

THE BROOKINGS INSTITUTION

THE PATH FORWARD FOR ACADEMIC MEDICAL CENTERS:
INNOVATION, ECONOMICS AND BETTER HEALTH

Washington, D.C.

Monday, April 27, 2009

PARTICIPANTS:

Introduction:

MARK B. MCCLELLAN

Director

Engelberg Center for Health Care Reform

Leonard D. Schaeffer Chair in Health Policy Studies

PANEL: VISION FOR THE FUTURE OF ACADEMIC MEDICAL CENTERS

Moderator:

KEN DAVIS

President and CEO

Mt. Sinai Medical School

Panelists:

VICTOR DZAU

President and CEO

Duke University Health System

ELAINE ULLIAN
President and CEO
Boston Medical Center

JOEL ALLISON
President and CEO
Baylor Health Care System

DISCUSSION AND NEXT STEPS: ACHIEVING THE VISION THROUGH HEALTH CARE
REFORM

MARK B. MCCLELLAN
Director
Engelberg Center for Health Care Reform
Leonard D. Schaeffer Chair in Health Policy Studies

* * * * *

P R O C E E D I N G S

DR. McCLELLAN: Good morning, I'd like to ask to everyone to take their seats. We're going to try to get started in just a minute please.

(Pause)

DR. McCLELLAN: All right. That was a very fast-responding group. Thank you, all, very much. So, I'm going to use that opportunity to get started just about on time.

Good morning. I'd like to welcome you all to the Brookings Institution, to this event sponsored by the Engelberg Center for Healthcare Reform with support from the Coleman Family Foundation on "The Path Forward for Academic Medical Centers."

We have a lot of ground to cover today because the role of academic centers in healthcare reform is both critical and I think underappreciated at this point in what is a very complex, yet very important and unique opportunity for improving our healthcare system if we do it right.

This project is intended to help play a role in bringing ideas about a vision for the future of academic medical centers together with a vision for the future of our healthcare system. One: there is strong bipartisan support for a vision with much more affordable and available healthcare, higher quality, better organized care, greater efficiency in

healthcare delivery, all very admirable goals, but all goals that have proved very difficult to achieve.

For this project, we hope to identify and develop some specific policy approaches, some specific supporting analysis to identify ways to address the challenges facing academic medical centers, especially those serving a disproportionate share of lower-income and uninsured patients that, at the same time, helps provide a better path forward for healthcare reform because, let's face it, the academic institutions in this country, and not only the leaders in the nation, but the leaders in the world, of where our healthcare tends to go.

So, today, we're going to lay out some foundations for this work. We're going to review and assess the challenges facing academic medical centers in the 21st Century and try to identify some promising directions forward. In doing so, we're going to put a particular emphasis, as I said, on effective ways to care for vulnerable Americans, including innovative models for delivering quality care at a low cost and any needed reforms in payment and other regulations to go along with that. We're also going to put a special emphasis on the role of academic medical centers in developing innovative approaches to care. That includes both innovative types of medical therapies and innovative ways of delivering these treatments. And then, obviously, academic medical centers play an essential role in medical education and training, another area where there's a big gap between where we'd like to be and where we are.

To support all this effort, as I mentioned, the Coleman Family Foundation has been critical, and I'd like to recognize Susan Coleman, who's here with us in the front of the audience.

She's a trustee at Mt. Sinai Hospital. I met her and her father, Edgar Coleman, about a year and a half ago, and that was really the genesis of this project, is their firm commitment to improving the role of academic medical centers, and this stems from I think about a century and a half of family involvement with Mt. Sinai in New York and firsthand experience with the challenges and opportunities going on there.

So, Susan, thank you very much.

I'd also like to introduce the rest of our group up here today. These are some members of the advisory board for this project, who represent a diverse range of backgrounds, including a diverse range of academic medical centers.

We're going to spend the first few minutes just with an overview from me on these efforts. As I said, our objectives include identifying the challenges, but especially focusing on the opportunities for the future, starting with a vision for the future of academic medical centers from several of our participants here and some discussion around that. We want to use that as a foundation for discussing the policy reforms that are going to be essential to get there and that are unquestionably on the table as part of the current healthcare reform effort.

We have a very distinguished group of advisors as part of this effort. Many of them are here today or most of them are here today.

I'm not going to go through the bios at this time. You'll get a chance to hear from them shortly, and you should have in the materials prepared for this meeting copies of background information on all of our advisory board members who you'll be hearing from shortly.

So, what I'd like to do is get right into a discussion of the issues at hand. I'm going to start out with a brief overview of some of the issues facing academic medical centers, and then we're going to turn to some presentations and discussion around a vision for the future of AMC. You're going to hear from some of the people who are leading these efforts and living these efforts from several different perspectives and several different AMC settings. Then we're going to turn later on in today's session to the interaction between healthcare reform and these possible better visions for the future of academic medical centers. We're going to close out by talking about next steps from here.

So, just to get started on this, I emphasized one of the key roles at academic medical centers in this country is to serve vulnerable populations. These centers are probably best known for their leadership and research and training. We're going to talk about that, as well, but they do have a critical role, as these statistics show, as a lynchpin of our healthcare safety net, compared to minor teaching hospitals and particularly the non-teaching hospitals, academic medical centers, the major teaching hospitals in this country, serve substantially more Medicaid patients and substantially more uninsured patients. This means that healthcare reform could have a big impact on making available better

coverage for these populations, but could also have some potentially concerning effects.

And, by the way, you all should have copies of all these in your packets. So, don't strain your eyes looking up at the screen.

This next slide highlights some of the distinctive services that academic medical centers provide, and, again, they are probably most famous for the more complex, cutting-edge services, such as bone marrow transplantation and advanced oncology services, which they disproportionately provide. COTH has counseled teaching hospitals. It makes up many of these major teaching hospitals.

In addition though, they also provide many services that go along with this complex and vulnerable patient mix. So, disproportionate representation and providing primary care services and providing psychiatric emergency services and providing substance abuse and outpatient services. Not as appreciated, but goes along with this key role of providing care for some of the most vulnerable patients in this country.

Well-known is that role of academic medical centers in fostering medical innovation. They are leaders. This statistic, taken from a McKenzie survey, highlights that the top five teaching hospitals in this country perform substantially more clinical trials than most other countries. In fact, in most other countries combined.

And there really is a disproportionate representation in clinical research of U.S. academic medical centers, over half of the Nobel Prize winners in medicine, for example, over the last 30 years, were

affiliated with these U.S. institutions. And there are some examples of some of the recent innovations and important innovations developed by these U.S. academic medical centers.

Obviously, these centers also have an important economic role, accounting for close to \$200 billion per year in direct economic impact from these academic American association medical colleges' medical centers' activities. They're important economic drivers; they're a main reason why healthcare is continuing to grow through our current, severe, economic downturn. And there are some examples on this slide, some of which are represented here on our advisory board, as well. So, this economic impact is very important.

There also is some evidence on quality of care at teaching hospitals, and this slide summarizes some of the good news, that a number of studies suggest that major teaching hospitals provide better care on average than other types of hospitals, including care for common conditions like heart attack, congestive heart failure, post-operative complications.

It's important to emphasize though that there's still substantial room for improvement. In fact, what the quality studies have shown, as many of you know, is lots of variations, so, there's some academic medical centers that perform very well, some that are doing a bit less well, just as there are for other types of hospitals, so, a lot of gaps that can still be addressed, a lot of variation in performance.

And this is reflected in resource use or treatment intensity, as well. This is a slide summarizing some well-known work from our collaborators at Dartmouth, Elliot Fisher and his colleagues. It's showing big variations in intensity of care and cost for patients near the end of life and in patients who are receiving more intensive biologics and other types of intensive care.

As a general matter, academic medical centers also use a lot more resources than other types of hospitals, as well, and I'll talk about that more in a second.

This brings up the issue of where do the revenues come from, and there are some important and distinct funding sources for academic medical centers, as well, which we'll be discussing today. Distinctive sources of funds for safety net care.

People are familiar with the so-called disproportionate share hospital payments, the DSH payments in Medicare and Medicaid, which go disproportionately to the major teaching hospitals that have this higher burden of providing safety net care, and there have been some changes to these payments recently, but, altogether, this is about \$17 billion, \$18 billion of funding per year.

In addition, academic medical centers obviously get a disproportionate share of the research funding. This includes not only NIH support, but also private philanthropy, industry support, and this has been an active issue in recent healthcare reforms, as well, particularly with the

increase in NIH funding and the increase in the new funding for coordinated comparative effectiveness research.

Finally, academic medical centers are the main target, the main recipient of special training funds, direct medical education funds and indirect medical education funds, DME and IME in the Medicare Program, or, perhaps, the best known part of this, Medicaid funding, Medicaid payments for medical education are also important, and have been the subject, as well, of a lot of policy debate in recent years. About 200 teaching hospitals account for over two-thirds of all of these IME payments, which collectively amount to, again, \$17 billion, \$18 billion per year, so, a substantial amount of resources.

As I mentioned, the costs are somewhat higher or considerably higher at academic medical centers, as well. The bottom-right of this slide, the estimated difference in average cost per case at academic medical centers versus hospitals overall, and you can see that there is a substantial difference. There are a number of contributors to this. Patients at AMCs tend to have more complex health needs. If you look at the number, wages, and the skill level of professionals on the healthcare teams, it's higher at academic medical centers. There also are these other special mission-related costs that we've already mentioned, such as training and education and teachings, such as research, such as having a standby capacity or some specialized capacity for these more complex procedures, and there are the other hypothesized reasons, as well, that academic medical centers tend to treat a given case more

intensively, and maybe because of all these factors, they're less efficient in the delivery of care. So, costs are a big issue here.

Higher costs mean that higher revenues per case don't translate into larger margins for teaching hospitals. That's what this graph shows. This compares teaching hospitals to other types of hospitals over time. Teaching hospital margins, the orange line, actually, they've been lower, though they've been training upward recently towards the margins for other types of hospitals.

And I want to highlight some of these distinctive academic medical center activities in the context of healthcare reform.

So, we've mentioned these earlier: Safety net care, where there's a disproportionate contribution of medical centers. Research, where there's a disproportionate contribution of medical centers. Training. All of this is part of the critical mission of AMCs. So, this is just to provide a little bit of context as we go into a much more concrete discussion about the current activities and especially the challenges and opportunities going forward for academic medical centers, so, a lot of issues ahead.

Our goal today is to move beyond these kinds of basic facts and the challenges toward promising directions for the future of academic medical centers as part of a brighter future for our healthcare system.

Now, for this next part of our meeting today, Ken Davis from Mt. Sinai is going to lead this component, which is going to have, again, a more concrete discussion of the challenges facing AMCs and what they're

doing about it, led by some people who live these issues and lead on these issues every day.

