Regions Emergency Medicine Residency

October 29, 2009

Felix Ankel, MD

History

- Accreditation 1995, 1999, 2003, 2009
- 90 graduates 1999-present
- 118 residents 1996-present

Mission: PAPEEMCE

Provide and promote excellence in emergency medicine care and education

- Patient centered
- Resident focused
- Team oriented
- Transparency
- Professionalism
- Knowledge
- Skills
- Attitudes
- Core competencies
- Contribution to specialty

Our residency efforts are guided by the Baldridge core values for educational criteria for performance excellence which include:

- Visionary leadership
- Learning centered education
- Organizational and personal learning
- Valuing faculty staff and partners
- Agility
- Focus on the future
- Managing for innovation
- Managing by fact
- Social responsibility
- Focus on results and creating value
- Systems perspective

Additionally, we strive to incorporate the Institute of Medicine's *Report on Health Professions Education: A Bridge to Quality* which suggests five core areas where students and working professionals should develop and maintain proficiency. They include:

- Delivering patient-centered care
- Working as part of interdisciplinary teams
- Practicing evidence-based medicine
- Focusing on quality improvement
- Using information technology

90 graduates 1999-present

- 59 Minnesota: 13 Regions, 10 EPPA, 7 Fairview-U, 6 North, 5 Abbott, 4 Duluth, 4 HealthEast, 3 United, 2 Waconia, Shakopee, Brainerd, Rochester, New Ulm, Princeton
- 29 out of state: SD 4, NE 3, IA 3, CO 2, IN 2, WI 2, ND 2, NY 2, WA 2, CA, MS, MT, NH, OR, UT, VA,
- 15 Academic: 13 Regions, Wishard, Mayo
- 14 Hybrid: 7 Fairview-U, 6 North, Mercy-Iowa City
- 60 Community
- 7 Fellows (2 toxicology, faculty development, critical care, simulation, informatics, ultrasound)

118 residents (1996 - present)
34 medical schools

- 41 U of M
- 8 UND
- 7 MCW, Iowa, USD
- 6 Mayo
- 5 Creighton
- 4 UW
- 2 Nebraska, Loyola, Indiana, Kansas, Chicago Med School, Colorado, Loma Linda
- SUNY-Buffalo, SLU, Des Moines, Nevada, Vermont, Penn, Hawaii, East Carolina, Arizona, Utah, Michigan State, SUNY-Syracuse, VA-COM, UCSF, Dartmouth, Yale, Tufts, Cincinnati, Morehouse

26 Faculty (12 Different EM Residencies)

- Regions x 12
- Henry Ford x 2
- Harvard Affiliated x 2
- Illinois x 2
- HCMC
- Brooke Army
- St Vincent's
- Christ
- Indiana
- Boston Medical Center
- Grand Rapids
- Michigan

Rotations (4 weeks blocks)

- Year 1: ED-I 5.7, SICU 1.3, Ortho 1, MICU 1, Cards/Hosp 1, OB 1, Mpls Kids 1, Plastics 1
- Year 2: ED 7.3, SICU 1.3, Community ED 1, MICU 1, St Paul Kids 1.3, Tox/Adm 1
- Year 3: ED/ St Paul kids 9.7, SICU 1.3, Elective 1, Community ED 1

Residency Strategic Plan 2005-2010

4/28/05

- SWOT analysis
- Conferences
- Simulation
- Mentorship
- Administrative curriculum
- Scholarly activity
- Individualization of educational experience
- Integration with U of M
- Integration with twin city hospitals
- National presence

2007-2008

- Conference changes
  - Move to Thursdays
  - Increase critical case to 90 minutes
  - Increase simulation time during conf
  - Pre-conference sim sessions
- Structured ultrasound workshops
- Schedule change from teams to sides, 10-hr shifts
- Doctors Dahms, Morgan and Taft assume roles as Asst. PDs
- Incorporation of Peds-EM faculty (Ortega & Reid) into Residency
- Hosting of Ecuadorian EM residents
- EM/FM combined residency discussions
- E-portfolio application submission to ACGME
- Specialized interview days
- Resident self-eval on shift cards
- Nurse mentorship program

2008 Retreat Minutes

- Strengths: critical care experience, procedural experience, collegiality/camaraderie
- Area of focus : ultrasound machines, documentation, EKG training, evening food availability

2008-2009

- Community ED rotations EM-2 & EM-3
- Clarification of back-up & pull residents
- Ultrasound afternoons during anesthesia rotation
- Melding of cardiology & hospitalist rotation

