Making a Difference

Patients First

NewYork-Presbyterian/Weill Cornell Medical Center

An Interview with Steven J. Corwin, M.D.,
Chief Executive Officer, NewYork-Presbyterian Hospital

EDITORS' NOTE *Steven J. Corwin has held his current position since 2011. Dr. Corwin joined the management team of Columbia-Presbyterian Medical Center (today known as NewYork-Presbyterian/Columbia University Medical Center) in 1991 and served in various management capacities. From 2005 to 2011, he served as Executive Vice President and Chief Operating Officer. A cardiologist and internist, Dr. Corwin received his undergraduate and medical degrees from Northwestern University, summa cum laude. He completed training in internal medicine and cardiology at Columbia-Presbyterian Medical Center and was named to the faculty of Columbia University College of Physicians and Surgeons in 1986.*

Steven J. Corwin

INSTITUTION BRIEF *Located in New York City, NewYork-Presbyterian Hospital (nyp.org) has academic affiliations with two of the nation's leading medical colleges: Weill Cornell Medical College and Columbia University College of Physicians and Surgeons. NewYork-Presbyterian provides state-of-the-art inpatient, ambulatory, and preventive care in all areas of medicine, and is committed to excellence in patient care, education, research, and community service at six major centers: NewYork-Presbyterian/Weill Cornell Medical Center, NewYork-Presbyterian/Columbia University Medical Center, NewYork-Presbyterian/Morgan Stanley Children's Hospital, NewYork-Presbyterian/The Allen Hospital, NewYork-Presbyterian/Westchester Division, and NewYork-Presbyterian/Lower Manhattan Hospital.*

What makes NewYork-Presbyterian so special and how has it remained so consistent in quality?

Prior to the merger of the hospitals, New York Hospital was founded by royal charter in 1771. Presbyterian Hospital was founded in the 1860s, so you're talking about a long tradition of excellence for the two hospitals that then came together as NewYork-Presbyterian.

From the board on down, the sentiment that started at the time of the merged enterprise in 1998 is that this should be a preeminent academic medical center. We're doing this to sustain academic medicine in New York, and we want this enterprise to represent the best quality, patient care, and patient satisfaction.

Instilling our value system and culture into every employee is critical to the organization's success. Our goal is to put the patient first all the time. Our physicians understand this, and our mission is to provide great care for everybody who walks through our doors.

Is it tough to differentiate in this space?

Ultimately, any hospital exists for public benefit. I hope we do it better than others, but we stress to everybody that whatever anybody else is doing is irrelevant to what we need to do. This means that every time you encounter a patient, the same standards and the same set of values apply. While this is not easy to do for 23,000 people, that is our culture.

How do you drive the service culture throughout the organization, and how do you put metrics in place to make sure you're meeting your standards?

As a patient, you are automatically in a stressful situation. So if someone is empathic enough to put themselves in your position and feel like they are treating a family member, then that reflects the service aspect of the industry we want to represent. We reduce patient anxiety, and we give them comfort, and we're encouraging and optimistic – this is a huge part of getting better.

People always take the technical expertise at a place like ours for granted. We're very proud of that. But if you combine that with real service, then it makes a difference.

Does technology detract from the personal relationships?

It can, but it doesn't have to. The technology should be of benefit to patients and staff. When it comes to electronic medical records and electronic systems, we're not as productive as we need to be, but that will get better over time.

Imagine if you have an electronic system that allows a nurse to spend 20 percent more of his or her time at the bedside – this is what we strive to do.

With our technology, we want to bring information to the clinicians' fingertips; we want them to be able to spend more time with patients.

Any time you introduce technology, the potential is that people will feel separate from the human interaction. But we try to flip that on its head – we want people to feel that technology enables human interaction.

Are there certain core focuses for the hospital or do you cover all disciplines?

Great academic medical centers need to be comprehensive because people look to them to solve very complicated problems and cure unusual diseases, as well as common ones.

So we pride ourselves on our comprehensiveness.

But as with anything else, we try to look at the things that kill the most people. We spend a lot of time on heart disease, cancer, and the neurosciences, but we also spend time on unusual diseases that only an institution like ours has seen or can treat.

Are you happy with the progress in battling the most difficult medical challenges and are we on the right track for more breakthroughs?

Yes. The narrative in this country which implies that the health care system is broken is wrong. Yes, there are aspects of our system that need to improve – prevention needs to improve; the ability to care for patients after they get home from the hospital needs to improve; the ability to provide the continuum of care needs to improve. Until now, hospitals have been responsible only for what happens in the acute hospital setting. We're expanding ourselves outside of that.

We have significant initiatives to improve prevention in our communities and care after someone leaves the hospital.

I think the progress we have made is tremendous. But we're still spending too much money as a country. We have to figure out how to reconcile innovation and progress with efficiency and to constrain the costs we're spending on health care in the U.S.

Is prevention getting the attention it deserves?

Imagine if nobody smoked in this country. Imagine if people understood the value of proper diet and exercise. There are clearly huge long-term benefits to every one of us living a healthier lifestyle and trying to avoid disease.

But also, when people get sick, if you give them proper instruction, you can prevent a recurrence of that disease.

In our health care system, 20 percent of the patients drive 80 percent of the costs. If you can take care of those people with chronic and multiple diseases well, and limit

their need to be in the hospital, this is a huge advantage.

