

BROOKINGS

QUALITY. INDEPENDENCE. IMPACT.

The Path Forward for Academic Medical Centers: Innovation, Economics, and Better Health

April 27, 2009

Agenda

10:30-10:35	Welcome and Inspiration for Project	Mark McClellan, The Brookings Institution Susan Cullman, Mount Sinai Hospital
10:35-10:45	Overview of Academic Medical Centers (AMCs)	Mark McClellan, The Brookings Institution
10:45-11:35	Vision for the Future of Academic Medical Centers <ul style="list-style-type: none"> • Overall Vision • A System's Perspective on Better Coordination of Care and Prevention • A Provider's Perspective on Better Coordination of Care and Prevention 	Ken Davis, Mount Sinai Medical Center <ul style="list-style-type: none"> • Victor Dzau, Duke University Health System • Elaine Ullian, Boston Medical Center • Joel Allison, Baylor Health Care System
11:35-12:25	Achieving the Vision Through Health Care Reform	Mark McClellan, The Brookings Institution
12:25-12:30	Closing Comments and Next Steps	Mark McClellan, The Brookings Institution

Objectives of Meeting

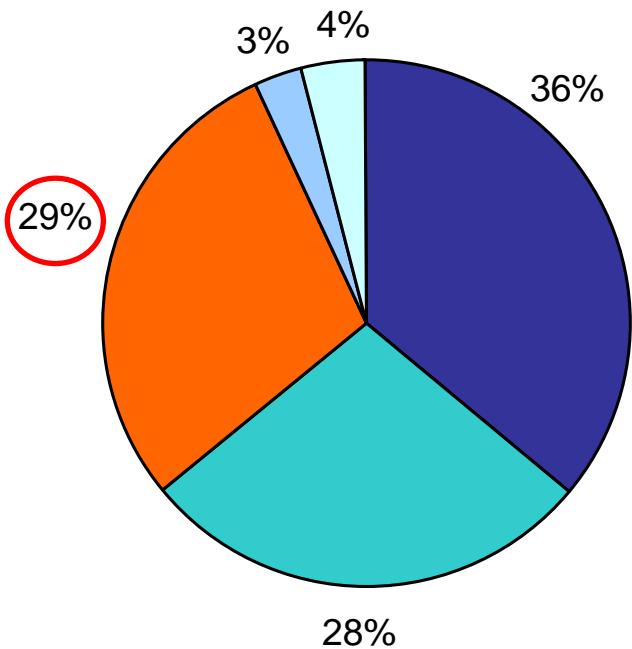
- To describe the current challenges faced by academic medical centers (AMCs)
- To begin to shape a vision for the future of AMCs
 - » That reflects the unique role in care, teaching and research of these organizations
 - » That reflects how AMCs can best fit into health care reform, with the emphasis on reliable coverage, higher quality care, and fewer avoidable health care costs
 - » That builds on promising initiatives and reforms that AMCs are implementing