Program review 2009

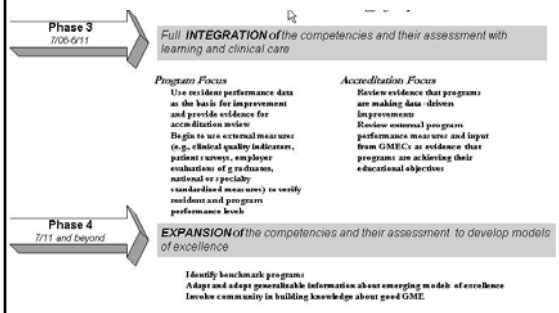
- Residency coordination
- Toxicology rotation
- Resident support
- Residency leadership
- Independence
- Progressive responsibility
- Cardiology rotation
- Admin rotation
- ED Conference rooms
- ED Exam rooms
- HCMC rotation
- Plastics rotation

2009-2010

- ED-I rotation (EM, Anes, EMS)
- 3 new ultrasound machines
- EM-3 Peds anesthesia
- New ED
- Cards/Hospitalist rotation
- Fellowship development (EMS, International)

Future Directions

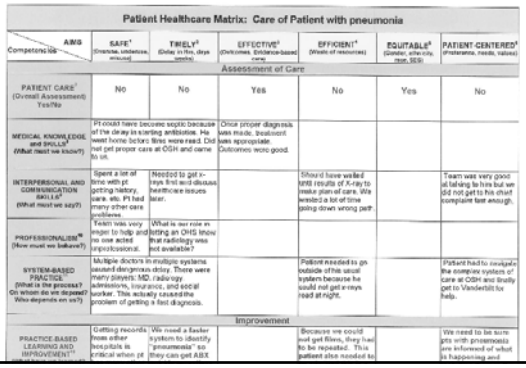
- Less resources for GME
- More resources for quality movement
- Quality movement based on sustained change in behavior
- Education = sustained change in behavior
- Change residency from knowledge-based residency to quality residency
- Quality matrix (Bingham, Quinn)



SAEM Annual Meeting
May 22, 2005
New York City, NY

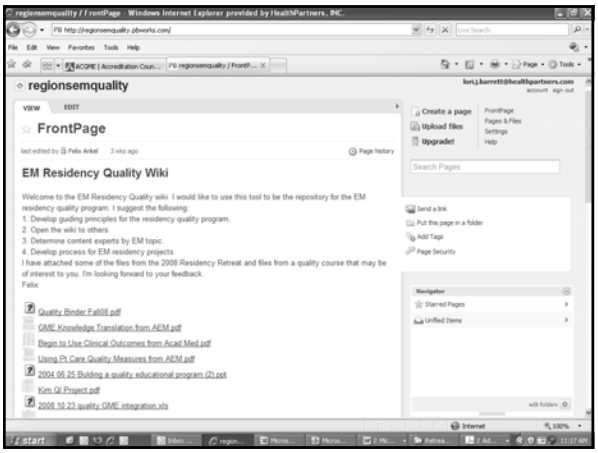
LUNCH SESSION: Closing the Quality Chasm: Research and Educational Initiatives for Academic EM
(12:00-1:30 pm), *Sutton North*
Arthur L. Kellermann, MD, MPH, Emory University
Felix K. Ankel, MD, Regions Hospital
The speakers will highlight the implications of the IOM report for education and research in EM. Using examples from their department, the speakers will provide specific ideas for incorporating the IOM's recommendations in EM training programs. Particular attention will be paid to the relationship between the IOM's goals and the ACGME's core competencies. The speakers also will discuss the specific steps academic EM must take to develop a translational research agenda for achieving the IOM's Quality Chasm goals. Extramural funding opportunities, research training programs, and opportunities for collaboration will be identified. At the end of the session, participants will: 1. Identify how the recommendations from the IOM's Quality Chasm Report apply to EM; 2. Acquire specific ideas for incorporating the IOM's Quality Chasm recommendations in their educational programs, including an explanation of how the IOM goals can be used to address the ACGME core competencies; 3. Identify specific steps for developing a translational research agenda in EM to achieve the IOM's Quality Chasm goals, including recommendations for research training, opportunities for collaboration, and funding sources.