Ken's session is on the vision for the future of academic medical centers. Ken is the president, the chief executive officer of Mt. Sinai Medical Center. You can read more about him in his bio sketch. He's worked for a long time previous to this as the chairman of the Mt. Sinai Department of Psychiatry, and he has led the Mt. Sinai through a period of significant growth and significant change, as well as been a leader in many scientific fields and recognized as one of the most highly-cited researchers on his own fields of research.

So, Ken, let me turn this over to you.

MR. DAVIS: Thank you, Mark, and I want to thank Susan Coleman for making this possible and Al Engelberg for creating Engelberg Center. It's great to be here.

So, my goal today is just to moderate this panel on the future of the AMCs. We're going to begin with three, brief statements by three of our prominent members of the panel: Victor Dzau from Duke is going to be first talking about his overall vision. That will be followed by Elaine Ullian from Boston Medical Center, and then Joel Allison from Baylor, the Baylor Healthcare System. Following their comments, I'm going to make a few comments, then we're going to have a discussion among ourselves, and, at the end of that for five or so minutes to respond to your questions.

So, Victor?

MR. DZAU: Thank you very much for inviting me and for setting this stage, if you will, for the overall vision. What I'm going to do is certainly speak from my perspective what I think academic medical centers should be thinking about in healthcare reform. Admittedly, some of my comments are related to what we're doing at Duke, and may not easily be transferable to all academic medical centers, but I think with healthcare reform, there's an opportunity for us to think about how the reform itself, if you buy the vision that I'm going to propose to you, can actually enhance the movement of academic medical centers towards that direction.

So, I think you all know about the challenges of healthcare, high-cost and access. The issue of fragmentation with care is important because there are so many handoffs from physician to physician, primary care to specialty care, hospitals, from tertiary to community hospitals. It is a real problem.

And I think the other area I want to emphasize because it's the lack of infrastructure and incentive for prevention, which we all agree would be a very important way for the future, a way to reduce healthcare cost and improve health, there are significant difficulties in developing new innovation, and, of course, we have persistently held in the qualities both locally and globally.

Now, President Obama, during his election campaign and now has identified that reform is one of the most important issues in his administration, and this morning, we heard from Bob Kocher a little bit

about choice, cost, and the quality. I think access, obviously, is another very important one, and prevention, as well.

I won't go over the eight principles of reform that he's talked about, except to point out that in order for him to realize his reform, he certainly proposed \$600 billion healthcare reserve fund over the next 10 years. Half is going to come out from reduced tax breaks, but the other half clearly has to come out from the system, Medicare, Medicaid, and I think a lot of money we take in our system, we would expect that academic medical centers would be affected in that regard.

Now, because you also hear from Senator Bachus' plan in which a number of areas academic medical centers is important: primary care, training, and reimbursement, quality, community models of care, use of IT, and others.

So, I think for academic medical centers, irrespective of what the reform looks like, the question is: Will we either react and defend or are we going to be proactive and lead? My feeling is that we need to do the latter.

This slide shows you the kind of pressure the academic medical centers face. We are blamed for contributing to the increase in costs because the government budget is tight and demand for care and service is rising. The public is pretty frustrated with the inefficient healthcare delivery system that we have today, and, certainly, there is an erosion of public trust and demand for more accountability.

My feeling is that, given these challenges, academic medical centers must change from a traditional model of the tripod(?), tri-mission(?), as know it (inaudible) in research, education, and care for those who come through our doors, evolving to, in fact, a model where we're called an academic health system.

This system should provide not only the traditional tripod, tri-mission, but, also, clinical care beyond those four walls, hospital clinics, to the community to improve community health. It should develop new models of delivery, including, as we discussed briefly, team-based approach and use of information technology. It should do research that certainly increased the translation of discovery into novel therapies and diagnostics, investigate new approaches to community and population health, and train people for the future that actually supports the direction we want health to go.

I think it's also important to recognize the academic health systems' community leaders, as well as an economic driver. I guess one in eight people nationally are employed one way or the other in healthcare.

So, the question is: How should we do this?

I think to do so, the academic medical centers must be engines of innovation and care and move seamlessly from bench to bedside to population. This requires, I believe, some significant changes in organizational priorities and structures that can overcome the existing fragmentation of research and care, and enable a seamless integration

from discovery to translation to community health, what we call the innovation care continuum.

So, I know there are many different models to approach this, and, certainly, the key issues to break down existing silo structures and develop system integrators. So, I think it's also important to fund partnerships, so, they create true networks and the focus mission that involves, in fact, not only translation, but also improve community health and eliminate (inaudible) qualities.

So, one of the issues, for example, in thinking about how academic centers, as Mark says, that do discovery and how it can move quickly, seamlessly, towards a product that can ultimately influence community health is the idea of creating integrators.

So, for example, I'll show you in this slide on the top panel the kind of handoffs one sees today. One has a discovery of trying to move it all the way to adoption and community practice and eventually having an impact on global health.

Below, you can see what we've done in Duke is to start experimenting by creating a number of integrators, what you call institutes. From bench to bedside, the Duke Translational Medicine Institute. From bedside to the community, the Duke Center for Community Research. And from local to global populations, the Duke Global Health Institute.

And what these institutes do is to try to help navigate and project manage any kind of opportunities at any point across the institution using IT call facilities and even internal venture funds so we can move

innovation quite seamlessly from implementation to sustainable impact on health. These are also reasons why we've gone out to partners, while external organizations, such as Research Triangle Park, and, globally, India, China, and Singapore.

So, this idea would be that we can actually internally be a pipeline that can move discovery quickly to reduce the time that it's taken in multiple handoffs. And here's a structure that shows you about the core competency that enables a discovery and any innovation, whether it's actually clinic, et cetera, to move towards a community practice.

Care delivery also needs to be integrated, and, by this, I will say a vertical integration. That is from tertiary care hospitals to community care hospitals to community practices, and from specialty care to primary care to home care and community-based programs. This, again, needs an evolution of a classical, academic medical center where it brings people through, sees people that comes through the walls to an academic health system. This is an integrated delivery system that creates a network of hospitals and practices aligned by quality and practice standards, shared goals and incentive, and connected by information technology, and also in close partnership with the community.

So, this is, therefore, what I called a vertical meets horizontal integrated matrix where you have a clear government structure, an ability to move things kind of seamlessly.

I just want to finish by talking about three areas that I believe are important for us to consider. One is personalized medicine, which I

believe will be a very important driver for the future. Here, what I want to point out is an academic health system needs to now begin to not only do research, but begin to practice this, and also educate its providers.

Second is models of care. I think you hear a lot of discussion of how primary care can be developed. My feeling is if we have a health system, we are the innovators that can try different ways of primary care.

In this context, in North Carolina at Duke, we've had the Community Care of North Carolina, which actually started in 1997, and they use a medical homes approach, a team-like approach, using social workers, nurse practitioners, community workers. And if we look at 2007, we've saved Medicaid in North Carolina \$150 million, and by estimate, \$200 million from the match from federal. And physicians are paid in this case to do care coordination, to oversee care coordination. They're paid \$2.50 per member per month, and it works. So, I think that's another issue about creating the right incentive and create a team-based approach towards this approach.

Education needs to be also looked at in this context. I believe that education needs to go well beyond physician education to team-based education that involves a team-like approach when we think about team care delivery. So, in fact, as we think about and we're doing this in our curriculum, by bringing PAs, nurses, physicians, and other allied health people to look at how we can have team-based learning.

I'm going to end by pointing out the fact that, of course, ultimately, I think the ideal way to go for academic medical centers is to evolve from that to a health system, to I think what Mark and Elliot Fisher called an accountable-held organization. In this case, an academic, health-accountable organization that actually can be responsible for a population that it serves in this community, and it was mentioned today at Hopkins, and we have such a model, by which we can look at how we can share incentives and also being able to look at reimbursement in this fashion by either directly within the system or in partnership with people in the community.

So, that, I believe, is my presentation. These are just backup slides. Thank you.

MS. ULLIAN: Good morning, everybody. I'm Elaine Ullian. I'm going to be using warrior discipline to do this in five minutes because I'd like to keep you here until August to talk about the Massachusetts Experiment. So, I will quickly go through my slides.

Two seconds of background about Boston Medical Center.

Imagine merging L.A. County and UCLA 13 years ago or a Health and Hospitals and NYU. That is what we did 13 years ago, when we put the city hospital system in Boston, we privatized it, and then merged it with the B.U. Medical Center System.

You saw a slide earlier by Mark that showed that 29 percent of academic medical center volume is Medicaid and uninsured. At our

institution, it's 51 percent are below the federal poverty level. Fifty-one percent of our patients, and we're a full academic center.

So, I'm going to talk to you a little bit about healthcare reform, and the reason why is that everywhere I go, not only in Massachusetts with my beloved Senator Kennedy, but everywhere in this city, I hear that Massachusetts is the template for the U.S., and I say holy smokes.

(Laughter)

MS. ULLIAN: So, the five principles of healthcare reform, and then I'll focus on the one that's affected academic medicine most.

Is near universal coverage? That is true. I'll tell you how they did it. They took away all the money from the poor to buy it. They took all the disproportionate share money, as you saw in one of Mark's slide, \$7.5 billion in state funds go to hospitals that care for the poor. They took that money from us and said they would buy insurance instead, and the way they would do that is they would pay us \$1 for \$1 for Medicaid. Medicaid, a lousy payer; all of you know that. The government is usually not a good partner when you're delivering care. But the promise was that we would pay you fairly, it would create a competitive environment so the patients would win because we would all be seeking to care for those patients because we were all going to be paid our costs. Did not happen. So, the Medicaid rate issue never came through.

Business does its share, and, ladies and gentlemen, it has, and this is a wonderful part of the success story in pushing its employees

to do coverage or paying a penalty, and they were the fifth element, is cost and quality, and they've done nothing on that respectfully.

So, just briefly, and you have my slides, the coverage is a wonderful story. Over 400,000 people have coverage who didn't before, everybody doing their fair share. The two problems with the low-income coverage is that it's a manual system designed to be impossible to get on and stay on because that's how you hold you spend-down, and the churning that goes on is unbelievable: 10,000 people come on the system and 10,000 people come off the system every month. Every month.

So, if you're the hospital treating Ms. Jones for lymphoma, and she fell off the rolls this week, then you're not going to get paid. If she shows back on the rolls 90 days from now, you will get paid. Is this the system we want in this country?

So, this slide just shows you that, though everybody has sort of jumped into the pool, 57 percent of the Massachusetts experience has been in subsidized products, products that are for people 300 percent above the poverty line or below that. It has been a success statewide, we're a very small state compared to many of you, but everybody enrolled, as we say, everybody took advantage of this wonderful program from a public policy.