Advisory Board Members

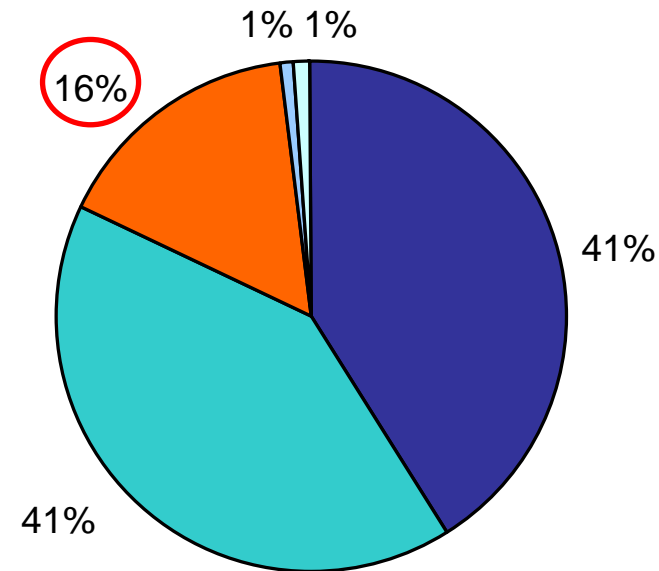
- **Joel Allison**, President and CEO, Baylor Health Care System
- **Anne Beal**, Assistant Vice President, Health Care Disparities, The Commonwealth Fund
- **Toby Cosgrove**, President and CEO, Cleveland Clinic (*not present*)
- **Ken Davis**, President and CEO, Mount Sinai Medical Center
- **Victor Dzau**, Chancellor for Health Affairs, Duke University and President and CEO, Duke University Health System
- **Gary Gottlieb**, President, Brigham and Women's/Faulkner Hospitals
- **George Isham**, Chief Health Officer and Plan Medical Director, HealthPartners (*not present*)
- **Thomas Lawley**, Dean, Emory University School of Medicine
- **Edward Miller**, Dean, Johns Hopkins School of Medicine and CEO, Johns Hopkins Medicine
- **Russell Robertson**, Professor and Chair of Family and Community Medicine, Northwestern University Feinberg School of Medicine
- **Nancy Schlichting**, President and CEO, Henry Ford Health System
- **Reed Tuckson**, Executive Vice President and Chief of Medical Affairs, UnitedHealth Group
- **Elaine Ullian**, President and CEO, Boston Medical Center
- **Tom Valuck**, Medical Officer and Senior Advisor, Center for Medicare Management, CMS
- **Mark Miller**, Director, MedPAC (*Ex-Officio Member, not present*)