The Matrix



Patient Healthcare Matrix: Care of Patient with pneumonia

AIMS / Competencies	SAFE[1] (Harmless, undersea, reduced)	TIMELY[2] (Delay in Rx, days waiting)	EFFECTIVE[3] (Outcomes, Evidence-based care)	EFFICIENT[4] (Waste of resources)	EQUITABLE[5] (Gender, ethnicity, race, SES)	PATIENT-CENTERED[6] (Preferences, needs, values)
Assessment of Care						
PATIENT CARE[7] (Overall Assessment) Yes/No	No	No	Yes	No	Yes	No
MEDICAL KNOWLEDGE and SKILLS[8] (What must we know?)	Pt could have become septic because of the delay in starting antibiotics. He went home before films were read. Did not get proper care at OSH and came to us.		Once proper diagnosis was made, treatment was appropriate. Outcomes were good.			
INTERPERSONAL AND COMMUNICATION SKILLS[9] (What must we say?)	Spent a lot of time with pt getting history, care, etc. Pt had many other care problems.	Needed to get x-rays first and discuss healthcare issues later.		Should have waited until results of X-ray to make plan of care. We wasted a lot of time going down wrong path.		Team was very good at talking to him but we did not get to his chief complaint fast enough.
PROFESSIONALISM[10] (How must we behave?)	Team was very eager to help and no one acted unprofessional.	What is our role in letting an OHS know that radiology was not available?				
SYSTEM-BASED PRACTICE (What is the process? On whom do we depend? Who depends on us?)	Multiple doctors in multiple systems caused disorganized delay. There were many players: MD, radiology, admissions, insurance, and social worker. This actually caused the problem of getting a fast diagnosis.			Patient needed to go outside of the usual system because he could not get x-rays read at night.		Patient had to navigate the complex system of care at OSH and finally get to Vanderbilt for help.
Improvement						
PRACTICE-BASED LEARNING AND IMPROVEMENT[11]	Getting records from other hospitals is critical when pt	We need a faster system to identify "pneumonia" so they can get ABX		Because we could not get films, they had to be repeated. This patient also needed to		We need to be sure pts with pneumonia are informed of what is happening and



Thoughts

- Caring for patients vs. treating patients
- Complex vs. complicated system
- Wisdom of Crowds, James Surowiecki
- The Culture Code, Clotaire Rapaille
- The Foucault Reader, Paul Rabinow (Ed.)
  - Enlightenment vs. obedience
  - Knowledge, power, ethics

Questions to Consider

- How do we build on our strengths?
- How do we address our weaknesses?
- How do we integrate quality and education? (conferences, clinical practice/rotations, projects…)
- What 9 quality service lines should we begin with? (e.g., cardiovascular, neurosciences, trauma, behavioral health…)

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Emergency Medicine
2008 Resident/Faculty Retreat

Residents				Support/Guests			
✓	Chris Dillon, MD	✓	Catie Carlson, MD	✓	Pat Anderson	✓	Choung Ah Lee
✓	Joe Dolan, MD	✓	Katie Davidson, MD	✓	Lori Barrett	✓	Paul Leon
✓	Danielle Jackson, MD	✓	Autumn Erwin**, MD**	✓	Bruce Bennett	✓	Louis Ling, MD
✓	Duncan McBean, MD	✓	Alex Gerbig, MD	✓	Eugenia Canaan	✓	Mary Ann McNeil
✓	Adina Miller, MD	✓	Kara Kim, MD	✓	Maddy Cohen	✓	Jarrad Maiers
✓	Tara O'Connell, MD	✓	Kolja Paech, MD	✓	Marcella De la Torre	✓	Lesley Moore
	Charis Thatcher, MD	✓	Eric Roth, MD	✓	Scott Donner, MD	✓	Patti Murakami
✓	Aaron Burnett, MD	✓	Jillian Smith, MD	✓	Shonette Doggett	✓	Henry Ortega, MD
✓	Nate Curl, MD	✓	Timmy Sullivan, MD	✓	Ashley Ellsworth	✓	Carl Patow, MD
✓	Aaron Feist, MD			✓	Jeff Fritz	✓	Eric Peterson
✓	Leah Gapinski, MD			✓	Kim Han-young	✓	Sara Pikus
✓	Shani Go, MD			✓	Mary Healy, RN	✓	Marty Richards
✓	Nicci Stoik, MD			✓	John Henkel, RN	✓	Debi Ryan
✓	Heather Sutherland, MD			✓	Rick Hilger	✓	Ted Sibley
✓	Greg Vigesaa, DO			✓	Becky Hofmeister	✓	Diane Taylor
	Brent Walters, MD			✓	Ken Holmen	✓	Susan Walls
				✓	Richelle Jader, RN	✓	Bonnie Wipple
				✓	Ji-Sook Lee		
Faculty							
✓	Felix Ankel, MD		Paul Haller, MD		Kevin Kilgore, MD	✓	Jessie Nelson, MD
✓	Brent Asplin, MD		Carson Harris, MD	✓	Peter Kumasaka, MD		Karen Quaday, MD
	Mary Carr, MD	✓	Cullen Hegarty, MD		Levon Ohaodha, MD		Sam Stellpflug
✓	Won Chung, MD	✓	Keith Henry, MD		Richard Lamon, MD	✓	Stephanie Taft, MD
✓	Rachel Dahms, MD		Brad Hernandez, MD	✓	Robert LeFevere, MD	✓	Michael Zwank, MD
	Kristen Engebretsen, PharmD		Joel Holger, MD		Barb LeTourneau, MD	✓	Drew Zinkel, MD
	RJ Frascone, MD	✓	Kurt Isenberger, MD	✓	Alda Moettus, MD		
✓	Brad Gordon, MD	✓	Kory Kaye, MD	✓	Matt Morgan, MD		