So, I want to talk about the money, because, respectfully, it's always about the money, because how can you care for your patients if you have no money?

So, Massachusetts took the safety net funding away from us, saying don't worry, everybody's going to have \$1, and we're going to pay you \$1, and then what they did is they said sorry, we don't have enough money for the \$1, so, instead, we're going to pay you 70 cents, which is taking everybody backwards.

For my institution, because it took care of so many poor people, they're paying us 64 cents on the dollar. So, the business and quality piece continues to be sort of a work in progress, business is happy, nobody's looked at quality.

And just to talk a little bit about our academic center. We understood this was a new day, a new paradigm, and, possibly, a new world for our medical center, and we jumped in with both feet. We enrolled more people in the product than all the other hospitals combined in Massachusetts. All the other hospitals combined. So, to say that we were a willingly partner is an understatement.

We personally serve 150,000 low-income people, and separate from that, we have the largest Medicaid health plan in Massachusetts, and, interestingly enough, Governor Romney, who was sort of the godfather of this plan, was the one who said, Elaine, you're going to do so well because we're going to use your health plan as the template for going forward.

So, why are we down to 64 cents on the dollar, ladies and gentlemen? We are down because this system was never funded adequately; we said it from day one. We then had the Urban Institute

come collaborate the dollars, and they said well, there's somewhere between \$700 million and \$1 billion short, number one, never enough money. The Commonwealth grossly underestimated the number of uninsured who would step forward. They thought 135,000 poor people. It was 175,000 poor people. And, ladies and gentlemen, they were sick. They were not 28-year-olds who just were not spending their money on insurance and going to Cabo. They were 54-year-old cranberry-pickers who were having their third bout of cancer. They were 62-year-old people who didn't qualify for any other benefits and came back very sick.

So, we look at, as we go forward, losing next year, starting July 1, \$220 million of our \$800 million revenue stream. A successful, full, highly-rated institution is at the precipice.

And my last slide tells you the whole story about Massachusetts healthcare reform. The bars at the top show you the number of people that are coming to our institution who are poor. You will see green is uninsured, the yellow represents the new product, the fantasy that people with the card would run to the fanciest hospital that never catered or welcomed them before has been proven to be a fantasy, but what you see is that our blue line shows our costs have gone up 4 percent a year, not bad with 10 union contracts, ladies and gentlemen, but our costs, our reimbursement is the red line, and the gap between the blue and the red is why we are facing an unsustainable business model as a very successful academic medical center.

So, that's my healthcare reform story for Massachusetts.

(Laughter)

MR. DAVIS: Elaine, thank you for that cautionary tale.

(Laughter)

MR. DAVIS: Joel is going to tell us about the Baylor Health System and why Texas wants to secede from Massachusetts.

(Laughter)

MR. ALLISON: Thank you, Ken, and good morning. I really appreciate the opportunity to be with you and thank you for the invitation to participate in this very important and timely conversation.

We are located in Dallas, Texas. We are still very much a part of the United States.

(Laughter)

MR. ALLISON: And my hope is to remain that way for quite a bit of time.

But, seriously, you do have our slides, and I would like to share with you today and talk about what we refer to as Vision 2015, as we have tried to anticipate what will the new model of healthcare look like as we go forward and how will we change in how we deliver healthcare and what does that mean to an academic teaching facility like Baylor?

Our vision is straightforward, it's to be trusted as the best place to give and receive safe, quality, compassionate care. We are an integrated delivery system with 15 owned, 1 leased, and then 4 affiliated hospitals throughout the 10 counties that serve the Metroplex. We have six short-stay hospitals, we have 18,000 employees. We have an

employed physician group, Health Texas Provider Network, with 485 employed physicians, and we operate 100 clinics across the Metroplex with Health Texas. They are responsible for 1.2 million medical charts throughout the Metroplex. That's about one in five of the population that our physicians serve. And then we have 3,000 independent physicians that serve us across the Metroplex through out facilities, as well.

Baylor University Medical Center, which is a 1,000-bed, flagship hospital, is the teaching center. We also have a family medicine residency program at our community medical center, Baylor Garland. We are also a disproportionate share hospital. We're a safety net hospital, and one of our challenges is how do we continue to meet the needs of our communities in these changing times around the reimbursement?

As I mentioned, we have 35 total teaching programs. Eighteen of them are sponsored by Baylor University Medical Center and ACGME-approved. Three are shared with the University of Texas Southwestern Medical School, which is in Dallas, and then we have 10 that are approved by the Texas Medical Board, the American Dental Association, our board specialty approvals. Currently, we have 210 house staff, and you can see how those approvals break down.

What is the ideal care process? And this is what we envisioned 2015 to look like because our mission has really been around developing clinical excellence supported by education and research. We also have a wonderful research institute that's a part of the Baylor Healthcare System, with over 800 clinical trials going on throughout our

system at any given time. And what we talk about is how we will provide primary, secondary, tertiary care, focusing on prevention as we go forward with risk appraisal, preventive schedules, health information, the patient's access to medical records, new therapy information, and protocol review. We also, because of our relationship with Health Texas, can move into the ambulatory setting with outpatient care, and, again, all this being underscored by connectivity and the electronic health record. We have primary and specialty care provided. It's seamless access that we hope to achieve for scheduling, payer support, prescription refills, specialty referrals, preoperative education, better leading practices, best practices, staff workflow tools.

Moving on then into the inpatient setting that we could provide care for our defined population, again, with all aspects of care as we look to a coordination of the care of the patient. It's emergency, elective, easy registration. Again, make it seamless for the patient. Reduce the redundancy, which there's a lot of the excess cost in healthcare. Home medical clarification for pre and post-hospitalization. We know we're responsible for the patient both coming into the hospital, post discharge. Patient family care maps and improve consultant communication, and, again, best practices in care management. And then post acute care, when they go either to a skilled home care setting or to the home, how do we support that through our connectivity and with our primary care physicians in creating the medical home, and then getting

back to focusing on prevention and wellness? And, again, this is what we see as the future.

All of this puts the patient at the center, and the center is what we concentrate is on what we call STEEEP. Those are the six aims that came from the Institute of Medicine study. To err is human, and we measure how we're doing on Safe Care, Timely Care, Effective Care, Efficient Care, Equitable Care, and then, most of all, Patient-Centered Care, to create the ideal patient experience.

And what we hope to achieve with our vision is to create ideal care for the patient, and you can see where we have made significant investments in our commitment to quality in creating the ideal care model with the chief quality officer. Our board of trustees' commitment to quality, we used the word STEEP, advised consultation with other leading systems. And then we have a chief medical officer and a chief nursing officer for the system.

This also is very important work that we're doing, and that's through the Institute for Healthcare and Research Improvement. The Center for Health Care Improvement is really one that leads our rapid cycle effort. Dr. David Ballard heads this up, and you can see the different commitments that we've made to move this agenda forward around the patient and around training, and I want to mention that we're looking at a new model of education because how are we going to continue to pay as a faith-based, voluntary, not-for-profit hospital for medical education and research, and you can see that we are attempting to move from a

continued healthcare improvement to do training. Nurse training. We had the Baylor University School of Nursing on our campus. Medical education, another clinical education in our non-clinical staff, and how do we learn evidence-based practices and in to post-graduate practice options for clinicians?

They can go into Health Texas, learn how to deliver community health. I think there's a model of teaching or going to independent private practice become hospitalists or work in our emergency care centers. And then they ultimately can become physician champions for us, and we make significant commitment on how we do that on investing on not only in medical education, but how we can continue to improve care for our communities that we serve.

And you can see we have 80 paid physician champions. Some are Health Texas provider network physicians, some are non, to really help us advance clinical excellence, and you can see what has happened as a result of the work that we're doing with our community-based focus in working in a new model of care that is really responsible for a defined population. And we've been recognized for the work that we're doing in this new model of integrated care, being a teaching hospital with a lot of work in the communities, and how we can improve the care of the communities that we serve.

DR. McCLELLAN: Thanks.

MR. DAVIS: Thank you, Joel.

So, I think we've heard a composite, compelling vision of what academic healthcare centers should look like going forward. We'd like to sustain what we do so well, which is take care of the sickest patients, be a place that patients come for miracles, be a place where the indigent can be served. Additionally, be a place that trains the next generation of clinicians. Trains them from all over the world. But, as Elaine talked about, we can't do that unless we have a sustainable business model, and the bottom line for lots of academic medical centers that sit in urban and underserved areas is there is no sustainable business model.

At a national level, healthcare expenses can rise by some 4 to 6 percent, and revenues for Medicare and Medicaid, in a good year, rise by 1 to 2 percent. That's an equation that doesn't equate. So, what are we going to do and what's at stake?

What I see is at stake is an extraordinary opportunity in biomedical research. Our country has invested an extraordinary amount of money through the NIH and to the Genome Project and the spin-offs that come from that. The advances that we see in the laboratory of molecular biology, cellular biology, and genetics open up an extraordinary potential for new therapeutics and new diagnostics. It's likely when the history of our time is written from the perspective of perhaps 100 years from now, what will be seen is a time in which medicine actually revolutionized humanity. There is a real possibility that can happen, but there's also a real possibility that our generation will lose that window

because the academic medical centers sit on such a fragile foundation and have so often an unsustainable business model.

So, my vision? My vision is really rather simple. I'd like to continue doing everything that we're doing because I think we're doing that relatively well, and, in addition, add the kind of integrated healthcare systems that our colleagues from Duke and Baylor talked about, the high quality care that we'd like to have, and we know we can do a better job, but, at the same time, do it in the context that provides us with a sustainability that we can exploit what are the opportunities that mankind now has at its fingertips?

So, with that, I'd like open it to the panel to talk about your vision of what you think academic healthcare centers should look like.

Reed?

MR. TUCSON: That was an interesting summary, Ken, and very, very impassioned.

Just to be a little provocative, let me sort of just -- and, obviously, I'm one of the panel, so, I am a true believer and a cheerleader for academic centers.

It's easily argued that continuing to do what academic centers have always done is a little bit like just running the boat into the iceberg. As a society, and I think the society is making a clear statement, we're not getting the value of what we are spending, and that is very frustrating.

And, so, that it would seem that the academic center, and I'm curious how you react, has to say that we're prepared to make some fairly profound changes. It is the academic center that is training the physicians who are going out and providing care that has such extraordinary variability.

There is some accountability for that. The academic center is very much, as you have taken great pride in, responsible for so much of how we use technology. Technology that is not giving us the returns that we think we ought to get for it. And, so, there's some accountability for change.