AMCs Serve Vulnerable Populations

Academic Medical Centers



Minor Teaching and Non-Teaching

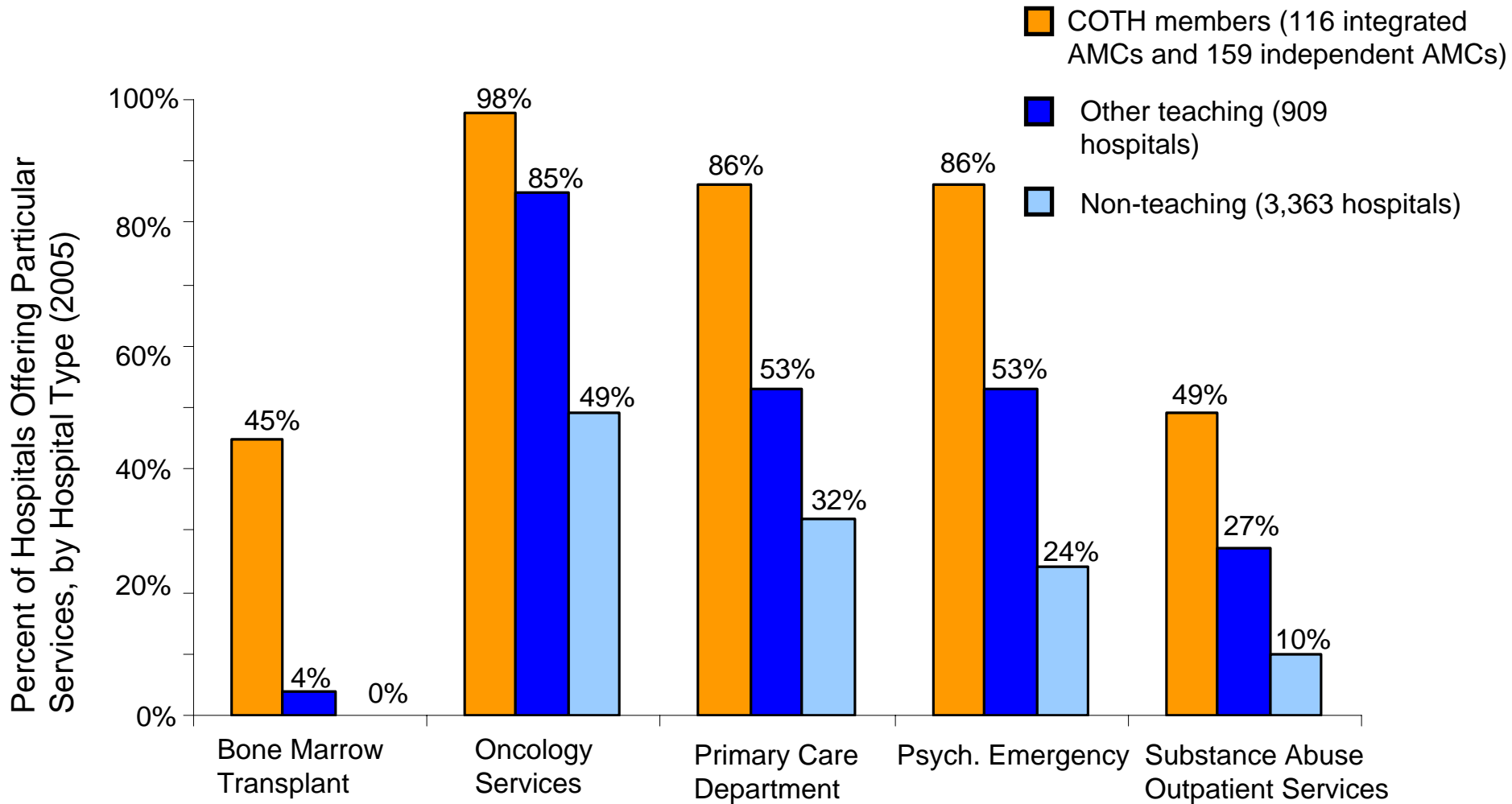


- Private payer
- Medicare
- Medicaid and uncompensated care
- Other government
- Other expenses

Includes reported community hospital data only.

Uncompensated care cost consists of the sum of bad debt and charity care charges converted to costs by hospital specific ratio of costs to charges.

AMCs Provide Distinctive Services

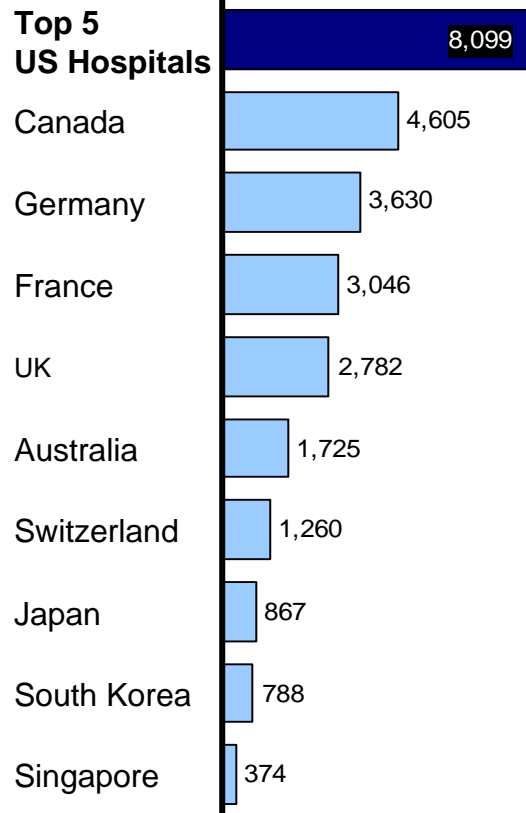


AMCs Foster Medical Innovation

U.S. AMCs are a dominant source of biomedical research

Clinical trials by country

Number of trials



- **Treatments developed and perfected:**
 - » Successful transplants, including bone marrow, liver, pancreas, hand
 - » Angioplasty and balloon angioplasty
- **Devices created:**
 - » Self-powered, implantable artificial hearts
 - » Insulin infusion pump for diabetics
- **New departments opened:**
 - » Intensive care unit for newborns
 - » Pediatric trauma centers
- **Scientific discoveries made:**
 - » Production of recombinant DNA

AMCs as Economic Hubs

- The medical schools and teaching hospitals that are part of AAMC were estimated to have a direct economic impact of approximately **\$196 billion** in 2005.
- AAMC members employed approximately **1.7 million full-time-equivalent people** in 2005.