Person	Agenda Item	Action Plan/Key Points
Ankel	Welcome and Historical Perspective	Dr. Ankel welcomed and acknowledged invited guests. Presented historical perspective.
Asplin	Update	The department had another outstanding recruitment year. Many of the faculty are involved nationally in organizations such as ACEP, SAEM, and CORD. Dr. Asplin discussed his transition to Mayo as Chief of Emergency Medicine. He is a graduate of Mayo Medical School, and did a fellowship in health care policy. He will work with the health policy Institute at Mayo. The department has a strong bench. An interim chair will be named soon and a national search is expected for a chair to start in July 2009. Expansion 2009 is going ahead on schedule. The ED is a major focus area of the new expansion.
Holmen	Hospital Update	Dr. Holmen discussed cost, quality and critical issues in healthcare and at the hospital. The ED is critical to the success of the hospital.
Hilger	ER/Triage Handoff	Presented tips for the ED when communicating with hospitalists regarding admissions.
Patow	GME Update	Marecella de la Torre has recently been added to the GME staff as Performance Improvement Project Manager. There is a national initiative linking GME and quality. EM residents and faculty members have taken part in this initiative.
Ling	Medical School Update	Medical school is moving toward competency based, portfolios, simulation, and more mentoring. Many of the initiatives are following GME outcomes. Dr. Ling discussed Med 2010: Transforming Undergraduate Medical Education at the University of Minnesota.

Jader	Operations Update	Department is great shape with a stable and creative operations group. Looking forward to 2009 expansion and getting into the new building. Operation/2009 planning teams working on how to make staff's lives easier – having what you need to provide great care.
Chung	Quality Update	Dr. Chung is the Quality Committee Co-Chairperson with Mary Healy. Discussed what does quality mean to our dept?
Henkel, Healy	Nursing Update	J Henkel distributed nursing structure chart. Any issue or problems can be directed to anyone on the chart. M Healy spoke briefly on quality in the ED. Highlighted that in recent months two items from patients were published in the St Paul Dispatch "Sainted" column complimenting the care they received at Regions Emergency Department. L Hart from the Quality Improvement will be working with the ED help build the foundation for our quality committee, and they are looking for residents to participate.
Ortega	Pediatrics Update	Over the last year , two residents have completed an elective pediatric anesthesia. Pediatric staff are actively involved in a pediatric critical case conference once a month.
Taft, Dahms, Hegarty	Residency Education Updates	- R Dahms is working with the work force planning committee regarding moving into the space and resident schedules. -New selective community rotation with for G2s and G3s -New guidelines for the Cardiology rotation have been established. -G1 residents now have opportunity to go to specialty center for pediatric airways during their anesthesia rotation. -Thursday morning simulations cases before conference is going well. C Hegarty is working with Jeff Fritz regarding a more permanent room, and also looking at options for video taping. -Ultrasound has been well received with M Zwank incorporating tutorials into the anesthesia rotation. -Conference feedback has been positive with the addition of small group days incorporating simulation cases, additional billing, and QI conferences.
Miller, O'Connell, Thielen	Chief Resident Update	-Clarified back up/pull schedule. -Opportunity to work on the RNC and also met needs of department. -Task force –working on implementing changes with move to the expansion for a smooth transition. -S Thielen is exploring alternatives to CORD tests to evaluate medical knowledge. - T O'Connell is involved in picking cases for critical case.
Kim, de la Torre	Continuously Improving Patient Care and Education	Marcella de la Torre and Kara Kim spoke briefly on quality. "Toast Kaizen" video was shown. This video showed how an ordinary task can be improved through critical observation.
	Small Groups	Attendees were divided into small groups. Group were led by A Burnett, K Kim, A Miller, S Thielen . Participants were asked to identify residency strengths and areas of focus.
	Large Group	Each facilitator presented their groups findings. Attendees were then asked to identify their top 3 strengths and top 3 areas for focus. **Strengths:** Listed below in order identified as participants top 3 choices.. ◆ **Critical care experience** (15) ◆ **Procedures** (13) ◆ **Collegiality/Camaraderie** (13) ◆ Conferences (8) ◆ Responsive Program (6) ◆ Residents as Leaders (4) ◆ Ultrasound – G1 rotation(3) ◆ Peds experience – critical case & anesthesia (3) ◆ Happy people (3) ◆ Morning simulation cases(3)