And then, lastly, Victor and Joel, I was very encouraged by your reorganization models, and I wonder, you don't state it as explicitly, and I wonder: Given that the things that are coming into your door is obesity, diabetes, preventive cardiovascular-related, do you have another box in your new vision that incorporates non-traditional folk, non-traditional, real community intervention, that creates a new science, a new model, a new paradigm, new providers, assets that really get at that stuff in a way that is transformative and that gets a higher proportion of your revenue than it gets today?

MR. ALLISON: Thank you, Reed, and let me respond to that question about new models. We are, in fact, entering into a very, I think, forward-looking model of disease management in dealing with an underserved population. Our board is committed to make \$50 million available over 5 years.

We're doing a partnership with the City of Dallas to go into southern Dallas, which is a highly economically-disadvantaged area, and we are going to focus on diabetes. It's a high minority area, it is an area that we see a lot of our patients at our flagship hospital, in the most acute situations in our trauma centers, because there is no real primary care, and we are going in, we are leasing from the city a recreational center that is in that area, 22 acres. We're going to do education, we're going to do prevention, we're going to do wellness, we're going to work with the elementary schools on obesity issues for childhood training and learning, teach people how to prepare nutritional meals, as well as have a center of excellence around wellness and treatment of diabetes.

And the city is putting in \$2 million. We feel like we can develop a footprint in this model and the president of that area is a lady that was the national American diabetes educator president, and is very, very familiar. We have our linkage to our tertiary center around diabetes so that we have the referrals opportunities, and we are going to prove, hopefully with the outcomes, that we have not only prevented diabetes, but we have managed that patient population.

The other aspect of this in partnering with the community is to really raise the economic abilities in that area, and really try to revitalize this community by the investments we're making there and trying to track more jobs, more people being healthy, go to work, and also attract other business to come in there, like grocery stores, that can provide healthy foods for these families.

So, this is a new model that we will be working in a collaborative effort. We think it's a model of a public-private partnership of how you improve not only the health of the community and the wellbeing of the community, we think, but also, the economic health of that community.

MR. DZAU: Yes, I think that I can answer in three fashion.

One cause, I talk about models of healthcare delivery. We are implementing quite broadly the medical homes, what we really would like to call connected care, which is a team-based approach, using information technology. I didn't have time to talk about real time tracking of patients and intervention. Certainly, moving away from a doctor-centric approach.

In that context, we actually are going to use this for all our employees. We're the second largest private employer of North Carolina, employing about 35,000 people. So, we're implementing that, and also in that context is the health and wellness and prevention program.

The CTSA has been very helpful in that regard because the dollars that we have acquired from the NIH through using Lloyd Michener's program in the Center for Community Research have actually engaged community together with the county government to look at what are their needs and how do we move that forward together?

I think health systems, really the best thing they can do is to bring in the evidence-based approach of prevention, and then being able to measure it and organize it because I think a lot of the problem to date is

a lot of individual initiatives in the community that's not well organized, and, therefore, hard to actually see sustainable effect. And we start with our own employees. It would be easily measurable to see how that would work. So, that's what we're doing.

MR. DAVIS: If I could just change the topic to medical education and what is the obligation of an academic health center to produce the physicians that we, as a nation, need?

Starting on the front page of *New York Times* today talks about considerable shortage of primary care physicians. I'm the chair of the Council on Graduate Medical Education. We learned last week that information collected from the AAMC's student graduation questionnaires indicates that only about 17 percent of all graduates of U.S. medical schools are thinking about a career in primary care, and that's down from the 35 percent of actively practicing primary care physicians right now, which includes pediatrics, general internal medicine, and family medicine.

Academic medical centers are absolutely wonderful places. I work at one. I love North Western. I think it does a fabulous job of educating students. We had 175 graduates this year; 7 went into family medicine. Part of the challenge that they face is that the environment they're exposed to, they see really very little in the way of primary care because of the intense and medically intense environment to which they're exposed, but they're also dealing with significant debt: \$150,000 to \$200,000 is not unusual. They look at the return on investment for

primary care as compared to other specialties, and there are significant disadvantages.

In light of the financial issues, academic medical centers or academic health centers are not incentivized from a graduate medical education perspective to provide the kinds of training experiences that are necessary in primary care because so much of the educational reimbursement is hospital-based and not based in the community. So, it's a real problem. I think people are working very hard to try to address it, but the pipeline is abysmal for what we need for the future.

DR. McCLELLAN: I think before we end, it'd be very important to listen to another perspective perhaps from Boston. Elaine experienced the -- Boston Medical Center raised the concern or the speculation that patients who were going to come to Mass General, that they're not coming.

In fact though, Gary, from your perspective, what's healthcare reform been like in Massachusetts?

GARY: I think there are a couple of things. First, the safety net itself is both a social contract, as well as a healthcare contract. It's important to understand that the safety net itself is both a social and a healthcare contract, and, therefore, places that have evolved themselves into being critical parts of the community have a richness that goes beyond the reimbursement that they received explicitly for fee-for-service medicine, and Boston Medical Center and Cambridge and others who

were the safety net hospitals or really are in the environment provide much more than just access to healthcare.

I think the Massachusetts story is a success in regard to coverage, as Elaine pointed out, and that we have essentially no or very, very few uninsured people relative to now the rest of the states, and those people, theoretically, have free and broad access to different healthcare. They are unlikely to change their behaviors.

The Massachusetts General Hospital (inaudible) to the third and fourth largest providers of Medicaid and what was uncompensated care, but the proportions which were provided in that care relative to the depth that was provided at the Boston Medical Center are considerably smaller. And the notion that that would just shift in one day is inappropriate, and, two, the notion that all of the other areas that would be reimbursed and sometimes reimbursed in such a way that there was still incentives to provide those services and then shifting those dollars to care for people with substance use disorders, care for psychiatric populations who also have chronic medical conditions, can't just be shifted to a fee-for-service system that inadequately recognizes the depth of those services, and that's been kind of the problem.

The other piece, I think the business community does deserve (inaudible) for having helped its populations to get insured. Those businesses themselves have only had to pay very, very modest amounts of money to participate in the system. It's been individual

coverage and individual payment that's substituted for what was otherwise uninsured in government payments.

MR. DAVIS: We have time to take questions from the audience.

Yes?

DR. McCLELLAN: And there should be microphones coming around, so, wait for the mike, and please identify who you are.

MR. LEWIN: Thank you. Larry Lewin.

I thought Reed Tucson's question was an interesting one, but I think about the kind of model that's produced, I must say I've been dealing with academic health centers since about 1972, and I can't escape a feeling that this is beginning to sound a little bit like the auto industry.

I remember some years ago Dave Lawrence said that what the academic health centers need is another near-death experience like the autos faced with Toyota. We are at a crisis point, and I think a big part of it is whether academic medical centers are producing the kind of products that people want, not just what they have always believed are valuable.

I personally am very committed to most of what they are producing, but I guess I also have to ask, reverse the question that Reed asked, and ask Tom Valik and Reed whether or not the kind of things that were being described, you're willing to pay for? That is to say is: Are we going to rely just on government and Medicare, medical homes, and things of that nature to create the innovation, or is the private sector, as

well as Medicare going to be willing to negotiate to reimburse adequately these new models which sound so promising in which academic medical centers can be at the forefront? I've been arguing for that for many years, but the answer is always: But who's going to pay for it? So, let's put the monkey back a little bit on the payers and ask what they're willing to do.

MR. DAVIS: Tom?

MR. VALIK: Excellent question, Larry. I think it goes right to what we're about here today.

From the Medicare Program perspective, Medicare and Medicaid, let's broaden it out a little bit, we've been bringing value-based purchasing tools to bear.

So, starting with the different kinds of provider payment systems, we're seeking to bring the performance base in as a part of what we're buying. And if you look at a lot of the reform models that are out there more closely tying performance to payment is a basis for moving forward to get better value out of the system. When you think specifically about Academic Medical Center financing, things like graduate medical education, and putting some kind of performance assessment or some kind of assessment of accountability for what we're buying with graduate medical education dollars, to make sure we're getting the work force that we need, that we're educating the folks who are coming out of those systems to practice in these new reform delivery systems and actually be a part of driving that change, the way we're paying physicians and

hospitals to pay, for example, differently for primary care, so that we can get more value for how we're spending the Medicare dollars.

We've talked about disproportionate share funding for Academic Medical Centers, a big chunk of what the public payers provide, and are we getting the value for that that we should be looking for.

And another thing that I would mention here is the evidence based practice of medicine, closely tied to what we would measure in terms of performance and get value. We don't have a good foundation yet for that, we're starting to move in that direction with more funding for comparative effectiveness, and I think that's a real opportunity for the Academic Medical Centers, to provide value here, and then that will link back to how to measure what we're getting for provider payments, GME, disproportionate share, et cetera.

SPEAKER: In the interest of time, since – to get another question, I'll just simply say that, A, I very much agree with my colleague from the public sector; B, things have to change, no question. Number three, we have to find a way to help make sure that AMCs survive, and that's why we have the panel. And I don't want to preempt our strategies because the process has to unfold.

So the answer is, there has to be a way to give an incentive in real dollars for academic centers to do a new, better version of what they have

been doing, but that version has to change, and they have to be accountable for the quality of care they deliver, and that has to be part of the same accountability and transparency that everybody else has, with some special provisions for the extra complicated patients that they see and for the burdens that they carry.

MR. GUNDY: Paul Gundy I'm with IBM Corporation, and I chair the Patient Center Primary Care Collaborative. And to Tom's point, and to the question, I represent the large buyers of health care, the other half of the spend. We spend as much in the public sector as any other nation on the face of the earth, and then we double that from large employers buying health care, which I think is probably more than enough for any country to spend on health care.

We are prepared to completely change the covenant of how we pay. We now buy stuff from you, you know, we don't buy comprehensive, integrated, quality care, we buy stuff, we buy procedures, we buy episodes of care, and so, you know, we've been having this conversation now for some time, and we think fundamentally foundational to that, and no society on the face of the earth has transformed their health care system to deliver value without a robust base of primary care and prevention at its very foundation.

When I can identify a primary care provider by name in one of my employee's lives, when they just tell me that they have a primary care provider who provides their usual source of care, it costs me one-third less, they have a 19 percent lower mortality, they're 12 percent less likely to be obese, and they're seven percent less likely to smoke.

SPEAKER: Now, you're talking about the IBM experience in particular there?

MR. GUNDY: Yes; but it's in the literature, it's duplicated hundreds of times, you know. It's profoundly powerful when you have a relationship with a healer and then that's amplified and cadenced by the other procedures. I would encourage you not to be disease focused, but to rather be relationship focused, honest, it's really important, because you can't ever get to the disease unless you have a relationship of trust with, you know, between the doctor and the patient.

