Hungarian George Berci, MD, was in Melbourne, Australia, on a Rockefeller Fellowship, and vexed with a major problem in gallbladder procedures. Surgeons could not see inside the common bile duct well enough to remove the stones.

"The stones were overlooked, and approximately 12% of patients had to undergo another procedure to remove them," he recalls. "I thought it would be nice to insert something in the duct that would let you remove the stones under visual control."

Berci sought help from a London physicist, and they developed a rod-lens system that vastly improved the visual field for this procedure. "The light was much brighter. And the optic had much greater quality of the image regarding sharpness and viewing angle," he says.

That was just one of many technical advances Berci has brought to the field of instrumentation in laparoscopy and several other endoscopy procedures during his career.

He helped develop ways to televise surgeries so that physicians were better able to teach medical students how to perform procedures. "We developed the first miniature endoscopic TV camera in 1962." His innovations helped develop numerous surgical instruments, including cytosopes, resectoscopes, and nephroscopes.

Berci stopped performing surgery 20 years ago, but at age 90, he continues as the senior director of the endoscopic research laboratory at Cedars-Sinai Medical Center in Los Angeles. He goes in every day around 6:30 a.m. "I run around the hospital," he says, even sometimes taking the stairs to quickly get up and down the building's four floors to help active surgeons to observe new procedures, using new modern video endoscopes.

—*Cheryl Clark*

Reducing the Disease Load

Patrick J. Quinlan, MD

Back in 2001 after he looked at some staggering state health statistics, Patrick J. Quinlan, MD, CEO at Ochsner Health System in New Orleans, and his executive team set out to improve the health and wellness of the entire community—starting with the children. Change the Kids, Change the Future is a program created and championed by his organization.

"I'm very concerned about the wrong turn healthcare reform has taken. It's put our focus on expenditures," he says. "We need to focus on reducing the disease load. If we look at those individuals who have particular risks, we recognize that the major driver for these problems is lifestyle. It's a set of behaviors learned early on and is a part of the family history—the behaviors are contagious."

Quinlan and his team decided to focus on obesity, which often leads to hypertension and diabetes, because it is a lifestyle issue, and the habits are formed in childhood. "This is an epidemic," says Quinlan.

The system puts \$250,000 in annual direct costs toward creating its school-based program designed to educate children and their families about the long-term impact of nutrition and exercise choices on their health. The money funds on-site nurse practitioners at schools and a mobile fitness unit that travels the region to teach parents and kids to incorporate healthier foods and behaviors into their lifestyle. The mobile fitness unit reached more than 2,500 students this year.

"We're not in banking or manufacturing; we take care of people. It's my hope that if we lead by example we can change the understanding of health in our community," says Quinlan.

—Karen Minich-Pourshadi

Collecting Brains, Combating Concussions

Chris Nowinski collects brains—specifically, the brains of deceased athletes.

Nowinski is the president, CEO, and cofounder of the Sports Legacy Institute, a Boston-based nonprofit that works to raise awareness about concussions and their long-term effects on athletes.

His career as a professional wrestler with World Wrestling Entertainment ended in 2003 when he caught a boot to the chin during a tag-team match. He struggled with that particular concussion for several years, visiting doctor after doctor in search of relief. Nowinski credits Robert Cantu, MD—the eighth doctor he saw for his concussion problems—with his turnaround.

Nowinski began his own research and concluded that athletes were “all just being lied to about the consequences of playing some sports.” He wrote *Head Games: Football’s Concussion Crisis* to educate parents, coaches, medical professionals, and others about the long-term effects of brain trauma.

He realized that people needed physical evidence to change their minds and started actively pursuing brains for study. He began calling families of deceased athletes and asking for brain donations for research.

His first brain—or rather brain tissue—came from Andre Waters, a former NFL defensive back who committed suicide in 2006. Examination of Waters’ brain tissue produced evidence that the 44-year-old suffered from chronic traumatic encephalopathy, which is a progressive degenerative disease related to repetitive brain trauma.