		◆ Graded Responsibility (2) ◆ Ancillary Staff (2) ◆ Communication (1) ◆ Team approach – cohesive group (1) ◆ Resident feel supported (1) ◆ Overseas Rotations (1) ◆ Financial Talks from Eric/Billing clerks (1) ◆ Approachable Staff (1) ◆ Small group conference (1) ◆ Alumni relationships (1) ◆ RNC/State Fair (adaptability & flexibility) ◆ National involvement ◆ Selective rotation at other ED's ◆ Patient mix ◆ Institutional support ◆ Tox – fellowship and rotation ◆ Anesthesia ◆ Continuous improvement focus ◆ Airway ◆ Good Environment ◆ Open to teaching ◆ Leadership – program/department ◆ Evaluations ◆ 10 hour shifts ◆ Inservice review
		Areas of Focus: Listed below in order identified as participants top 3 choices.. ◆ **Ultrasound machines** (23) ◆ **Documentation** (19) ◆ **EKG Training** (10) ◆ Epic Challenges (8) ◆ C-Arm (9) ◆ Voceras – verbal communication (7) ◆ Work-out space (7) ◆ Discharge process (7) ◆ Thru put (6) ◆ Call room (6) ◆ Food options at night (4) ◆ Lactation facility (4) ◆ More billing/Coding (2) ◆ Fast-Track Exposure (2) ◆ Communication (2) ◆ Elective time (maximizing) (2) ◆ Admin experience (2) ◆ Child care (2) ◆ Research, infrastructure, 1st years, ED assts (2) ◆ Permanent simulation home (1) ◆ Conference space (1) ◆ PICU/Peds anesthesia (1) ◆ Case files (rotation) (1) ◆ Airway scope ◆ New ED staffing ◆ Cards rotation ◆ "How to for G1s" ◆ Debriefing (team) ◆ Communication with off service providers ◆ Transfer calls ◆ US skills -> off service ◆ Ortho call ◆ Sin bin

	Large Group	**<u>Top Focus Areas</u>** **Ultrasound machines**: Discussed issues relating to ultrasound machines, including need for new machines, and documenting when machines are down, etc. K Davidson and A Gerbig volunteered to work on an ultrasound facility quality improvement project in the ED. **EKG training**: Discussed ways to improve EKG training within the ED department. Suggestions included incorporating into regular conference, asking EKGs of the week, follow-up system to look at final reading of cards EKG. A Erwin, A Fiest, and C Carlson volunteered to work on an EKG quality improvement. **Documentation:** Discussed the need for best practices for time management and documentation and how best to work within the system. N Curl, D Jackson, R Dahms and S Taft will work on this . **Evening Food Availability**: Eugenia Canaan has been communicating with dietary on this issue. N Stoik has agreed to work on this issue.

HEALTH POLICY REPORT

Medicare, Graduate Medical Education, and New Policy Directions

John K. Iglehart

It has been more than a decade since Congress enacted legislation that significantly altered the policies under which Medicare supports graduate medical education (GME). Now, the political ground under this relationship is beginning to gradually shift again, and if this development gathers momentum, it could lead to greater support for the training of primary care physicians and more scrutiny overall of how these Medicare GME monies are spent. As an increasing number of medical-school graduates pursue specialties with a "controllable lifestyle" and shun careers in primary care, there are distinct signs that Congress will face new demands to examine Medicare payments to teaching hospitals. Although the forces fueling greater specialization are far more powerful than any potential incremental change in federal policy, the Medicare Payment Advisory Commission (MedPAC) has pledged to examine physician workforce issues more closely, "especially with respect to the supply of primary care providers" and "the choices medical students and residents make about their career specialty."[1] As a first step that reflected its concern, in its latest report the commission recommended that Congress increase Medicare fees to primary care physicians in a budget-neutral fashion. This proposal provoked controversy because budget neutrality means, one way or another, that fee adjustments that are intended to award physicians who deliver primary care services would divert money from practitioners who do not — most of whom are specialists.[2]