And the way I buy care as a buyer of care makes me the enemy, as Pogo says, I am the enemy, it's us. I mean I change the care for my employees to save a nickel, from one plan to another, from year to year as a buyer of health care. I mean we really disintermediated and we help you go down the road of being dead last, 19 out of 19 developed economies in the world in terms of the value that the health care delivers us, you know, for twice the cost.

I mean we've got to focus like a laser, you guys, like a laser on comprehensive, integrated care, and transform ourselves to buy value, because I mean, you know, employers like us are already looking at Bomagrat you know, we're already looking at Apollo in India. Believe me, I mean it's going to be a global competitive environment. Some of the health care medical centers are doing the same, by the way. I mean I understand that they're moving out there, as well, but, you know, it's really an end game for us, the point of the autos.

SPEAKER: Well, thank you.

MR. GUNDY: It's really an end game.

SPEAKER: That's really a wonderful transition to move to health care reform.

SPEAKER: Let me just ask if there are any quick comments on this very forceful notion about, look, it's not just changing the payment systems, particularly changing the payment systems to focus on coordinated care, primary care relationships.

MS. SCHLICHTING: Mark, if I could make a comment. I'm Nancy Schlichting from Henry Ford Health System in Detroit, Michigan. So the issues of the autos are very close to my heart, and frankly, when I think about the question of what should be the vision for the future of AMC's, I think it's a different question. I think we need to ask the question,

what is the relevance of the Academic Medical Center to the future of American health care, and how do we create the focus on the issues of access, quality, and cost that are on everyone's minds and bring the strengths of Academic Medical Centers to help solve those issues.

And when you think about the core of an Academic Medical Center's mission, it is very central to how we could redesign care and think about the opportunities for research around health care delivery, not just clinical care, but how do we deliver that care most efficiently and effectively.

Secondly, it's about team medicine, it's about integration, and to do that, we have to train our physicians, our nurses, our allied health professionals differently than we do today to create that culture in our organizations.

And finally, we need to deliver care. We are the safety net in many communities, and finding different models for creating lower cost care, better access, and improved primary care delivery is very important, and yet we have to change the way we reimburse people, because as I've said many times, we get exactly what we have designed in this country. We have a fee for service mentality, we have a procedurally based focused reimbursement system, we are rewarding people that do the same thing every day as opposed to those that think about the integration

of care and how to deliver it. So we really need to figure out ways through our academic centers we can create better models and also research what needs to happen differently.

MR. DZAU: Victor from Duke; I mean I watched the program on NBC that you guys – and it's fantastic, but unless we can fundamentally transform how we reimburse you, how we pay you, unless we change that covenant, you guys don't have a hope in hell of transforming.

SPEAKER: All right. That's a great transition, so thank you for setting this up. We've had I think a great discussion about some of the key and critical missions of Academic Medical Centers going forward in a transformed health care system. We've talked about some of the obstacles, as well as the opportunities in reimbursement reforms and other health care policy reforms.

So what I'd like to do for the rest of our time together is put the two more directly together. What's going on with health care reimbursement, and let's take the discussion we've already had and see if we can start down a road for linking the two. What special issues do we need to pay attention to with respect to achieving this kind of vision that Academic Medical Centers can potentially contribute to? And let me start by just making a few minutes of remarks about health care reform.

There are a lot of issues on the table now, and this is going to be the big issue I think, at least the big domestic issue for the next 100 days of the Obama Administration. One way to think about them is in these four big categories.

First of all, as opposed to previous efforts around health care reform, there seems to be, there certainly is in this room, a very strong consensus that reforming health care should include reforming health care delivery.

So a lot of emphasis, as you've heard today, on issues of over use, under use, and misuse of care, which goes back to medical centers as to other areas of our health care system, a lot of discussion about gaps and coordination of care and having primary care centric reforms, a lot of discussion of the huge gaps and evidence about what works best for particular patients and particular circumstances. All those are things that AMC's can potentially help address. Coverage reform is going to be part of this effort, obviously with the goal of getting affordable health care coverage options to all Americans. There's been a lot of emphasis on doing this in a way that is not too disruptive, yet still provides a foundation for transformational care, in particular, by making better options available in non-group coverage while sustaining, if not

strengthening, employer coverage and Medicare and other public coverage that people in those systems would really like to keep.

There's been some discussion about the need for a greater emphasis on individual responsibility, to focus on prevention, to focus on patient involvement, personal involvement in chronic care management and support for these efforts, and possibly more individual responsibility if affordable coverage options are around to get coverage.

Finally, the hard part with all of this is, how do you pay for it, especially given the fact there's been so much discussion that many of these reforms are going to take some up front investment in the short term before they start paying off. So just a few more minutes on some of these key issues which we've already been talking about today. Improving health care delivery you've heard can have – could be driven by leadership, new kinds of leadership from Academic Medical Centers. You've heard about the vision; now, the question is how you actually translate that into practical health care policy reforms. There has been a big emphasis on accountability, actually measuring quality of care, actually measuring overall costs of care and tying that into reimbursement, so that we get more of what we really want, have accountability for value and payment, and in benefit reforms, in patient co-pays perhaps.

There may be special issues involving Academic Medical Centers there, special challenges related to their patient populations and otherwise. Also, in terms of implementing these effective models of coordinated care, you've heard some of the evidence that this seems to save money.

There may be different ways of doing this in different settings, and there certainly is a need for better evidence on actual reforms and delivery systems that work. Related to this is the whole issue of training and graduate medical education support. You heard from Russ, who's in a very key position in terms of the views of AMC on this issue, that it's time to put medical education payments on the table as part of health care reform. Without fundamental changes there, we may not be able to support the kind of training and education that we need. We need training and education changes, we need changes in the reimbursement models to promote this kind of care, and obviously a need for better evidence.

There's new funding coming for comparative effectiveness research, for identifying best practices, for more targeted therapies. This next slide shows a couple of recent examples of legislation along those lines, new kinds of funding for comparative effect in this research, what is the role of Academic Medical Centers, in helping to lead those efforts, as

they've been such a big part of traditional biomedical research, which also was increased again recently and which President Obama is talking about today, as well.

In terms of coverage reforms, there is a lot of interest in building on the Massachusetts experience. And as you heard from Elaine, it may be time to think about whether there are some new steps that need to be considered as part of that process, of doing things like expanding Medicaid and providing new subsidies through insurance exchanges for individuals who don't have good coverage options now, possibly including a new requirement for coverage for individuals. And this will likely put some more pressure through either competition or government planned reimbursement rates or otherwise to get costs down, which may be tougher for Academic Medical Centers, especially given their current burdens, and in some cases, maybe the way that they're organizing and delivering care.

And then finally, to pay for all of this, you know, President Obama talked about, and Victor mentioned a down payment of over \$600 billion, and that's the down payment, you know, you're talking about some real money here.

There is a lot of hope that reforms in health care delivery, we've already been mentioning, could lead to significant savings, but I

don't think there's, at least among the hard nosed actuarial and budget analyst crowd, a belief that that is going to be anywhere near sufficient to pay for the costs of these steps to make affordable coverage available in covering the cost of care for patients who are involved in these coverage expansions. And so that's led to putting other sources of funding on the table, such as reforms in the tax treatment of employer health insurance, such as reforms in Medicare or other public health care financing, dish payments and others we've talked about now is almost certainly going to be part of this debate, such as new fees for employers that don't offer coverage, and maybe other sources of revenues, as well, so big challenges which will involve some rethinking of at least the existing public support for Academic Medical Centers and the special funding streams that have been disproportionately directed Academic Medical Centers as part of this overall reform effort.

Now, I don't have the answers to all of these issues with respect to AMC's, but what we'd like to do as we move forward with this initiative is start a discussion now about how these kinds of steps might fit together.

For example, in the last few minutes you've heard from Reed, you've heard from Larry, you've heard from others in the audience about the importance of accountability based payment reforms; what

would those look like with respect to Academic Medical Centers? Can they work on the trajectory that we're currently on now? Medicare is moving forward with implementing some pilot programs in this area, private payers are, as well, as you just heard about. What about evidence development? Are there steps that Academic Medical Centers could take to help translate the goal of comparative effectiveness research into the reality of much better personalized evidence relevant to a particular patient being available as opposed to the risks that some have seen in a push towards comparative effectiveness research, having over simplified guidelines that do not take account of recent medical innovations or specific patient characteristics.

And what about the medical education changes? If we really are going to have a serious discussion about reforming GME payments, what's the right direction for moving forward with those?

So lots of questions we could talk about. Let me open it up to the panel to see if there are any comments on these or other issues that I haven't raised. Russ, thanks for biting.

RUSS: Just a couple. I'll kind of bounce around a little bit. One of the things that we've talked about is the medical school admission process, that there are significant disparities with regard to providers in medically underserved communities, whether they're rural or urban. The

vast majority of medical school – successful medical school applicants don't come from those areas, and so it's no surprise that they don't go there when they complete their training. So I think there's some evidence to suggest that we should look different at how that's done. That's being done in, let's see, Wyoming, Washington, Alaska, Montana, Idaho, they have a process to deal with that. Jefferson Medical School also has an admissions process that's selected to produce physicians that will practice in medically underserved communities in Pennsylvania, so there are successful models that are out there.

The other issue is that when medical students make a decision, it's mostly a laissez-faire decision. Most of them know a lot about what's going on in health care and the needs for health care reform. But for a variety of reasons, that doesn't seem to inform the specialty choice that they make. And they're depending on an economy that continues to look like the one that we have, where we spend \$2.2 trillion on health care.

And I feel bad for students who think that that's what the next 30 years of their career is going to look like. I don't think we're doing them a very good service by not better informing them on that.

One issue with regard to GME that Coney has brought up repeatedly is, why should the government be the sole payer for graduate

medical education when insurers get a tremendous benefit and at no cost to that and they've successfully resisted that I think in the past, and I'm sure with all that's going on in the economy right now, we'd probably not embrace that.

And then just the last comment is about the whole idea of inner professional care. There's real good evidence that when you put health care providers in a non-hierarchical setting, they quickly subdivide the tasks and get the work done. But when you then gather us together in terms of our specialty societies and/or the constituencies we represent, we don't get along very well under those circumstances.

But there's a real opportunity for something called task shifting, that as medical procedures become more easily done, you don't necessarily need a physician to do them. They could be off loaded to technicians, and there's certainly evidence from this study that came out in the Lancet this year where nurses were taught how to do upper and lower GI endoscopy and did so with the same level of skill as physicians. So those are the kinds of things where the current crisis really does create opportunities for change.