Nowinski’s campaign to publicize those results is credited with driving the national discussion about the effect of repetitive brain trauma on athletes.

—Margaret Dick Tocknell

Studies in Sleep, Success in Handoffs

Vineet Arora, MD

Vineet Arora, MD, MPP, FACP, an associate professor of medicine at the University of Chicago’s Pritzker School of Medicine, says she was always interested in finding out why things work—or don’t—in healthcare, and that inquisitive nature led her to sleep.

Not necessarily her own sleep, mind you, although Arora will tell you when she was a resident she had her share of sleepless nights like many of her colleagues.

Arora, also assistant dean of scholarship and discovery at the Pritzker School of Medicine, is leading research that is reshaping sleep schedules for residents to improve quality and safety of patients.

“You don’t want doctors fatigued to the point they are hurting anybody,” she says.

“It’s a fascinating area to work in. It’s complex. If you change one thing in the system, you can change a lot of things. Everybody needs sleep. It doesn’t matter who you are. You can’t function without it. You’ll die.”

Arora also has concentrated on studying handoffs from one physician to another in hospital settings as they change shifts, with a specific emphasis on communication procedures. In the 1990s, “when I was a resident, you never had to hand off anything,” she says. “A good handoff was no handoff. That meant you stayed until your work was done. People are now aware it’s a problem, and the challenge to the system is to make better handoffs.”

Arora’s resident days are long gone. “My husband will tell you, I always try to get enough sleep.”

—Joe Cantlupe

The Innovator’s Frustration

Clayton Christensen

Clay Christensen’s writings about disruptive innovation—the concept that new technologies often have the potential to turn industries upside down, yet are exceedingly hard for established companies to recognize and harness—gave the Harvard Business School professor status as a management guru in the late 1990s. Manufacturing and technology executives, in particular, read Christensen’s books and sought his advice. Hospitals weren’t part of the discussion, for the most part.

But Christensen always saw the U.S. healthcare system as ripe for disruptive innovation. In 2009, he coauthored a book, *The Innovator’s Prescription*, and entered the public debate on how to fix healthcare. Simultaneously, he experienced a series of illnesses that gave him an unwelcome firsthand view of the healthcare system.

Disruptive technology has altered the practice of medicine many times over, yet the structure of healthcare institutions and the healthcare system has resisted change, to its detriment, Christensen says. “Over time, we’ll need fewer and fewer hospitals. Boards of those institutions need to just remember that the scope of what they need to do is to be responsible for the health of people, not the preservation of the institutions,” he says.

Christensen finds that the national healthcare debate is unhealthy. “I’m frustrated,” he says. “It’s the politicians—it’s not that they are inert or that

they don't want to do it, but they don't have time to sit down and wrap their arms around the problem or the solution, and their mind-set is so fleeting that they want a simple answer.”

—Edward Prewitt

Developing Social Norms

Peter Orszag

Peter Orszag is part of the executive team at one of the world's largest banks now, far removed from his time as director of the Congressional Budget Office and White House Budget director. But his thoughts are never too far away from healthcare.

Orszag was one of the chief proponents of the individual mandate being included in the legislation that became the Patient Protection and Affordable Care Act of 2010. Whether you love or hate the law, Orszag's contention that the individual mandate is the linchpin of the success or failure of the legislation has gained traction on both sides of the political aisle.

“Clearly, the coverage impact depends on the degree to which individuals sign up and whether employers drop their existing coverage,” he says. “And the mandate influences that. But a lot will also depend on the social norms that develop around insurance. If you examine Massachusetts, everyone also thought the penalties were not high enough and no one would sign up. That hasn't happened. Part of the reason that many people have signed up is because a norm was set that you're supposed to sign up, so people do.”

If that seems like shaky ground upon which to build a healthcare system that lowers costs and improves outcomes, Orszag draws an analogy to seat belt use.

“The social norm has developed in a way that you're just supposed to wear your seat belt ... That type of dynamic is going to turn out to be very important in the coverage impact of the health bill. Financial incentives are important, but expectations and norms matter, too.”