Mayo Clinic

- Minnesota's largest private employer, with 30,000 employees in Rochester alone and several thousand more in the regional health system

Cleveland Clinic

- Ohio's second-largest private employer, with 37,350 employees

Biotechnology Centers

- California, Massachusetts, and North Carolina

Better Care on Average at Teaching Hospitals

- **The most rigorous studies suggest that major teaching hospitals provide better care on average than non-teaching hospitals.**
 - » Including for common conditions
 - Some conditions studied include: heart attack, congestive heart failure, post-operative events
 - » Still room for improvement
- **There is significant variation *among* AMCs in the amount of care they provide.**
 - » High treatment intensity does not equal higher quality care, even at AMCs.

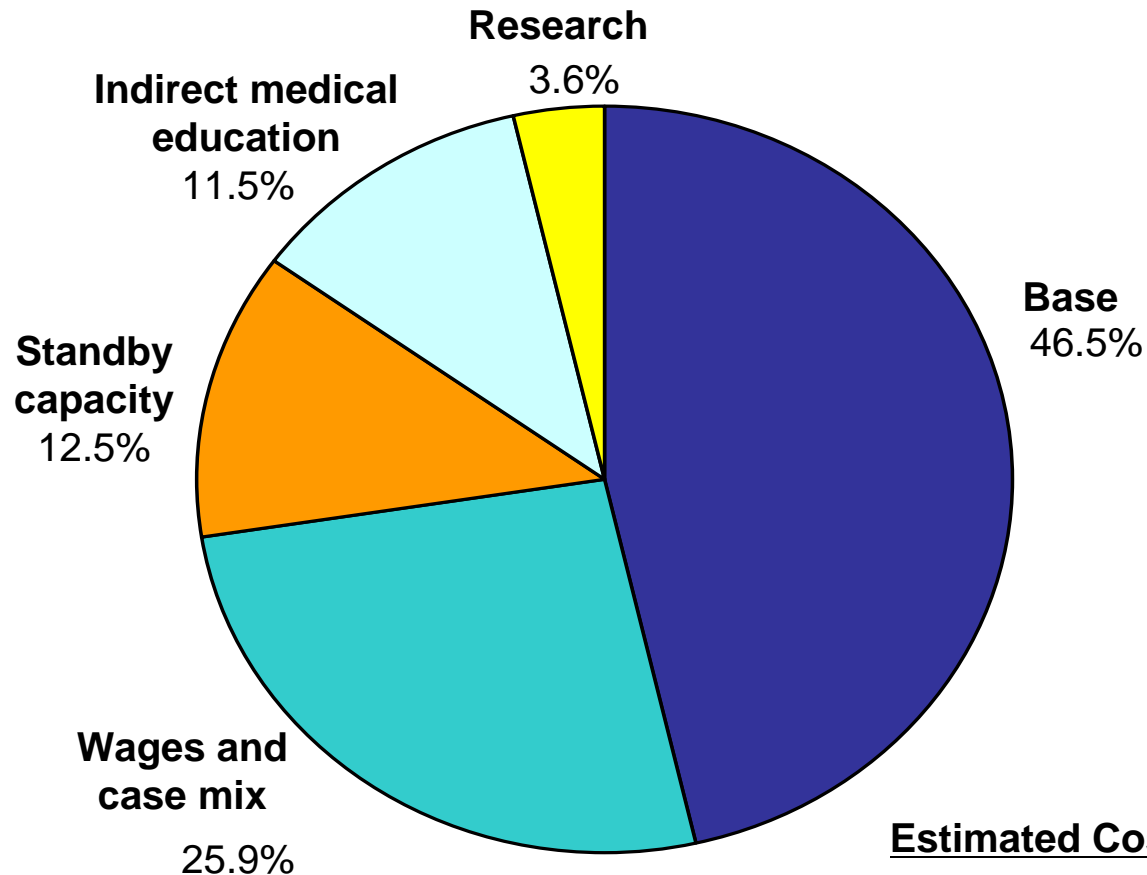
Large Variations in Treatment Intensity Among AMCs

	<i>UCLA Medical Center</i>	<i>Massachusetts General Hospital</i>	<i>Mayo Clinic (St. Mary's Hospital)</i>
Biologically Targeted Interventions: Acute Inpatient Care			
CMS composite quality score	81.5	85.9	90.4
Care Delivery and Spending Among Medicare Patients in the Last Six Months of Life			
Total Medicare spending	\$50,522	\$40,181	\$26,330
Hospital days	19.2	17.7	12.9
Physician visits	52.1	42.2	23.9
Ratio, medical specialist/primary care	2.9	1.0	1.1