SPEAKER: Thanks, Russ. Reed, does this respond to some of the issues that you raised about the accountability, and what

about insurance payments that are more tied to some of these key education –

REED: Well, there's no question that private sector dollars that are reimbursing care delivery have to be arranged in a way that – in a different way to support and be part of the equation of fueling the reinvigoration, the re-engineering of the academic center.

I think that one of the things I'm looking forward to, and now I'm more excited about being on this committee than I was when we started, quite frankly, especially having listened to the presentations from my colleagues here, but I think that there are two things that are going on here that I see; one is, of course, the excitement of the academy, and the brilliance of the intellectual resources that are contained within the academy to think carefully about innovation around not only traditional, basic science, its translation into clinical care, and the evaluations that go on through health services research, that brilliance is terrific, but also the academic center, in addition to its academy function, is a service, it is a business, it is an operation. And so why isn't it that the academic center is not able to come to us and say that we will – we know that half of the escalation of health care costs are controllable, and that is from price inflation and utilization.

We know that utilization is so much dependent upon the increasing preventable disease in the community in which it exists. They understand that, and they also understand the escalation is so much a part of inappropriate use of existing and expensive health care assets.

So to say, the academic center has a terrific opportunity to, number one, make sure that the people that get admitted to their hospitals need to be in the hospital and not in the hospital, that they need to be – that they could have been treated at a more cost effective place, and that they have instituted those reforms such that the students that are being trained in those environments get a sense of what excellence is, and they understand a model of care that will prepare them for their involvement in hospitals for the rest of their lives.

Their vision in what they're doing is that only the best specialists, who have the best quality, the least complications, who get their people in and out of the hospital fast, will be the ones that their primary care medical home folk will refer to. This is a specific thing that they can do. They understand who's good and who isn't good in their system, and if they don't, they should.

And so I won't belabor it any further. I'm trying to make a directional comment. But the directional comment is that the academic center ought to be able to create the model that is the training vehicle for

the future, and, by the way, one that, because it is addressing those issues, their compensation then makes sense when you put the pieces together and we start to think, okay, let's pay these people differently because they're thinking differently, and their results are different, because they don't put – because their use of the hospital is appropriate, because they're using the right specialists, their results are transparent and measurable.

SPEAKER: I'm going to ask Victor and Joel to comment first, and then Tom, turn to you. I know all of you – you two have laid out visions already. Tom, I know is taking some steps in the same direction towards reforming how Academic Medical Care Center – Academic Medical Center care works from the standpoint of these goals. Victor, are you all ready to make these kind of reimbursement changes that Reed was describing that would create some real accountability about demonstrating that these reforms actually improve care and reduce cost?

MR. DZAU: Well, you heard from my presentation that I actually strongly believe that we can become more accountable, that we should be responsible, in fact, for a population health, in addition to individual health, and consequently to look at and begin to stratify about academic health centers – systems in accountable organization with the population.

Then we can begin to measure the kind of things you can say, look, what we care about is how much reduction in diabetes, what's the overall outcome, and that we get paid for it.

Now, the issue here has got to do with, how do you find resources to do those experiments while we, in fact, are living in today's world, and that's the key issue, right. So we are doing those experiments, and, in fact, doing it on employees was the easiest because we insure them. So we can begin to say, can we actually do things somewhat differently in this population. But I think the issue is – I certainly believe that at the end of the day, yes, we can do this. But we have to, in fact, start somewhere and create new models. That's what academic health systems do, is create new models. But we need to find a way to transition from one to the other, whereby you can actually see that, as Ken says, yeah, we do not destroy the successful model today.

And coming back to your issue, I think, you know, as we think about the – model, people will have to kind of understand that the traditional relationship between a physician and the patient is somewhat different. So Russ emphasizes a lot on the education of physicians. But you've heard from Nancy and others, we strongly believe that education in the future is not just about physicians, but about a whole team. And I think

that changes the curriculum dramatically, and that changes expectation from the patients quite a bit.

Now, for the horizontal team, the patient's best relationship could be with a PA, right, and using significant successful information technology and physician, perhaps somebody who's going to oversee this, you know, this and care coordination, et cetera. So that's going to be a whole series of I guess preparedness of society and funding agency for us to move in that direction. And I think, given the opportunity to do so, with the right kind of end point support and incentive, I bet you Joel would agree with me that we're already doing that in many different ways.

DR. MCCLELLAN: Joel, do you agree?

MR. ALLISON: Definitely, Mark. And I could just underscore everything that Victor said, because that's what our vision is, is to create this accountable health care organization where we can blend the best of all worlds. We've got the academic teaching facility, but we also have our community hospitals. We've got the physician network. And, in fact, our physicians now, we're seeing the results of where they are doing more and more on the preventative health side, creating the medical home.

And I always work with the payers, as Reed talks about, look at the total cost of the care of that patient for the whole year versus looking at what you pay for each individual procedure.

And the fact that we can now do team training, we can have outcomes looked at through our institute for health care research and improvement. A part of that is using the work that we have with our physician linkage to be able to show evidence based best care and really focus on how we can improve the health by prevention wellness, as well as when they choose who they're going to refer to for a specialist, it is the best.

DR. MCCLELLAN: Now, Joel, are the payments actually keeping up with these changes and delivery that you're implementing?

MR. ALLISON: Not yet, no.

DR. MCCLELLAN: What's the big obstacle there?

MR. ALLISON: I think it's the way in which we are paid now. We're still paid on volume and procedures rather than paid on keeping people healthy and well. And I think the key is, how do we move from where we are today, paying people, both primary care and specialist, to where we need to be in the future that's really paying for quality and value, and as we say, delivering the right care at the right time and the right

place and the right amount and being able to prove it, and then the outcome becomes very important.

I mean we have to be able to prove that we are reducing the cost to the community and to the patient. But, again, it gives us a chance to really blend the best of academic medicine with what we're doing in delivering care, both in the primary setting, creating medical homes, as well as the prevention and the wellness.

SPEAKER: Mark, may I point – I think the NIHCTSA has been a very important experiment. It provided some stimulus dollars to bring people together, and whether it's T1 or T2 translational area. But when you have those opportunities to transition into a new model, it asks the question, can, in fact, Academic Medical Centers work with a community to do a series of community research, and that research to look at what's engaging the community.

And you should see the kind of enthusiasm and response in many of the programs that, in fact, are brought to community. For the first time with a stimulus, people have some money to say let's work together.

So I think there are some opportunities to think about putting the right stimulus in there to create these models. So you ask how are we being paid; so in North Carolina, we have the CCNC, so that, in fact, works quite well.

As I said, again, on the employee group, you know, we so paid, so that can work well. And there can be a series of models where you can really measure the population and bring back to say here's how we do it. And here, we don't want to go back to capitation, that's not what we're talking about, we're talking about incentive to measure performance that actually have an up side in addition to capping the dollars.

DR. MCCLELLAN: Tom, what's the experience in Emory, and then I'm going to –

TOM: Well, I'm going to – I want to just turn the discussion just a little bit. As we move forward, it seems to me, with new systems of health care delivery that put, in many ways, more responsibility on the patient to help manage their care and to have perhaps computer literacy and these sorts of things, we need to remember that we are also safety net providers, and we deliver care to large numbers of individuals who have – are challenged with health care literacy.

And we need to be very careful that as we advantage one group, as we surely want to, that we're not inadvertently damaging or disadvantaging this other group. And we need to figure out ways to be able to intervene in those individuals lives with health care navigators or whatever it turns out to be necessary in order to be sure that, again, that we're not helping with one hand and disadvantaging with the other.

DR. MCCLELLAN: Have you seen any payment reforms actually implemented in your practices that help address that or is it still just a tough challenge?

TOM: Not yet, no.

DR. MCCLELLAN: It's a tough challenge.

TOM: A tough challenge.

DR. MCCLELLAN: Gary.

GARY: So we – I think we all agree that there have been perverse incentives and we have responded to those incentives as a system and as organizations. And at the same time, I think that the auto industry is not a fair metaphor. I don't think we've been tone deaf.

When – in the early 1990's, when the system started to shift to a more capitated environment, I think we tried to shift our organizations, tried to build and capitalize and spent an extraordinarily capital in building primary care and other physician networks and started to move the paradigm – a populist outcry to what was essentially another set of perverse incentives in which there were barriers to access as opposed to too much in the way of access and the over capitalization of a system. Essentially those efforts receded and we moved back into the same place that we were before, and then, frankly, responded to another set of over capitalization on the ambulatory side, substituting those payments. It's

important to realize that these are very, very complex organizations, and that unwinding them just for the focus specifically to get best value of purchase of unit service in one area may, in fact, unwind and have other unintended consequences that will have severe outcomes.

These places are academies, they are research institutes, as well as the providers of a lot of care, some of which needs to be in our venues and some of which needs to be elsewhere, so that payment reform needs to consider each of those issues very, very carefully.

We've been doing pay for performance contracts for more than five years, and they focused in the areas, like steep, around safety, around accessibility, around responsibility as it relates to key areas where there's been hyper expensive or over capitalization, and around care management.

We put ten or 15 percent of our resource dollars at risk in those contracts, and we responded to those incentives. At the same time, they haven't accounted for all of our payments, and we've continued to respond simultaneously to the other incentives that exist in the system. The worrisome metaphor to me is the airline industry, where we're very severely capitalized, we have very substantial debt service around that capitalization, and we have a very specialized professional work force that may not be that flexible to be able to respond to the demands over time,

and that's what we need to be able to nurture, and we have to be very, very careful around it.

SPEAKER: Can I respond to Tom, just ten seconds, which I thought was a very important point? And so maybe we need to broaden a little bit the notion of the relationships between parts of the system, so that we – as we deal with these folks who must counsel and guide the individual to make better choices and decisions, the – what's really going on out there now is, there are lots of people in the system who are care coordinators, disease managers, coaches.

The academic center and the models that we've sort of heard, it would be terrific to see a box in there that would start to bring some of the non-traditional clinicians into the box, and that there would be that sense that they would be incorporating to that model, and it's probably there, just, you know, and that you really push that out. The other thing, though, is that if you take experiments like the medical home model, which is still early, still needs to move much more rapidly, but one of the I think brilliant elements of the primary care model, primary medical home model, is that it says health plans, like ours, we will dump all of our data around the coordination of care for that person into the primary care office itself, and there will be a partnership about how you then go through that.

So the opportunity here is, do we – can we dump our data around the care opportunities, the coordination issues, the missed opportunities, the social support needs, all of that into the academic center, and work together, using both of our sets of resources?

This may not always be economic, but it's shared responsibility and investment of resources to make a better outcome for that patient. These are new opportunities.

DR. MCCLELLAN: Sounds like a good opportunity. Let me turn back to Elaine. Based on what you've heard now – in your perspective.