—Philip Betbeze

Connecting Human Networks and Human Health

Nicholas Christakis, MD

Trained as both a physician and a social scientist, Nicholas Christakis, MD, PhD, MPH, says his intellectual toolkit spans a broad set of concepts and materials. “I live my life at the intersection of different ideas. I try to see if there are ways to bring knowledge from disparate fields to improve public health and public policy.”

Christakis is a professor of medicine and medical sociology at Harvard Medical School, and is the scientific founder of Activate Networks, Inc.

For the past decade Christakis has been studying human social networks and their effects on health. These aren't Facebook networks. Christakis analyzes the old-fashioned, face-to-face networks that people form with friends, families, neighbors, coworkers, and others.

Christakis says the overarching idea of his social network research is that “people are connected, so their health is connected.” Your individual health depends not only on your own choices and behaviors, but also on the people who surround you, including people you know and people you don't know. Within a network, the fact that a person unknown to you has the flu has meaning for you, explains Christakis. “What this suggests is that we need to think about health interventions in a way that's more collective and not as individualistic.”

Christakis says studying networks is not just an intellectual exercise. “What can we do with this knowledge? We know that germs flow through networks, ideas about drug prescriptions and health practices flow through networks, and behavioral phenomena such as weight gain or smoking cessation flow through networks. How can we exploit this knowledge to intervene in the network to make the world a better place?”

—Margaret Dick Tocknell

The Nurse Practitioner—Run ED

Robert D. Donaldson, NPC

There are times when patients are ushered into the emergency department in tiny Ellenville Regional Hospital in Upstate New York, and they ask: Is there a doc here? “There are no doctors here in the ED. I'm the one you are going to see,” says Robert D. Donaldson, NPC, in his well-worn refrain.

Donaldson is a nurse practitioner, as is every member of the ED staff at the 25-bed critical access hospital, which is in the Catskill Mountains, about 40 miles from Kingston, NY.

So is this really working, a nurse practitioner in charge of the ED staff at the 25-bed critical access hospital? “Yes, there is an answer to that. We are admitting patients, making money for the hospital, and the hospital is in the black year after year. What does that say? The hospital has received an award for its emergency department for patient care. What does that say?”

Donaldson, 68, came to Ellenville in 2004 at a time when the hospital was ailing financially. In 2009, he became medical staff president with 70% of the vote. He could not even vote for himself; only physicians could vote. He says he was becoming popular with the physicians because he did “the entire workup for them, and essentially managed their patients prior to admission. It goes a long way and makes their job really easy.”

While Donaldson has certainly made inroads in how nurse practitioners are perceived in Ellenville, it's still a national problem, he says. He's says

he's still fighting turf wars. "There's a huge medical lobby out there, and they got a huge amount of dollars; they don't really want to hear that nurse practitioners are doing what docs have done," Donaldson says.

—*Joe Cantlupe*

Breathing Easy: Simple Research Solutions

Thomas Hansen, MD

His goal as CEO is to breathe new life into the patients of Seattle Children's Hospital. But that's not enough for Thomas N. Hansen, MD, the brainchild behind the Hansen ventilator, a device that could lead to low-cost care for infants in impoverished places the world over.

Developing countries with limited resources currently lack an alternative for costly mechanical ventilators that can save thousands of infant lives. Hansen's option is a ventilator with fewer parts, but that provides babies with a small increase in air pressure above atmospheric levels and stabilizes the lung. The result reduces the work of breathing and can cut down infant mortality rates.

The project, though consuming, remains a priority for Hansen. If friends could use one word to describe him, it would be workaholic, Hansen says. He spends 60-plus hours a week working as CEO, but still makes ventilator research a priority, dedicating time every Monday for work in the lab.

"The intellectual stimulation of doing research—I can't live without it," Hansen says. "It's very exciting and an opportunity to change the outcomes for patients all over the world. It's a passion that keeps you fresh and enthusiastic and prevents you from being burned out."

Hansen and his team are submitting the ventilator for Food and Drug Administration approval in March, with the goal of releasing the device for use in developing countries by 2014.

