Summary

- The Academic Medical Center has historically played a leading role in advancing biomedical and clinical research, training the nation's physicians, providing cutting edge quality clinical care, serving as the safety net for disadvantaged communities and advancing research and practice in global health. Over the years, it has built a deep and unparalleled reservoir of expertise and resources that support these activities.

- Given the challenges of reshaping the nation's health care system, NewYork-Presbyterian determined that the time was right to convene senior leaders from Academic Medical Centers (AMCs) across the country for a one day conference to discuss how AMCs can bring this array of resources to bear on the critical health care reform issues of quality, access, cost efficiencies and graduate medical education.

- The one day conference was designed to facilitate candid exchange and discussion. The day opened with a keynote address by Dr. Thomas H. Lee, MSc, CEO of Partners Community Healthcare and Network President of the Partners Healthcare System. This was followed by four panel sessions: Driving Down Operating Costs, The Science of Quality, Innovative Care Delivery Models, and Graduate Medical Education's Response to Reform. A summary of each panel follows.
Driving Down Operating Costs

Panel focused on innovative approaches to bringing costs down while maintaining high quality and patient satisfaction. Discussion topics include throughput, clinical resource utilization, supply chain, physician level incentive systems, and other strategies to address cost reduction.

Moderator:
- Phyllis R. Lantos, MS, Executive Vice President, Chief Financial Officer and Treasurer, NewYork-Presbyterian Hospital

Panelists:
- Amir Dan Rubin, MBA, President and Chief Executive Officer, Stanford Hospital and Clinics
- Keith Kasper, MBA, Senior Vice President and Chief Financial Officer, University of Pennsylvania Health System
- Peter Markell, Chief Financial Officer and Treasurer, Partners Healthcare
- Peter J. McCanna, Executive Vice President, Administration, and Chief Financial Officer, Northwestern Memorial Hospital
Driving Down Operating Costs: Key Takeaways

- **Institutions can no longer focus on improving the bottom line through increased revenue:**
  - Need to focus efforts on lowering cost per case/episode, reducing unnecessary hospitalizations through improved care coordination and management of high-risk/high cost patients, and reducing administrative/overhead costs

- **Success requires coordination across departments, clinical engagement, data, and tools:**
  - Coordination and collaboration between Finance and Quality needs to occur
  - Engagement of clinical leadership and staff is essential and can be accomplished through formal arrangements such as:
    - Forming unit-based teams consisting of a Physician, Nurse and Quality Project Manager
    - Employing Physician Quality Champions/Service Directors (salaried positions)
    - Developing a shared savings plan with physicians
  - Robust data is key for problem identification, measurement and ongoing monitoring:
    - Utilize dashboards (unit and project-level) capturing performance and process metrics
    - Sustain results through ongoing measurement and monitoring
    - Assign responsibility to ensure accountability
  - Disciplined use of a process-improvement methodology: DMAIC and/or Lean (or similar methodology) needs to be engrained in organizational culture
    - Evaluate processes through the patient’s experience
Driving Down Operating Costs: Key Takeaways

- **Key focus areas include:**
  - Labor productivity and staffing (use of benchmarks)
  - Clinical Department productivity (RVUs)
  - Benefits Expense
  - Supply Chain
  - Operational efficiency (LOS, ED, OR Utilization)
  - Delivering care in lower cost platforms (i.e. community-based settings vs. AMCs)
  - Elimination of duplicate clinical programs in multi-hospital settings

- **Deployment of capital is being scrutinized:**
  - No longer focusing on bricks and mortar
  - Need to invest in IT/data systems to enable more robust data availability and analytics

- **Traditional AMC structure may need to be re-considered**
  - For organizations that are not formally integrated, alignment can occur through:
    - Development of a shared strategic plan across the enterprise (Hospital, University and Physician Organization)
    - Breaking-down cost silos across Hospital and University
    - Development of a single budget and financial plan
Science of Quality

Panel focused on innovative approaches to addressing the quality and safety provisions of health care reform. Discussion topics include: value based purchasing, readmissions, hospital acquired conditions, and meaningful use.

Moderator:

- Eliot J. Lazar, MD, MPH, Chief Quality and Public Safety Officer, NewYork-Presbyterian Hospital

Panelists:

- Benjamin K. Chu, MD, MPH, MACP, President, Kaiser Permanente Southern California, Group President, Kaiser Permanente Southern California and Hawaii
- Elizabeth Mort, MD, MPH, Vice President Quality and Safety, Massachusetts General Hospital and Massachusetts General Physicians Organization, Senior Medical Director, Partners HealthCare, Associate Chief Medical Officer, Massachusetts General Hospital
- Robert J. Panzer, MD, Chief Quality Officer; Associate VP, Patient Care Quality & Safety; Professor of Medicine, and of Community & Preventive Medicine, University of Rochester Medical Center
Science of Quality: Key Takeaways

- **Success requires actionable, real-time information provided by electronic tools:**
  - Patient registries can illustrate how physicians are performing on overall patient panels
  - Encouraging reporting and public sharing of incidents can highlight key learnings

- **Identifying and addressing gaps of care is essential for ensuring patients' health:**
  - Managing care has become so complex that it cannot solely be the responsibility of the PCP
  - Use of physician dashboards can show gaps in care for individual patients and for the entire panel; sharing the information with each contact point (from call center representatives to specialist MDs) can provide them with relevant information and can enable them to suggest appropriate preventative care to the patient
Science of Quality: Key Takeaways