MS. ULLIAN: I now know my role on this panel, Susan, it's to bring it to the pedestrian level. All of you are talking about the promise, and I think it's exciting, but I think we need to talk about the reality of how we get paid and where the money comes from. And, Reed, I need you in my life, because I have to tell you what goes on at least in our Academic Medical Center, and it would be interesting for this group to look at the tipping point.

So if you're 29 percent sort of focusing on the poor, do you get a certain treatment from payers as opposed to 40 percent, 50, or whatever? Our experience in Massachusetts is, the insurers with tons of money are telling us we are not their problem, that they can pay us 20 to

40 percent less than they pay any other Boston teaching hospital because, respectfully, your patients are not our subscribers, they never will be, we're not going to be here by the time you're worried 25, 35 years, what diabetes does to this community, and so, therefore, your only hope is the government.

And I have been told that for 12 years, in good times and in bad, when the economy was strong or weak, it was about what you do is somebody else's problem, and we're really glad you do it, but we're not going to give you a dollar for a dollar worth of care. And I think fundamentals of any reform we talk about, and I agree with you about over use, under use, all of that, until we get a commitment that, regardless of who was paying you for the services you need, you will be paid a dollar for a dollar of care that's delivered, we are going to continue this incredible tension in our country where the patient loses, because the only way we can stay open is to play the parties against each other, and the way to guarantee that won't happen is to know that once we decide what the evidence is and how we treat X, Y, or Z, then we know we'll get paid.

And so I will tell you, we have to keep pushing this as a fundamental part of the promise of what we want to do, is making sure we don't end up in a very bad place unintentionally.

DR. MCCLELLAN: So the promise sounds good, but we're not there in terms of accountability and the payments really being tied to what matters at least to your more vulnerable safety net patients?

MS. ULLIAN: Right, absolutely. It's about paying for the social contract. Let's define what the social contract should be and let's all commit that we'll honor it.

MR. DAVIS: Like Elaine, I like to live in the real world, and let me tell you about the real world where my hospital is. We live on the – position of the richest and poorest zip codes in America. And this – line runs right through our emergency room. We like to say that we give the same care to everybody who enters Mt. Sinai, and we do, but we know that where they come from has a big impact on the cost of care.

So we've had a number of demonstration projects to look at ways to diminish the costs and to improve the outcomes of patients with congestive heart failure, asthma, obesity, and those demonstration projects have been for the community just north of us.

And what we found is that, indeed, we can diminish the utilization of services in our hospital, but the actual cost of doing so is not less than it was before we used those increased resources, they're, in fact, more.

And when we throw all those resources at the community north of us that's less advantaged than the community south of us, and we improve outcomes, here's what else we learned, that for the kind of chronic diseases that we're talking about that really cost a lot of money, at the end of the day, everybody still dies. You may be preventing disease, you may be keeping your IBM employees from paying while you employ them, but you're shifting the burden down the road for the diabetic care when they become older and they're now in the Medicare system. So ultimately there's still a big cost, and unless, and this is what I'd like to add to the dialogue, unless we can get a grip on how people die in America, and really do something about cost, the way people die in America, we're really not going to change the slope of the curve.

I would argue that all the wonderful things that we want to do that Duke is doing, that Baylor is doing, that Mt. Sinai is doing, I'm sure that Partners is doing around integrated health care models is all wonderful, and it's going to provide a lot better quality, but it's not going to save a lot of money. What's going to save a lot of money is the end of life care, and I think in America we have been unable or unwilling to really address what that means.

DR. MCCLELLAN: Let's follow up on that, but just, Ken, for people in the audience who may not know the exact geography of your

hospital, when you're talking about the neighborhood north of you, that's Harlem?

MR. DAVIS: Right.

DR. MCCLELLAN: Okay. So lots of challenges around, not just in life care, but coordination of care for patients who are frail, who have multiple chronic diseases, in cases where – in some cases the Academic Medical Center has done a good job of heading off the deaths from heart failure or some of these other more traditional killers, but now it's a complex medical management problem.

It does seem like a type of patient, who we're seeing more of, not less of in this country, and also a type of patient where the Academic Medical Centers may really have something to offer, so how can we move that forward?

SPEAKER: The question on how we can do that, I think what we can do is learn from the best models of palliative care. Those models of palliative care are often not accepted by the average clinician. It will take some re-education to get them to understand what is good palliative care and what is appropriate and what are appropriate outcomes.

SPEAKER: So we've – I am curious from my colleagues, we've been, at our place, really focused on the end of life care and trying

to see what we could do to – by providing clinicians, the 600 and some thousands physicians in our networks with information, the best evidence on end of life care, and we've been doing a lot of stuff on advanced directives and so forth. The question is, when Dartmouth put out their studies that showed that extraordinary variation, it was frightening what they said; did that lead to immediate scramble within the life of the academy to change, or did it just go, oh, that was interesting? I mean isn't that problem resolved now once it was laid out in such stark contrast?

SPEAKER: That was a rhetorical question.

SPEAKER: I guess the question becomes, why didn't – I mean because I think that Ken is really onto it, I mean he's really put his finger on a major issue that's low hanging fruit. The question is, if things are going to change, what more was necessary than to put it out like that, with the economics involved, put it public, let everybody know you actually published the data around the performance, why doesn't – what more does it take to get folks to say, hey, we've got to do something about this because this is within our control?

SPEAKER: Let me offer some hope. And I come from an organization that does have a slightly different model of payment for physicians than perhaps others of Academic Medical Centers. But the Henry Ford Medical Group has 20 percent lower average Medicare cost

than the nation. We are in a community that is, you know, very devastated. Fifty percent of the people who live in Detroit are either uninsured or underinsured. We pay the medical group as a salaried medical group. They have some incentives for customer service and some level of productivity and some protection – protected time for education and research, however, the fundamental issue is, we create an environment where there's no incentive to do things that they don't need to do, and we provide support in terms of palliative care support and lots of other support in terms of looking at their performance that creates a level of accountability, and yet we don't instruct – I mean it's not a situation where the physicians feel instructed, they just do the best job they can, but the payment model is very different.

And I've worked in private physician hospitals, teaching hospitals for most of my career, I will tell you, when I came to Henry Ford, I saw a very different level of performance because of how we pay our physicians.

DR. MCCLELLAN: Can you say a little bit more about the payment model, and in particular, I want to push you on – tying back to these last couple of comments about care for patients who are frail, care for patients near the end of life.

SPEAKER: Well, there are two components that I think have really driven the way the physicians behave; one is that we have our own health plan, and 30 percent of the patients that they take care of are on a capitated model, so they constantly are looking at resource issues around their care.

The second issue is the fact that they don't make anymore money; if they do more procedures, they do more things, so they're more tempted, frankly, to have the conversation with the patient and the family around issues of how far this care should go.

You know, it's not perfect, but it does create a different environment around, you know, how they want to deliver their care. And because that conversation takes place often, the end of life decisions are made differently. And the conversation is the hardest thing to have.

I mean as we talk to our palliative care team, they are there to help the physicians, actually to teach the physicians how to have those conversations, because they're not easy to have, and many families, frankly, don't want to hear them. But it is a different environment around just what's in their psyche and how they look at the care process, and it does create this lower than average performance, which, you know, we, frankly, didn't know until recently.

SPEAKER: But do they get paid better if there are savings in the capitation?

SPEAKER: No.

SPEAKER: No; so they're – essentially if – if you over utilize – utilization – you get paid the same as if there's under utilization?

SPEAKER: But the group as a whole – the difference between probably --

SPEAKER: And there are no group bonuses around?

SPEAKER: -- yeah; the difference between most faculty practice plans in a medical group is that the group as a whole does look at the performance.

SPEAKER: Right.

SPEAKER: And there's a finance committee of the group that evaluates what's going on in terms of that performance.

SPEAKER: Right; but does the group overall benefit from that savings?

SPEAKER: No.

SPEAKER: So, essentially, if you overspend the medical budget, the group is – has no negative –

SPEAKER: It is what it is; I mean we look at it as a system. The medical group as a whole loses about \$30 to \$40 million a year. The

hospital makes the money, but we look at it collectively. So it's a very integrated model.

DR. MCCLELLAN: Let me ask Russ – Russ I think has a comment and then I want to open this up to discussion with the rest of you who are here.

RUSS: I'll just be real quick. I have a certificate of qualification in geriatrics and was a nursing home medical director, and it comes down to the trust relationship that the patient and family have with the physician. If you've got that trust relationship, then you can have that discussion and they don't think that you're somehow trying to save money or some of the other suspicions that are out there.

And, unfortunately, if you look at geriatrics, that's another area, from a physician supply perspective, that's even more dismal than the other primary care specialties. These are wonderfully rewarding experiences to have as a physician, but we don't really create a model where certainly with now the hospitalist system being so widely accepted, there's a break in that continuity, and I think it's very difficult for a person who doesn't – a physician who doesn't know the patient and family to have those kinds of discussions that would lead to a much different outcome.

DR. MCCLELLAN: It does seem like the kinds of transformations that people have been talking about all morning are needed in our health care system and Academic Medical Centers could potentially help lead or absolutely dependent on this issue of trust.

And the last time I checked the surveys, I think the levels of trust for government getting this right or insurers getting this right no where near the level of trust in providers, and particularly in academic centers that have such a reputation around getting people the right care for their needs. So it seems like a critical role in health care reform there, too. Any comments from the people in the audience? And please wait for a microphone.

SPEAKER: My name Dmitry Novik, I am your customer. I have hip replacement from the left side, I have five bypass – My question is this -- so I have some experience with health care. I have two questions; number one, what is general opinion, is health care independent – center or private physician must be non-profit organization or profitable organization – call of the problem of health care system, as I see it, maybe I'm wrong.

And the second question, I am from information technology community, and, of course, without new technological achievements, it's impossible to improve the system, from the effectiveness system and

deficiency system. And my question is this, you mentioned about information technology; what kind of information technology, because information technology is very general term, what do you need? Or as reported, information technology to change paper documents to digital files or some more sophisticated information technology, what do you need?

DR. MCCLELLAN: Okay. Thanks for the two questions. The first one, for Academic Medical Centers here, anyone who's not non-profit? So all of you are non-profit, but I assume the financial incentives still matter, yes? Okay. So even if we have non-profit institutions, we still are going to have to –

SPEAKER: We're not for loss.

DR. MCCLELLAN: That's right; we're still going to have to pay attention to these issues. And on the IT, so more sophisticated IT systems, what's the most promising directions, any comments on that?

SPEAKER: I think the most important stuff on the IT is really to be able to usher in and support true patient centered care, such that the individual, first of all, has the right information that they need to be able to promote their health, identify disease early, and then act on it appropriate and get to the right physician and hospital to meet their needs.