In this report, I discuss key issues that surround GME policy as it relates to Medicare and Medicaid. These matters are integral to the consideration of a broader issue: whether a shortage of physicians exists or soon will exist, as the academic medical community and an array of other interested parties assert, and if so, whether the government should take action to increase the supply of doctors or influence the mix of generalists and specialists.[3] Although there is no consensus on the issue of physician supply, the adequacy of the workforce may become a more pressing matter if the next administration seeks to extend coverage to millions of uninsured people and discovers that there is an insufficient number of doctors, nurses, and allied personnel available to care for them. Newly insured people in Massachusetts and a few other states have already reported that they are having problems making appointments with physicians in some locales.[4,5] The Institute of Medicine recently reported the findings of a study that documented an acute shortage of geriatricians as the baby-boom population nears retirement.[6]

A LONG-STANDING FEDERAL COMMITMENT TO SUPPORT GME

In 1965, when Congress enacted the legislation that created Medicare, it assigned to the program functions that reach well beyond its basic mission of providing health insurance to an eligible population that now numbers 45 million people who are elderly, disabled, or have end-stage renal disease. One of the most important of these functions provides substantial support to the training of new physicians through GME programs, most of which are operated by major teaching hospitals.[7] At the time of enactment, Congress determined that educational activities in teaching hospitals should be regarded as a reimbursable expense by Medicare until "the community [society at large] undertakes to bear such education costs in some other way."[8,9] Fast-forward 43 years and, despite attempts to broaden the explicit sources of support (from private insurers, for example) for training new physicians through GME, no policy has ever been crafted to achieve this goal of academic medicine. In 2007, Medicare provided $8.8 billion to teaching hospitals in support of their GME programs and re-

lated patient-care activities. Private insurers do support GME implicitly through the higher payments they negotiate with teaching hospitals on behalf of the inpatients they cover. Although one report estimated that private insurers contributed $7.2 billion in support of GME in 2006,[10] it is almost impossible to calculate such a number because the portion of these higher prices that defrays the costs of advanced training is neither separately negotiated nor specifically identified. Regardless, private insurers have strongly opposed any public policy that would mandate that they pay a portion of GME expenses.

THREATS TO FEDERAL SUPPORT OF GME

Of the federal programs and agencies that support GME (e.g., Medicare, Medicaid, and the Departments of Defense and Veterans Affairs), Medicare has become the major battleground for debate over GME policy, because among these sources its contribution is by far the largest. Medicare recognizes the costs that teaching hospitals incur in training and other activities in two ways. First, it provides direct payments for medical education to hospitals that cover a share of the stipends paid to residents, salaries of supervising faculty, and other allowable program expenses. Second, it provides an indirect medical-education adjustment, the goal of which is to cover the added patient-care costs associated with training.

On February 4, the Bush administration submitted its 2009 budget to Congress and proposed reductions in an array of domestic programs, including Medicare and Medicaid, while calling for increases in spending on defense and homeland security. The budget also would extend tax cuts that expire in 2010 and which Democrats have criticized as mostly benefiting wealthy people. If enacted, the budget would slow the annual growth rate of Medicare over 5 years (from 2009 through 2013) from 7.2% to 5.0% by reducing expenditures by $182.7 billion over this period. Medicare expenditures totaled $432 billion in 2007.

Among the cuts sought by the administration is one that would decrease by 60% over 3 years the add-on payments that Medicare makes to teaching hospitals for their expenses for indirect medical education; these payments are based on the number of residents these hospitals employ. In 2008, for every 10 residents per 100 beds, a teaching hospital received a 5.5% add-on adjustment to its Medicare payment rate for hospital care. Indirect payments for medical education to training facilities totaled about $5.8 billion, three quarters of which went to major teaching hospitals and averaged about $14 million per institution. The lowering of the add-on payments for indirect medical education from 5.5% to 2.2% would yield savings to Medicare of $12.9 billion over 5 years. The administration's proposal is consistent with an analysis by MedPAC that concluded that "the current adjustment is set at more than twice what can be justified empirically, directing more than $3 billion in extra payments to teaching hospitals with no accountability for how the funds are used."[2] The president's budget also proposed to eliminate the adjustment for indirect medical education that teaching hospitals receive when they treat patients who are enrolled in Medicare Advantage, the program's managed-care component. The elimination of this adjustment would yield estimated savings to Medicare of $8.85 billion over 5 years.