Mission-Related Sources of Revenue for AMCs

Safety Net Care	<ul style="list-style-type: none"> • Disproportionate share hospital (DSH) - Medicare and Medicaid
<p>91% of major teaching hospitals received DSH payments in 2004.</p> <p>After ARRA, Federal Medicaid DSH allotments available to states are estimated to have increased by \$269 million to approximately \$11.34 billion in FY 2009.</p> <p>CBO estimates that Federal Medicare DSH allotments will amount to \$9.8 billion in 2009.</p> <p>State and local government spending on Medicaid DSH totaled \$7.5 billion in FY 2006.</p>	
Research	<ul style="list-style-type: none"> • NIH Grants • Private philanthropy • Industry
<p>At the 20 medical schools that conduct the most research, federal grants make up 80-85% of research revenues.</p> <p>\$1.1 billion for comparative effectiveness research in the American Recovery and Reinvestment Act (ARRA)</p>	
Training	<ul style="list-style-type: none"> • Direct Graduate Medical Education (GME) • Indirect Medical Education (IME)
<p>100% of major teaching hospitals received IME payments in 2004.</p> <p>Medicare paid out \$6.0 billion for IME and \$2.9 billion for GME in 2007.</p>	

Components of Mission-Related AMC Hospital Costs per Case



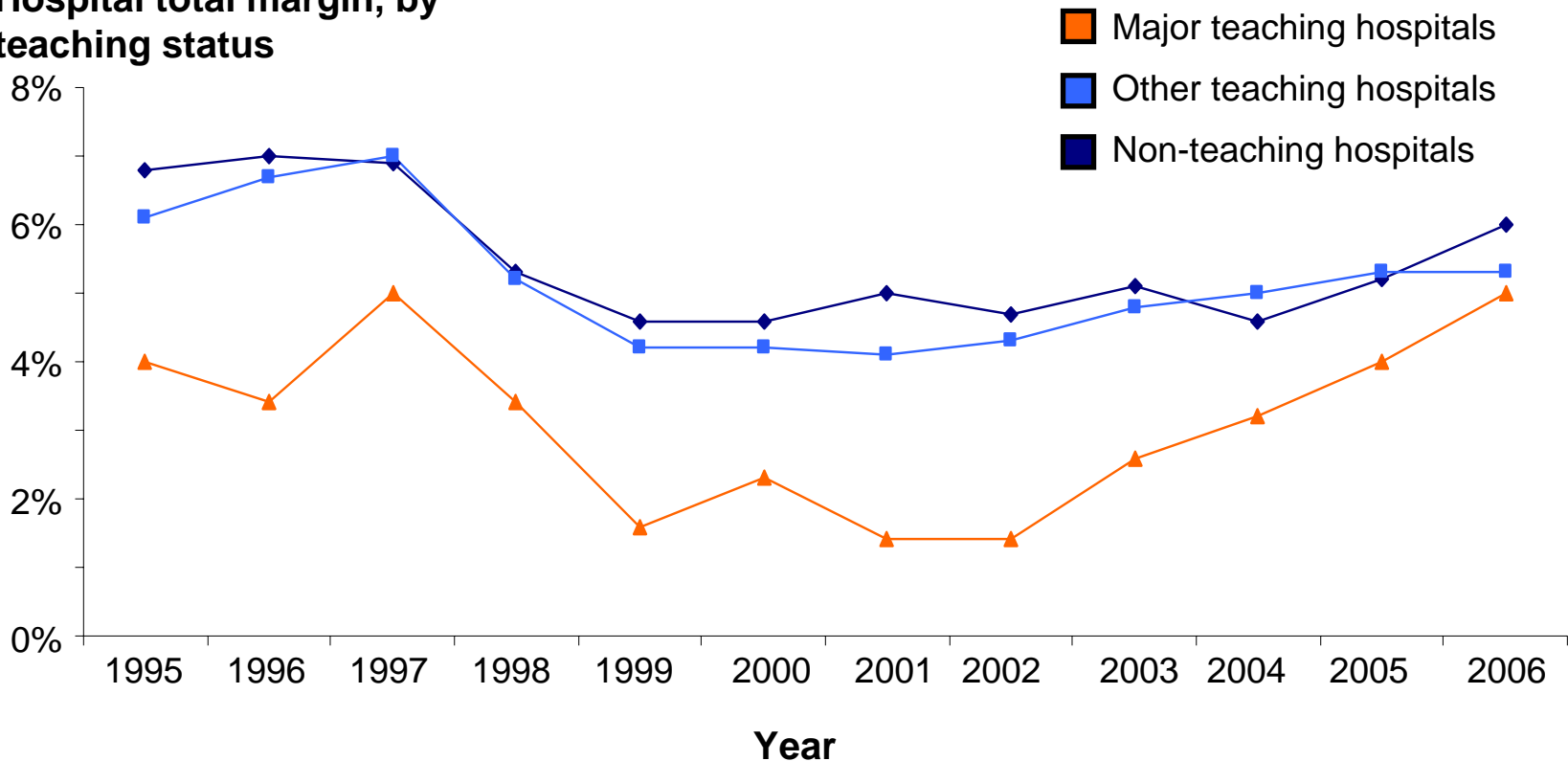
Estimated Costs of care per case at:

