INTERVIEW

Interview With Ramanathan Raju, MD, FACHE, FACS, President and CEO of NYC Health + Hospitals

Ramanathan (Ram) Raju, MD, FACHE, FACS, is president and CEO of NYC Health + Hospitals, the largest municipal healthcare system in the nation. Dr. Raju was appointed by Mayor Bill de Blasio in January 2014 to lead the 42,000 employees of this $7.2 billion health system that provides essential services to 1.4 million New Yorkers, including more than 425,000 uninsured patients every year.

Dr. Raju was a practicing vascular and trauma surgeon in Brooklyn for 25 years before serving as the chief operating officer (COO) and medical director at NYC Health + Hospitals/Coney Island. In 2006, he became NYC Health + Hospitals chief medical officer (CMO), corporate COO, and executive vice president. During his tenure, the system earned national acclaim in quality, patient safety, and healthcare data transparency.

From 2011 to 2014, Dr. Raju served as CEO of Cook County Health and Hospitals System in Chicago. Under his leadership, the healthcare system secured a Section 1115 Medicaid demonstration waiver from the federal government, resulting in the creation of the CountyCare health plan and the system’s financial and strategic transformation.

Dr. Raju has been recognized as one of Modern Healthcare’s 100 Most Influential People in Healthcare (2014 through 2016), 50 Most Influential Physician Executives (2013 through 2016), and Top 25 Minority Executives in Healthcare (2012 through 2016), as well as one of Becker’s Hospital Review’s 20 Hospital and Health System Leaders to Follow on Twitter and Chicago United’s Business Leaders of Color.

Dr. Kash: Your education and training as a surgeon and business professional is unique. How did you end up as president and CEO of NYC Health + Hospitals?

Dr. Raju: When I was growing up, most medical students around the world would say they wanted to go to America because it has the finest medical education and training. As a student in India, I was no exception. I knew the United States was, and remains, the epicenter of medical education.

By the time I came to the United States, I was already a surgeon, trained in India and England. I wanted to pursue a medical and academic career that included education, teaching, and research. I followed what I considered the best advice for a young surgeon: research, teach, and take care of patients. I eventually became chief of surgery at a hospital in Brooklyn.

A turning point in my career occurred in the mid-1990s as Medicaid managed care began in New York State. Hospitals in Brooklyn, including Lutheran Medical...
Center where I worked, sought the best managed care rates by aligning with large academic medical centers in Manhattan. Lutheran decided to partner with other local hospitals and create a market club to obtain a better rate for managed care, but that partnership did not work out well.

A consultant hired by the hospital proposed drastically reducing the number of operating rooms to increase efficiency. As director of surgery, I believed that would be problematic because reducing the number of operating rooms meant the loss of coveted 8 a.m. start times and difficulty in recruiting and retaining surgeons. I was concerned that we might lose surgical volume to neighboring hospitals. To counter the consultant’s proposal, I suggested the hospital create a Level I trauma center. Such centers are usually busy in the late afternoon and evening and at midnight. Conventional wisdom holds that trauma centers lose money, but I believed that our trauma center would make money because of its geographic location. The hospital was situated near the intersection of two busy highways. I predicted that we would start receiving many patients with blunt trauma (motor vehicle accident) injuries, which, unlike penetrating trauma (gunshot wounds or stabbings), brings in revenue. The hospital’s board of trustees told me I had to reach 500 admissions annually to break even, but during the first year, our new trauma center received close to 1,500 admissions.

As predicted, almost 84% of the trauma cases were caused by motor vehicle accidents, not gunshot wounds. The trauma center became lucrative financially and remains so today. With that success, I became interested in the profit-and-loss of the trauma center: how to develop a successful operating strategy, how to handle marketing, how to engage staff. As the head of a Level I trauma center, I was responsible for all these things. If I wanted to earn the respect of hospital administrators, I needed to understand how a hospital is run. With that objective in mind, I left the hospital and earned a master’s degree in business administration. When I returned, my first job was as CMO, but I quickly became the COO. Normally, when physician executives in hospitals become CMOs, they excel at medical affairs. But to be a leader, a physician must understand operations.