—*Anna Webster*

Creating Awareness, Protecting Nurses

AnnMarie Papa, DNP, RN

It wasn't until 2009 that senior hospital administrators really began paying attention to the prevalence of hospital violence, especially that which occurred in the emergency department, says AnnMarie Papa, DNP, RN, CEN, NE-BC, FAEN, president of the Emergency Nurses Association.

That's the year ENA researchers published their first survey of emergency nurses' reports of violent attacks while on the job. The paper was accepted for publication in the *Journal of Nursing Administration*, which meant that the C-suite who read it would learn some disturbing statistics.

"It was an eye-opener for them," Papa says. "Once they read this, they said, 'Wow, this is something we really need to take a look at.'"

Nurses said they were spit on, hit, pushed or shoved, scratched, and kicked in psych units, EDs, waiting rooms, and even in geriatric units.

The perpetrators were usually patients and their family members and visitors.

"Administrators just don't spend a lot of time down there, and nurses never used to complain; they thought of it as part of their job." Additionally, some nurses said they didn't report incidents because of hospital reporting policies that were unclear.

Papa has become a leading voice for this issue, speaking at events internationally and helping format a guideline for hospitals to safeguard their emergency workers.

In 2010, it started to pay off. The Joint Commission published Sentinel Alert #45, Preventing Violence in the Workplace Setting, which called attention to the issue on multiple levels.

Papa says that the past three years have been very rewarding because she feels she's empowering other ED nurses to speak out, and that has made a big difference. "Yes, we're here to care for patients, but we also have to care for each other," she says.

—*Cheryl Clark*

Beyond Emotion: Ethics and Results in Infection Control

Michael Edmond, MD

Back in 2003, Virginia Commonwealth University Medical Center epidemiologist Michael Edmond, MD, realized that the way hospitals try to prevent infections—with active surveillance—just didn't make any sense.

They were testing so many patients for just one type of infection, Methicillin-resistant *Staphylococcus aureus*. If the patients were found to be carriers, they would be isolated, with potential for adverse consequences.

"Isolation is not a benign procedure because it increases patients' risk of falls, pressure sores, and electrolyte disturbances, and we know they get fewer visits from doctors and nurses," Edmond says. And from an ethical standpoint, he says, "Here's a group of isolated patients who don't get any benefit from that, but just bear the burden, because all the benefit accrues to the patients who are not colonized and not isolated."

Instead of testing for MRSA, hospital staffers at VCU focus on central venous catheter insertion bundles, head-of-bed elevation for mechanically ventilated patients, chlorhexidine baths for patients in the intensive care unit, and simple hand hygiene.

The drop in all hospital-acquired infections for all organisms has been remarkable. “From 2003 to the first half of 2011, we’ve had an 86% reduction in infections in our ICUs, from 21 infections per 1,000 patient days to three. We’ve had an 84% reduction in central line–associated bloodstream infections and a 93% reduction in ventilator-associated pneumonias. One of our ICUs has not had a single ventilator-associated pneumonia case in over three years.”

In all, Edmond says, the hospital has saved \$20 million in avoided costs of treating bloodstream infections, ventilator associated pneumonia, and urinary tract infections in the ICU.

Now, Edmond can say with confidence, “it really appears that you don’t have to do active surveillance in order to reduce infections in your hospitals.”

—Cheryl Clark

Orchestrating Care, From Ground to Air and Back

Jeanne Yeatman, MBA, BSN

Coping with the emotional connection to patients is one of the biggest challenges nurses who work at Vanderbilt LifeFlight and similar air-medical programs nationwide face, says Vanderbilt LifeFlight Program Director Jeanne Yeatman, MBA, BSN, CEN, EMT. “You are invited into people’s lives at their worst moments, so you become emotionally connected to the patients that you serve,” she explains. “When you see someone with burns over 90% of their body who is talking with you and you know that you are the last person they will talk to, there is no training for that—no book on what to say. That emotional wear and tear is difficult.”