In yet another attempt to reduce federal support for GME, the administration also proposed a regulation in 2007 that would bar state Medicaid programs from using any of their federal matching dollars to fund advanced medical training in hospitals within their states. Overall, the federal government pays about 57% of the costs of Medicaid, an estimated $204 billion in fiscal 2008. In 2005 (the latest estimate available), Medicaid provided support totaling $3.2 billion to GME programs within their respective states.[11] The release of the administration's 2009 budget provoked concern in the academic medical community; however, in all likelihood, Congress will accept very few of these proposed spending reductions.

THE FITS AND STARTS OF U.S. PHYSICIAN WORKFORCE POLICY

After supporting GME through Medicare's open-ended payment policies for more than 30 years, Congress, in the Balanced Budget Act of 1997, placed a cap on the number of residency positions that the program would support.[12,13] The law stipulated that Medicare would not pay its share of the allowable GME costs of residents in allopathic and osteopathic medicine beyond the costs of the number of residents who were training in a given teaching hospital as of December 31, 1996. At the time, there was no opposition to

the cap.[14] Indeed — reflecting the fits and starts of U.S. physician workforce policy — the provision was actually supported by six major medical organizations. These organizations issued a consensus statement in 1996 that asserted that the United States was on the verge of a serious oversupply of physicians. As a consequence, they said, the number of entry-level GME positions should be aligned more closely with the number of graduates of U.S. medical schools, and "this realignment should be achieved primarily by limiting federal funding of GME positions."[15]

In 2006, the Association of American Medical Colleges (AAMC), one of the six organizations, reversed its position and recommended the enrollment of 30% more students in schools of allopathic medicine than the 16,488 enrollees in 2002, or an additional 4946 students, by 2015.[16] In addition, it called for elimination of the cap on Medicare-supported GME positions and an increase in entry-level residency positions. The association said its policy reversal derived from the failure of tightly organized managed-care plans to materialize as the major delivery model in the United States. Had this development occurred, the AAMC said, it would have "drastically change[d] the way that health care is organized and delivered." The American Medical Association is also on record as favoring an increase in the capacity of U.S. medical schools to educate doctors.

EFFORTS TO LIFT THE MEDICARE GME CAP

Legislation has been introduced in the House and the Senate to modify the cap policy, but the scope of this policy is limited and the formula for creating new residency positions is complex. The measure would support new training positions only in the 24 states in which the ratio of resident physicians to the population is below the national median. The AAMC estimates that 1222 new positions, slightly more than 1% of the total number of positions that Medicare currently supports in the entire country, would be eligible for Medicare support under the legislation (Knapp RM: personal communication). To limit the costs associated with this policy shift, the new positions would be phased in over a period of 5 years. In addition, the Department of Health and Human Services would be required to determine whether a hospital seeking to add positions could fill them within 3 years. It would also be required to take into consideration (but not dictate) whether the new slots would be in primary care, preventive medicine, or geriatrics. Although the legislation has influential sponsors, including Senate Majority Leader Harry Reid (D-NV) and Senator Bill Nelson (D-FL), its early enactment is unlikely, given the overall financial challenges that Medicare faces and the substantial support the program already provides to teaching hospitals. Moreover, because of the limited scope of the legislation, many major teaching hospitals would derive little or no benefit; thus, support for the measure has been less than strong.

Underscoring the value that teaching hospitals attach to their educational mission and to residents who provide considerable amounts of patient care during their on-the-job training at low salaries, these facilities have created approximately 6500 new positions that receive no GME support from Medicare. In 2002, the number of residents in GME programs approved by the Accreditation Council for Graduate Medical Education (ACGME) totaled 98,258. By 2006, that number had risen to 104,879, an increase of 6.3%. But relatively few of these new positions are entry-level slots, the expansion of which the AAMC is advocating. According to Michael Whitcomb, a former senior vice president of the AAMC,

> Virtually all of the positions that were added [by teaching hospitals after imposition of the Medicare cap] increased the number of subspecialty fellowship positions in the system. Thus, if the removal of the caps simply allows teaching hospitals to continue recent practices, it will have no meaningful effect on the number of PGY-1 [first postgraduate year] positions. Accordingly, it will have no impact on the aggregate supply of physicians in the long term. Thus, any policy that evolves at the federal level to increase physician supply must link the removal of the caps to an increase in PGY-1 positions.[17]