As COO, I learned about laundry, meals, labor contracts, onboarding, human resources, supply chain, contracting, and so forth. Eventually, I became COO at Coney Island Hospital in Brooklyn and then COO and CMO of the entire public hospital system during the Bloomberg administration. So my trajectory as a healthcare leader began with a trauma venture and grew into managing a more cost-effective operation on a broader, hospital-wide scale. So I have been a practicing physician, surgeon, frontline hospital leader, medical educator, COO, and, ultimately, CEO.

That breadth of experience over many years enables me to make decisions and interact with the healthcare system’s COO as effectively as with the chief human resources officer or chief quality officer. I understand the issues they face, instead of knowing a lot about medicine but not a lot about the complex operations involved in managing a modern hospital. I understand how meals are placed on patients’ trays...
and how the linen gets laundered and processed. It is important for me to know these things.

**Dr. Kash:** *Share your philosophy on population health and your system’s efforts to keep people healthy.*

**Dr. Raju:** As a young physician, I believed that if I could keep my patients healthy and everybody else in healthcare did their job as well, the entire population would be healthy. That was naïve thinking. I discovered the degree to which the country is beset with healthcare disparities. Why is the mortality rate higher and the longevity rate lower on the south side of Chicago than on the north side? Why do patients with diabetes who live in Brooklyn experience more complications than those who live on the Upper East Side? Eventually, I realized that a caregiver’s dedication alone is not determinative of a patient’s health. Environment also plays an important role. A patient’s zip code matters in addition to his or her genetic code.

Initially, I thought the best way to deal with this disparity was to increase the number of clinics in underserved areas. We tried this model in Chicago when I ran the public health system there. We opened 136 primary care access points across Cook County to eliminate disparities. But this initiative did not make a significant dent in the disparity level. We postulated that perhaps the emphasis should have been on culturally competent access points. However, after many decades, we could not produce a healthcare workforce in this country that looked like the patients we served. The people who provide healthcare in this country are different from those who receive it. To bridge this gap, we tried teaching people to be more culturally competent, but a half-hour training session is insufficient. I considered the possibility that healthcare workforce diversity might be a better, more effective way to reduce health disparities.

After many years of trial and error, I have come to believe that providers cannot deliver healthcare in isolation, because health depends heavily on socioeconomic factors that are traditionally outside the medical silo. In other words, if you decide to establish a health clinic, need is no guarantee that the clinic will succeed. You must ensure the public’s safety in and around the clinic, have adequate public transportation to the clinic, make available nutritious food in the neighborhood, and have sufficient employment and educational opportunities for people in the community. We as healthcare leaders cannot concern ourselves with medical issues alone; we must also be social change agents.

In the past, if you wanted to open a clinic you found a location, erected a sign outside, hired a couple of nurses and physicians, and pronounced the clinic open for business. Now, before opening a clinic, we conduct a comprehensive assessment to determine if the location’s public transportation is adequate. We work closely with the police to determine whether the neighborhood is safe and the lighting is adequate. We also investigate how the neighborhood is served by the nearest supermarkets. All of these factors are taken into consideration when deciding where to locate branches of New York City’s public healthcare delivery system. To put it bluntly, there
is no point in keeping a patient with diabetes in stable condition if the chance of his or her getting shot outside a clinic is higher than the risk of dying from the disease.

Before delivering healthcare, we must get out of the C-suite. We need to figure out the community’s needs in terms of healthcare and how it can access that care. The burden, of course, is on the public system because the private systems will locate healthcare where people can pay for it, which is much easier.

**Dr. Kash:** How can other health system leaders learn from your experience of caring for a large population of uninsured patients?

**Dr. Raju:** Many healthcare leaders sought equal healthcare access in the fight over the Affordable Care Act (ACA). I applauded its passage because I strongly believe that healthcare is a fundamental right and a civil right, and it should be a constitutional right. Although the ACA expands access to healthcare, the law that emerged from Congressional horse trading did not cover everyone. A great many uninsured people remain. Undocumented immigrants are specifically excluded from coverage under the ACA. A second group, whom I refer to as “young invincibles,” cannot imagine becoming ill or being injured and, thus, forgo purchasing coverage. Others cannot afford the premiums, even at the subsidized rates under the ACA, so they would rather incur the penalty than buy insurance. These groups constitute the still-sizeable uninsured population, and many of these people live in New York City.