We run a large community initiative called the Regional Health Collaborative for the Washington Heights and Inwood communities. We have achieved a 20 percent reduction in emergency room visits and hospitalizations of patients who have extremely complex medical conditions.

I also think it's important that people understand that a mental health problem associated with a disease can double or triple the cost of caring for that person because of medication compliance and other issues.

So as a country, if we can put these preventive aspects in place before someone gets sick, we can save a significant amount of money.

We have taken that challenge on at NewYork-Presbyterian, and many of my colleagues around the country have as well. It's incumbent upon the academic centers to focus on it.

Are you happy with where the physical product is today?

We're a very capital-intensive industry. We constantly need to look at not only new technologies to acquire but also at the age of our infrastructure and of our buildings.

We're constantly looking to build new facilities that reflect the ability to carry on and perform modern medicine.

We're constantly looking at our infrastructure investments, our information technology investments, and our investments in buildings.

Our information technology has to operate 24/7 and can't go down; the same is true of our infrastructure.

Our energy expenditures increase over time as we develop new technologies, so we have to be very careful about the way we design buildings with large power plants to satisfy the energy needs of a large institution.

We are conscious of all of this. Much goes into making sure patients are safe and comfortable.

Does the medical profession still attract the top talent it requires?

We are clearly attracting the best minds in the country, and we are training terrific young men and women at our institution who are dedicated – the country is in good hands.

That said, we have to be very careful about how much pressure we place on our physicians in terms of how many patients they have to see during a day.

We have to consider if they can make an adequate living and whether it is a job they can still find rewarding. This occupies a lot of our time.

A lot of physicians are reluctant to go into primary care because it's extremely demanding physically and the remunerations are more limited, and that is something we have to deal with.

The biomedical industry in this country is the leader in the world. At times, the narrative can suggest the system is broken in this country. No one would argue with the fact that the training system in the U.S. for physicians is the best in the world. We are asked by other countries to help train their physicians.

So we need to keep that training program intact. We need to make sure that medicine is attractive to young men and women. It's a noble profession. It's great to take care of people and make them better. It's a great mission-driven exercise, and it's something people have a calling to do.

But we have to be careful as we try to extract efficiencies out of the system, and we have to make sure the cost parameters of the system meet with the macroeconomic picture.

Is it imperative that your workforce mirrors the diversity of your patients?

Two-thirds of our workforce are minorities. We believe strongly in diversity. We also believe that people coming into this workforce should have the opportunity to advance themselves. We help people to educate themselves and move through obtaining advanced degrees. We encourage our nurses and all other employees to get advanced degrees.

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We think careers in health care are rewarding and a great source of jobs. These are jobs you can't outsource – jobs that require great education and technical expertise. We have people who started out as housekeepers and ended up in management.

We like that our workforce is diverse and mobile. From the entry level on up, we try to promote from within, and that happens about 65 percent of the time. We want people to feel there is mobility here.

There is always an opportunity to recruit someone from outside who can bring a different perspective, and there is always that balance, but we think it's important that people feel that they can be promoted and advance here as they grow.

We're an elite institution in terms of the type of care we deliver, but we're not elite in terms of who we deliver that care to. We exist for the public good in this city and we want New Yorkers to feel, if they come to us, that they can access the very best care. About 30 percent of our patients are Medicaid, 30 percent are Medicare, and 40 percent are commercially insured, and we're very proud of that. You can walk into our emergency room and no matter what coverage you have, you will get a single standard of care.

How do you guard against complacency?

We're an aspirational culture. We're not going to rest. We're cognizant that things can change quickly. There is a lot of pressure on the health care dollar, and we have to deliver value every day we come to work. We tell that to our doctors all the time and they're with us 100 percent, and our employees are as well.

Have we addressed the key issues in health care reform and is true reform taking place?

To start, you have to address access to care – we have to insure more people. We can't reduce the cost of care in this country unless we insure more people because people have to get preventive care.

We have to deal with the cost issue – our cost structure has to go down.

We also have to deal with quality – the quality of our care is good but it has to get better, and universally better.

In addition, we have to deal with all three of these simultaneously because they are inextricably intertwined.

The good news about the Affordable Care Act is it tried to deal with all three of those issues. The bad news is that trying to change a fifth of the GDP of this country is very difficult to do in the first iteration.

So we're going to go through a period of time where this iterates itself and things will change. It's unfortunate there wasn't a bipartisan approach to increasing insurance coverage; it was unfortunate that there wasn't a bipartisan approach on the cost; and I think that a 2,000-page bill is hard to digest when you're dealing with a fifth of the economy.

But a public/private partnership addressing insurance, making sure people have access to care, insisting on quality, and insisting on cost reduction efforts, will pay off.

The insurance industry, the providers of care, and the government have to work together. I don't see a single-payer system as being effective in this country. Using private insurance, the providers, and the government is the right approach. We have to work through this in a bipartisan way.

In the future, will there be just a few very large health systems?

There will have to be some consolidation in the industry because, inevitably, you get into the issues of scale and trying to have uniformity and quality, as well as reductions in cost. You can't do it if you have a series of stand-alone institutions.

What we can't lose in that consolidation is competition, and we also can't reduce quality.

This is true in the insurance industry as well as the provider industry.

But I do think there will be a move to consolidate, and it's appropriate to do so. ●