- While many payment models are being explored, all will require a focus on value (defined as cost versus outcomes) and efficiency:
  - HAC penalties, readmissions penalties, Value-Based Purchasing and other Medicare programs mean that 10% of Medicare revenue will be risk-based within a few years
  - Bundling may be an opportunity to weave quality into an episode of care; with appropriate tools, key spending drivers for each episode and potentially avoidable costs can be identified

- Hospital leaders must decide which metrics to make the domain of front-line clinicians, and which to make the domain of the administration
  - Organizations such as HealthGrades are in the business of producing rankings; while these rankings may not be clinically valid, they require attention from a business standpoint
Innovative Care Delivery Models

Panel focused on innovative approaches to clinical care models at peer academic medical centers. Discussion topics addressed the following:

- Delivery of patient care in blended work force models (i.e. models that engage Attendings, House Staff, Advanced Practice Nurses, and Physician Assistants).
- Redefining primary care including innovative approaches to treating the entire spectrum of disease for the chronically ill with multiple co-morbidities.
- Highest and best use of advanced practice nurses, physician assistants and other non-physician staff.
- Benefits and challenges to implementing alternative delivery models (i.e. impact on LOS, efficiency, cost, patient satisfaction, etc.).

Moderator:
- Emme Levin Deland, MBA, Senior Vice President, Strategy, NewYork-Presbyterian Hospital

Panelists
- Steven Kravet, MD, MBA, FACB, President, Johns Hopkins Community Physicians
- J. Emilio Carrillo, MD, MPH, Vice President and Medical Director, Community Health Development, NewYork-Presbyterian Hospital
- Timothy G. Ferris, MD, MPH, Medical Director, Massachusetts General Physicians Organization, Associate Professor of Medicine and Pediatrics, Harvard Medical School
Innovative Care Delivery Models: Key Takeaways

- **AMCs must explore alternatives to current reimbursement systems**
  - Achieving meaningful alignment along all layers of the organization is a critical challenge
  - Success requires shifting from a hospital-centric approach to a delivery system focus
  - Ensuring optimal performance along value-based purchasing measures requires developing incentives that flow to all levels of clinical staff

- **The future of academic medicine is equally dependent upon clinical and delivery system innovation**
  - Successful population health programs include culturally competent care, integration with the community physicians and a Targeted Care Intervention program for the sickest patients
  - Properly structured payor contracts can incentive institutions to evolve towards population health models of care delivery

- **Culture can be one of the biggest obstacles to success under new delivery models; culture must shift from individual gain to succeeding as a group or even as an institution**
Innovative Care Delivery Models: Key Takeaways

- Current payor- and disease-specific case management efforts tend to focus on some patients while neglecting others
  - For an intervention program to succeed, all four steps must be successful: patient identification, patient engagement, identification of opportunities for improvement, and intervention
  - Care management needs may vary across clinical practices; pooling funds for care management can more broadly help to address varied care management requirements
  - To ensure that care managers are accepted by and accountable to both the institution and individual practices requires having them to report to both the institution’s Medical Director and the practice in which they are embedded
Graduate Medical Education’s Response to Healthcare Reform

Panel focused on how academic medical centers are preparing graduate medical education programs to respond to the imperatives of health care reform (Cost, Quality, Patient Satisfaction, and Care Delivery Models).

Moderator:
- Richard S. Liebowitz, MD, Chief Medical Officer, NewYork-Presbyterian/Columbia University Medical Center; Vice President, Medical Affairs and Designated Institutional Official, NewYork-Presbyterian Hospital

Panelists:
- Debra Weinstein, MD, Vice President, Graduate Medical Education, Partners HealthCare
- Steven H. Rose, MD, Vice Dean and Designated Institutional Official, Mayo School of Graduate Medical Education
- Donald W. Brady, MD, Designated Institutional Official, Associate Dean for Graduate Medical Education, Professor of Medicine, and Professor of Medical Education and Administration, Vanderbilt University Medical Center
GME’s Response to Healthcare Reform: Key Takeaways

- GME reform needs to occur at all levels (government, provider, university) and must be aligned with healthcare reform.

- GME impacts all aspects of an enterprise and is important to continue to invest in:
  - Healthcare reform cuts should not focus on cutting GME.

- Key proposed changes in GME include:
  - Limits on resident hours
  - A curriculum based more on competencies instead of time-based training
  - Supervision requirements
  - Increased emphasis on ambulatory training

- Limits on resident hours are contradictory to the value of true patient care:
  - Mentality shift from patient focus to learner focus
  - Enhances the risk of errors due to increased handoffs
GME’s Response to Healthcare Reform: Key Takeaways

- The curriculum for GME is the centerpiece of training programs
  - Programs should shorten “core training” for subspecialties and be driven by educational need
  - Innovative curriculum offerings include:
    - Establishing Centers for Expertise where trainees can choose thematic areas, attend national meetings, take external courses, and have career development mentors in the institution
    - Developing programs focused on teamwork and inter-professional learning including medical, nursing, pharmacy and social work
    - Creating multi-disciplinary team seminars

- Knowledge of key information systems (e.g., EMRs) and data sharing is essential for residents
  - Involve residents on clinical IT development teams