To help her staff of more than 150 professionals cope with the daily rigors of the job, Yeatman has tried to build a level of self-awareness among LifeFlight crew about dealing with the emotion of transporting such high-acuity patients. For example, when a flight crew has performed CPR or there has been a patient death, Yeatman has found chaplain Ray Nell Dyer, MDiv, BCC, from Vanderbilt Children’s Hospital, who is willing to volunteer her time to reach out to that crew and offer emotional support.

Yeatman is also developing programs at LifeFlight to help improve care coordination among flight crews, paramedics, and ED staff. About one year ago, Vanderbilt LifeFlight launched its iFly program, which strives to help paramedics and ED physicians and nurses learn more about care delivery during the “golden hour in trauma,” Yeatman says.

—Carrie Vaughan

Improving Care Through Accountability and Loyal Relationships

David Fox

In 2004, Advocate Good Samaritan Hospital in Downers Grove, IL, determined it wouldn’t thrive in the future if it kept to the status quo, says David S. Fox, president. So he launched an initiative called Moving from Good to Great. “The strategic intention was to become the best place for physicians to practice, associates to work, and patients to receive care,” says Fox.

At the time, Fox, who comes from family of physicians and grew up working in hospital settings during his summer vacations in Chicago, had no idea that the initiative would help Good Samaritan earn the 2010 Malcolm Baldrige National Quality Award.

The organization established 27 standards of behavior that staff must adhere to. A group of employees and managers created these standards, which are representative of a high-performing and compassionate organization. “We said to the whole organization that we are going to live these behaviors, and anyone—myself included—who doesn’t live these behaviors will be asked to remediate,” Fox says.

The results have been outstanding. Not only has Good Samaritan achieved higher physician, patient, and employee satisfaction rates, which are all in the 90th percentile, but it has improved clinical quality as well. For example, in 2004, Good Samaritan’s outpatient satisfaction score was in the seventh percentile, Fox says. “No change happens without leadership saying, ‘We can do better,’ so we said outpatient satisfaction is going to be important.”

—Carrie Vaughan

Eliminating Pressure Ulcers

Diane Whitworth, RN, CWOCN

Diane Whitworth, RN, CWOCN, has been a wound ostomy and continence nurse for some 22 years. During the past six years, she has become a champion in the nationwide effort to prevent hospital-acquired pressure ulcers.

St. Mary’s Hospital in Richmond, VA, part of the Bon Secours Health System, always looked at its HAPU statistics on a yearly basis, says Whitworth, who is the manager of the wound care team at St. Mary’s. “But it wasn’t a concentrated focus,” she says. Then in 2006, some areas of the hospital were showing HAPU rates at 20%. The national average at the time was roughly 5%–6%, says Whitworth. “We said, ‘This is totally unacceptable.’ We set up a goal and started our journey to zero. It was a pretty lofty standard, but that was the vision.”

To ensure St. Mary's was doing everything it could to prevent HAPUs, it created an interdisciplinary team, including nurses, physicians, dietary, physical and occupational therapy, and quality staff, to review processes and guidelines. St. Mary's also brought in subject matter experts and conducted research reviews.

"It was a matter of realizing we did have an opportunity here, and it was an issue across the country—and that we need to have the focus on what we can do here to make a difference," says Whitworth.

The hospital's HAPU rates dropped from 20% in 2006 to 2% in 2007, and is now around 0.5%. "We started out on a six-lane highway. We had so much out there to improve—we got the low-hanging fruit and improved dramatically in a short amount of time," says Whitworth.

—*Carrie Vaughan*

Dealing With Epidemics, Again

Jim Geary

Jim Geary has been challenging the healthcare system to be better for 30 years.

Geary moved to San Francisco in 1974, and he worked for three years as an attendant on an oncology unit. Later, he found solace as a volunteer for the Shanti Project, a support group for people with life-threatening illnesses. In 1982, while serving as executive director, Geary spearheaded a change in mission, turning Shanti into what's considered the first support agency for the disease that came to be known as AIDS. His efforts played a key role in educating the public and healthcare professionals. Healthcare organizations could do a better job of supporting patients in concrete ways, as well.