The HIT system then needs to follow that patient or facilitate the navigation of that patient throughout a comprehensive care system that allows all of the people that participate in their clinical care, when that is necessary, to be able to talk together and coordinate effectively and efficiently the services that are delivered, that's one way to look at it.

SPEAKER: Also, clinical decisions support, that's really a very important part.

SPEAKER: Right.

DR. MCCLELLAN: We have a question here and here, and that may be all we have time for.

MR. KAROWACK: Mark Karowack from the University Health System Consortium. You spoke eloquently about differential payment when it comes to primary care versus specialty. One of the biggest problems I think AMC's are facing is the differential payment between specialist employed in the academic center versus specialists employed in private practice.

Often times those specialists are generating either hospital revenues or deans taxes that are helping to fund the teaching mission or the infrastructure that Victor and Joel eloquently spoke about. And there's an almost constant gravitational pull of specialists away from the AMC to go across the street or to go into private practice, where they can often

make twice as much money as their academic colleagues. I hope the panel tries to tackle this very difficult issue.

It bumps right into another thing, a core American value, which is freedom of choice. You know, given you've spent all this money on building these systems, how are you going to keep people in them? I had a front row seat at an Academic Medical Center in Massachusetts that attempted to build an integrated delivery network and do population based health care back in the '90's. What caused us to really get into trouble, number one, was this differential payment issue, but also that we lost 15 to 20 percent of our revenues from people electing to leave our system and go to private practices that had nicer amenities, better access, et cetera.

So how one tackles this issue of freedom of choice for the patient is also a complicated undertaking. So I'm not sure there's an answer for that, but I just hoped it was on your radar screens.

DR. MCCLELLAN: Answer or at least a comment, anyone?
I see a lot of heads nodding. Gary.

GARY: I think that many of the models of health reform and health payment will actually – are at least focused on reducing some aspects of provider induced demand, which is the volume based kinds of payments that have made that kind of private practice so – mostly talking

about specialists, procedurists of some kind or another who have made this economic fees in the system.

So the question – there is ultimately an advantage I think that we have in being systematic, because we'll be able to nurture those changes for people over to different kinds of paradigms.

SPEAKER: I think Academic Medical Centers are better positioned than most private hospitals right now around that issue, because if, in fact, we move toward more integration, more bundled payments, it is going to be much harder in that setting to work with multiple private practicing physicians in multiple practices as opposed to the Academic Medical Center environment.

SPEAKER: Two quick responses; one would be that we are at the beginning, obviously, of this revolution in consumerism and health care, and while it'll take a few more years before patients are educated and are experientially able to appreciate the value of a truly integrated system that works for them, but that will happen over time, it doesn't solve the problem tomorrow, which is what your question throws out there.

But it will happen over time, where people will see the value. But what is actually going to also drive a lot of this, and we always, as you – the premise of your question was choice, obviously, no one can – you don't want to limit people's choice. But benefit design is going to be very

clearly tied to the satisfaction that patients experience, as well as benefit design to encourage them through financial incentives to go to systems that have been able to demonstrate a better outcome and better value experience. So there are some things that can encourage movement in the direction, but neither one of those responses is completely satisfactory to your question.

MS. HUGLEY: I'm Elissa Hugley, and I'm here because I blog about health care issues, and trying to educate the public to become more savvy consumers, and increase health literacy.

SPEAKER: Thank you.

MS. HUGLEY: But I wanted to ask specifically about this changing the incentivizing and how we pay for things, because there's been a lot of mention about managing health populations. But as long as plans can dump and shop for patients, as long as our public system, the fee for service designs allow it so that, although we have these great integrated delivery systems, it's not pushed out into community health, we're not going to get the benefits that we're looking for by managing a public, you know, by managing a population. And I only see one public health professional on your board, I'm sorry, as an Emory MPH graduate, so thank you.

SPEAKER: I'll answer, I'll just say – I'll say quickly, you're right, you're right, you're right, and I think this is why I keep coming back to the real basic stuff. The promise is great, I'm a little worried about the reality of now as we go to our future. So everything you said is well taken.

SPEAKER: I would just say, for the record, that I, in the form of Commissioner of Public Health –

DR. McCLELLAN: There is a lot of public health expertise on this panel. John, you get the last question.

MR. EIGLEHART: John Eglehart, the *New England Journal of Medicine*. A quick comment on end of life care and then a question. The comment on end of life care is, over the last decade, the number of Medicare participating hospices has increased by about 1,000 facilities. Virtually all of them are organized on a for profit basis, all of the news over the last decade, so there's about 1,000 new for profit hospices in the USA.

My question relates to the indirect medical education support that Medicare provides to teaching hospitals. As you all know, the Congressional Budget Office, MEDPAC, GAO, have all concluded that that adjustment is about twice what any empirical data suggest it should be based on what the costs are. My question is whether any of the Academic Medical Centers would be willing to offer up some of that

support or tilt it in a direction that would promote more primary care practitioners?

DR. MCCLELLAN: Now, my impression was that the answer was yes, but I don't know if people are willing to go on the record with that.

SPEAKER: No; this is the zero sum game that we're getting into. This is how – you know, the reason that that IME was there, and you probably know this as well as anyone, and the history, particularly in our state with – and what it came for, was cross subsidized things that we otherwise are not funded for.

We're going to have to rationalize everything in health care before we take a zero sum game, which we take something from one compartment and put it in another compartment and believe that we've, you know, in part, on good, and forget what we've, you know, just lost.

DR. MCCLELLAN: Now, this gets back to the point that we raised earlier about accountability is good provided that accountability expands to all of the key aspects of the AMC mission, particularly around vulnerable populations. Any further comments about how to move forward on addressing that? Russ, I know you all are struggling with this set of issues.

RUSS: You know, I think, again, it's not fair to the Academic Health Centers to assume that they're going to pay for all of this when they're not the sole providers. I think the only other comment that I would make is that when you look at when Academic Health Centers to add GME positions, they almost uniformly add them in specialty and fellowship care, including when they have to fund that out of their own resources. You generally don't see that when it comes to primary care.

And, unfortunately, the way Medicare/GME regulations are structured is, they don't pay for care, or they don't pay for educational experiences that take place outside of the hospital, and so there's a built-in bias against some of the training funds that need to be made available for primary care –

DR. MCCLELLAN: So addressing that bias by redirecting training funds, that's absolutely on the table?

RUSS: Yeah, definitely; I mean we've had – I've continued to have some nice, interesting sidebar conversations with some of the MEDPAC staffers as we've tried to bring that to their attention. And, you know, I'm not interested in any – creating any kind of, you know, an inner conflict with regard to GME funding. It's just that we have this phenomenal disparity, and the current system as it's structured isn't

designed to produce primary care physicians from a variety of different perspectives.

SPEAKER: I would also add that I think that as we look at primary care, we need to look at that public health perspective, the community health and prevention, because it really is a broader issue of how do we design care in the future that is going to create what we're looking for.

DR. MCCLELLAN: Victor, and then I – okay, Victor and Gary, or Gary and Victor.

MR. DZAU: I think that, yes, shifting GME funds one direction or the other can recalibrate the system to some extent. But I think the issue still comes down to what model delivery do we want, because it really has to do with – ultimately, we could run out of specialists all of a sudden, and we would say what are we going to do now.

And also, whether, in fact, when you talk about the Kaiser experiment of using, you know, nurse practitioners do endoscopy, whether, in fact, specialty care should be done with different model, and I think that's the direction we ought to be talking about. How's primary care done different model, how specialty care done different model, then I think the GME issue can be put in that context. But to shift it abruptly, without

thinking through this, the kind of concern – has put on the table and the, you know, parallel experience something – worried about.

DR. MCCLELLAN: That really argues for an integrated approach here.

SPEAKER: I think it's fair to say, though, that we're the creature of what incentives are around. Once, in the beginning part of the 1990's, we were all willing to start to look at departments of family medicine to increase the sizes of residencies to try to focus in that regard, and then we shifted rapidly when those incentives went away in a way that was, you know, overly profit maximization, to some extent, but we – so I think that there's a possibility being able to move in that direction relatively quickly and embrace the academic in that regard.

The other piece in the Massachusetts experiment that we should just think about when Victor talks about models of primary care is that, we do have this wonderful asset of these 330 health centers, as one of the first places to have so many of them, and that network was part of the fantasy that the legislators had that essentially, the way that health care reform would work, it would enrich the 330 health centers and the partnership between them –

SPEAKER: Get people out there.

GARY: -- and the Academic Medical Centers is remarkable. We do have our trainees in those places, we are subsidizing care. Several of us own them that aren't 330's because they couldn't be fairly qualified because of their governance, and that was part of the image of how we would -- because those are great medical homes.

DR. MCCLELLAN: That's similar to what Joel is trying to do, as well.

GARY: That's exactly right; and there are tons of them that exist there. We haven't yet exploited the partnership or the model well enough.

SPEAKER: But they are getting killed in Massachusetts, too, because they're getting paid 64 cents on the dollar also, and I'm part of a network of 15, so --

SPEAKER: Back to that core payment issue.

SPEAKER: Right, another unintended consequence.

SPEAKER: One last question, we're running over, just to finish this up. Ken mentioned the key aspects of Academic Medical Center mission, they're not addressed directly that are implicitly addressed in those, you know, "excess GME payments" or excess relative to cost. What would be at the top of the list if there were steps to create some more direct accountability around those key aspects of AMC mission?

SPEAKER: I think that's, you know, something for this panel to think long and hard about.

DR. MCCLELLAN: Well, that may be a good point to end on if we don't have the answer to that yet. A very good question. And so I want to thank our panel for a great discussion, thank you all. Before you leave, just some more information about next steps, this is an effort that's going to continue over the next couple of years with a final report in 2011, given all that is going on with health care reform and a strong desire, as you heard from this panel, to integrate steps that are taking place in improving the Academic Medical Center's ability to address their mission with the steps that are taking place in health care reform. There will be a series of inner meetings, findings from this effort, to influence that process. It's going to touch on issues like the AMC role in transforming health care delivery and the financial reforms that go along with that, it's going to go to issues like improving innovation process around new topics like comparative effectiveness research and new kinds of collaborative models of research that get towards more efficient development of target therapies.

It's going to go to issues like these education and training reform topics that we've just been discussing. And most importantly, it's going to pay careful attention to the safety net care issues which are going

to be a critical part of reform, but as we've heard, needs some very special attention if they're going to be addressed effectively. Thank you all very much.

* * * * *

CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

/s/Carleton J. Anderson, III

Notary Public in and for the Commonwealth of Virginia
Commission No. 351998
Expires: November 30, 2012