In response, NYC Health + Hospitals offers charity care through our “Options” plan, which is heavily discounted or free. If we do not coordinate care for uninsured people and they do not have a medical home or an identified plan with their physicians, they are not going to go away. They are going to obtain very expensive care in the emergency departments (EDs) of various hospitals.

Primary care offered in the ED is much more expensive because emergency physicians are trained to look at the most life-threatening situations first. For example, if a patient with a headache sees a primary care physician, the physician is probably going to check the patient’s blood pressure and history, prescribe medication, and tell the patient to return in a week if the symptoms persist. If the same patient visits an ED, the physician might order a CT scan of the head because of concern about bleeding in the brain. Because the uninsured do not have a primary care home, they end up in the ED. My advice to healthcare leaders is this: If you have a group of uninsured people in your system, connect them to primary care. You will be giving them better care and better health while reducing healthcare costs tremendously.

**Dr. Kash:** What are the three most challenging issues that the U.S. healthcare delivery system will face in the next 3 to 5 years?

**Dr. Raju:** First and foremost, disparity in healthcare. On one end of the spectrum, the best medicine is being delivered. People come to the United States from all over the world to access this care. But around the corner, people are dying from disease. They do not receive the proper examinations, so they die of breast cancer.
They die of diabetes complications. They lose kidneys and end up on dialysis because their condition went untreated. The United States has a two-tiered healthcare delivery system. One group of people—usually the affluent—receives the best available care, and the second group of people receives inadequate care because they happen to be poor and live in places where healthcare is not available. Delivering high-quality care to all populations continues to be U.S. healthcare's biggest challenge.

Our second challenge pertains to the rapidly changing demographics in this country. Population models predict that by 2040 or 2050, the Latino population will be the biggest demographic group in the United States. Healthcare needs to recognize this and plan for it because care providers should look like their patients. If we want more Latino physicians, we need to make sure that schools offer better education, that kids don’t drop out of school, and that they are able attend college, medical school, and residency programs. Creating a diverse workforce will take years, perhaps a decade or longer. Healthcare leaders can serve as role models for promising students. Many healthcare systems, including the one I lead, are making great strides, but we need to do more. NYC Health + Hospitals is vigorously participating in a youth leadership program, and senior staff members are mentoring young Latinos to follow a healthcare leadership career path.

The third challenge facing us is financial. Healthcare costs are very high largely because of waste and a lack of coordination among providers. During the past century, we developed the mind-set that we can offer the best healthcare to everybody, irrespective of cost and insurance status. Our new mind-set should be that cost-effectiveness and quality are not mutually exclusive.

**Dr. Kash:** What core skills and competencies make a hospital administrator effective in today’s environment?

**Dr. Raju:** People need to understand that we are in the business of healthcare, not in the healthcare business. Unfortunately, the core skills developed by healthcare leaders often relate more to the business aspect than to the health aspect.

We cannot lose compassion for the people we treat. That compassion—caring about people—should remain paramount. Healthcare is probably the noblest profession because we meet people in the most difficult moments of their lives. I pursued a career in healthcare primarily because of the chance to reach people in these moments and offer them a helping hand. Unfortunately, in this highly competitive environment, delivery systems are evaluated not by the social good they do but by metrics such as days cash on hand. This situation is distressing because it is not what healthcare should be about. I am not suggesting that leaders should not be effective and control costs, but doing so should not be at the expense of people’s care or their lives. The core skill is heart. Heart is what makes great healthcare executives.

Healthcare leaders also need to understand the communities they serve. An academic arrogance has persisted for many years; we suggest to patients that healthcare is complex and they should listen to us because we are the experts. We must let
go of this mind-set, and drill down to really understand a community’s needs and how we can best serve its members.

Hospitals and healthcare systems need to stop concentrating on cutting into competitors’ market share and start focusing on how they can collaborate with competitors to deliver better healthcare. I hope the day will come when evaluative tools, bonuses, and promotions in healthcare focus on the competencies that value social consciousness and well-being. I do not know if I will see it in my lifetime, but that is what healthcare should be about.