"Support groups are as needed today as they were 25 years ago," Geary says. "There's an array of issues that medical personnel cannot really address or don't have the time to address. The patient is not necessarily in need of physiological or therapeutic counseling, but they really want to meet someone who has gone through or is going through a similar experience."

Hospitals should play an active role in forming support groups to lessen the alienation that people newly diagnosed with a disease or condition feel and increase their sense of empowerment, Geary says.

"You treat someone at the hospital and then you send them home, and oftentimes you send them to a home where they don't have that type of emotional support available. They don't know other people with the illness," Geary says. The support group, he adds, "would also have the benefit of empowering patients to be able to articulate more clearly what they need from their doctor-patient relationship."

—*Gienna Shaw*

Investing in Innovation, from the Outside

Rebecca Lynn

Some argue that the healthcare industry is innovation-proof. It is risk averse. It is too slow—even unwilling—to change.

It doesn't have to be that way, says Rebecca Lynn, a partner at Morgenthaler Ventures, a venture capital and private equity firm with offices in Menlo Park, CA. But the healthcare industry isn't going to save itself, she adds. Change will come from outsider entrepreneurs unfettered by the status quo—who can tame the healthcare data beast and who are willing to try new ideas, such as outsourcing some care to patients themselves.

Lynn, who has a background in consumer and finance products and services, has turned her attention to investing in companies that are "reinventing healthcare [and] bringing healthcare closer to the patients, that are making doctors more efficient and better able to do their jobs," she says.

Patients have proven they are capable of tending to their own health issues: Diabetics manage to measure their insulin levels and women take pregnancy tests at home all the time.

So why should it fall to outsiders to reinvent healthcare? Because they "don't know where the walls are," she says. They have a clearer vision of what works in other industries and tend to be more consumer-focused than providers, she adds.

"They don't have an entrenched interest," she says. "There's been a ton of resistance from the industry because they want to preserve the status quo. And that's typical of any industry that's about ready to be changed and reinvented."

—*Gienna Shaw*

Working Hard for a Good Day

Min-Shin Chen

A "good day" for family caregiver Min-Shih Chen is often measured by what doesn't happen for his wife Gloria, 71, who is battling Parkinson's disease.

"A good day for her is there are no incidents. She is cared for. She is content. There are no expected illnesses or difficulties," says Chen, 68, of his wife of 42 years. "It's a good day when I can take sufficient care of her. If my wife has a good day, then that makes me happy."

Chen is one of 65 million Americans—roughly 29% of the population—who provide a total of \$375 billion in uncompensated healthcare each year for a family member.

Gloria Chen was diagnosed with Parkinson's in 2004, and since then it's been a tactical retreat against the relentless degenerative disease. When Gloria, a retired music therapist, was still able to walk, Chen took her to a physical therapist and watched the treatments, using what he learned to help his wife. He devised a set of portable parallel bars in their Ann Arbor, MI, home to help her exercise.

The Chens' life now revolves around four daily "cycles" starting around 8 a.m. and ending around 8 p.m. Each cycle lasts about three hours and involves bathing, feeding, administering medications, rest, and moving Gloria—who has been rendered nearly speechless as the disease progressed—from her bed to her wheelchair, from her wheelchair to her recliner, and back again.

When time allows, he is also a frequent contributor to a website established by the National Family Caregivers Association. "It is my social outlet, my outside contact. Sometimes we have new people join and the first thing they realize is 'Oh, I am not alone.'"

—John Commins

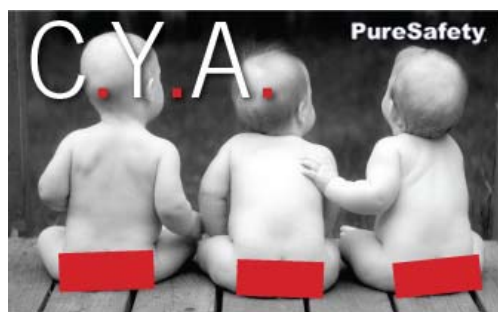
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