AMCs: \$8,817

All hospitals: \$4,928

Major Teaching Hospitals Have Lower Margins than Other Hospitals

Hospital total margin, by teaching status



Distinctive AMC Activities in the Context of Health Care Reform

- **Safety Net Care**
 - » Council of Teaching Hospitals and Health Systems (COTH) hospitals make up 6% of all hospitals and provide 41% of charity care
- **Research**
 - » 56% of NIH extramural awards were given to COTH hospitals/AAMC medical schools (2006)
- **Training**
 - » 76% of residents trained at institutions that are members of COTH (2006)

Vision for the Future of AMCs

Topic	Speaker
Overall Vision	Victor Dzau, Duke University Health System
A System's Perspective	Elaine Ullian, Boston Medical Center
A Provider's Perspective	Joel Allison, Baylor Health Care System

Questions for Discussion

- What should be the vision for the future of AMCs?
- How do we achieve this vision?

Key Challenges of Health Care Reform

- Reforming health care delivery
 - » Overuse, underuse, misuse
 - » Gaps in coordination of care
 - » Gaps in evidence
- Coverage reform
 - » Affordable, reliable options in non-group coverage
 - » Sustain employer and public coverage
- Individual responsibility and support
 - » Prevention and chronic care management
 - » Coverage
- Financing

Improving Health Care Delivery: Distinctive AMC Issues

- Quality and cost measurement
- Accountability for value in payment and benefit reforms
- Effective models of coordinated, innovative care
- Comparative effectiveness
- Predictive medicine

Examples of Recent Reforms

Evidence development

- \$1.1 billion for comparative effectiveness research in the American Recovery and Reinvestment Act (ARRA)
 - » IOM report on National Priorities for CER this summer
 - » Creation of a Federal Coordinating Council for Comparative Research

Accelerating biomedical Innovation

- \$10.4 billion to NIH in ARRA
 - » Approving more R01s
 - » Targeted supplements to current grants
 - » New NIH Challenge Grants Program
 - » Intramural and extramural infrastructure: buildings, labs, instruments

President's FY 2010 Budget

- » \$6 billion to NIH for cancer research
- » Part of multi-year plan to double cancer research funding

Possible Elements of Coverage Reform

- Combination of Medicaid expansion and new subsidies (refundable credits) for individuals not eligible for employer or public coverage
- Insurance exchanges
- Possible new requirements for individuals to obtain coverage
- Possible “Play or pay” fees for employers

Financing

- Savings from delivery reforms – unlikely to be sufficient
- Reforms in tax treatment of employer health insurance
- Medicare, other public health care financing sources
- Possible “Play or pay” fees for employers
- Other revenue or cost savings sources?

Next Steps

- Two-year timeline for analysis and reports
- Interim meetings and findings on key topics as part of health care reform
- Final report expected in fall 2011

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