However, increasing the number of PGY-1 positions may not necessarily increase the number of trainees who enroll in primary care programs. The reason is that the number of slots in family medicine (the specialty that produces the largest number of doctors who devote their practices to primary care) that are filled by all appli-

cants, including graduates of foreign medical schools and colleges of osteopathy, has been decreasing for a decade and has decreased precipitously among graduates of U.S. medical schools (Table 1). In 1997, of 3262 training positions offered in family medicine, 2905 (89.1%) were filled — 71.7% by graduates of U.S. medical schools. In 2008, of the 2654 positions offered in family medicine, 2404 (90.6%) were filled but only 1172 (44.2%) were filled by graduates of U.S. schools. The total number of matches in family medicine in 2008 represented a modest increase from 2313 matches in 2007. Overall, the latest results, which were released March 30 by the National Resident Matching Program, again underscored the increasing popularity of specialties that have a more controllable lifestyle.[18-21] These specialties enable physicians to schedule more regular hours and, in most cases, earn incomes well above those of primary care doctors. Specialties that generally fall into this category include anesthesiology, dermatology, emergency medicine, neurology, ophthalmology, otolaryngology, pathology, plastic surgery, psychiatry, and radiology.

In its 2006 statement on the physician workforce, the AAMC emphasized that "individual medical students and physicians should be free to determine for themselves which area of medicine they wish to pursue and GME programs and teaching hospitals should be free to offer training in specialties they wish to offer if accredited by the ACGME."[16] By contrast, a 2008 report issued by the Association of Academic Health Centers, which has 100 member institutions that consist of a medical school and one or more other schools that provide training in a health profession, called for sweeping change that would recognize broader societal considerations. The report asserted that "traditional approaches to decision making are no longer viable" and recommended the creation of "an integrated, comprehensive national health workforce policy that recognizes and compensates for the inherent weaknesses and vulnerabilities of current decentralized and distributed multistakeholder decision making."[22]

CHANGES IN THE WIND OVER HEALTH WORKFORCE POLICY

Fifteen years ago, the Clinton administration, individual members of Congress, and the Physician Payment Review Commission all put forward proposals that called for federal regulation of the mix of generalist and specialist residents who were supported by Medicare. These schemes never generated much support and lost favor as Repub-

Table 1. Number of Applicants Matched to Family-Medicine Programs According to Applicant Type, 1997 and 2008.

Applicant	1997			2008		
	Applicants (N=2905)	Placements (N=2905)	Positions Offered (N=3262)	Applicants (N=2387)	Placements (N=2387)	Positions Offered (N=2636)
	no.	%	%	*no.*	%	%
Senior in allopathic medical program	2340	80.6	71.7	1156	48.4	43.9
Non-U.S. citizen, student or graduate of international medical school	198	6.8	6.1	494	20.7	18.7
Student or graduate of osteopathic medical program	159	5.5	4.9	264	11.1	10.0
U.S. citizen, student or graduate of international medical school	103	3.5	3.2	397	16.6	15.1
Student or graduate of fifth-pathway program*	66	2.3	2.0	6	0.3	0.2
Previous graduate of allopathic medical program	35	1.2	1.1	69	2.9	2.6
Canadian citizen	4	0.1	0.1	1	<0.1	<0.1

* The fifth pathway is an avenue by which students who have attended a foreign medical school for 4 years may complete their supervised clinical work at a medical school in the United States and become eligible for residency training in the United States. Such students who successfully complete residency training can ultimately obtain a license to practice in the United States. Data are from the National Resident Matching Program.

licans gained control of the government during and after the end of the Clinton administration. The Bush administration has been particularly opposed to regulating the composition of the physician workforce. It believes that the market will equilibrate any distortions in the number and types of doctors, and it proposes, time and again, to zero out virtually all of the programs in the health professions that have been authorized under Title VII of the Public Health Service Act. The administration has also thwarted or delayed the release of health workforce studies that have suggested government action; most of these studies have been prepared by the Council on Graduate Medical Education (COGME) and produced under contract with other offices of the Health Resources and Services Administration. When agencies that advise Congress (e.g., the Congressional Budget Office, the Government Accountability Office, and MedPAC) have recommended major alterations in workforce policy or issued reports that propose to do so,[23-25] legislators have opted for approving only incremental changes and have left many issues untended.

In recent months, however, somewhat stronger interest has begun to emerge on physician workforce issues because of the decreasing number of students who are pursuing careers in primary care. Several interested groups have also expressed concerns that an overall shortage of doctors looms or already exists in some locales and, thus, medical schools should expand their capacities to educate students.[3] Thus far, these developments have provoked only a few ripples in Congress, and they do not begin to match the dire forecasts of groups such as the American College of Physicians, which asserted that "primary care, the backbone of the nation's health care system, is at grave risk of collapse."[26-31]

The most active, government-based policy discussions on physician workforce issues have emerged from the COGME and MedPAC, which is the more influential of the two advisory groups. In its June 2008 report, MedPAC expressed the view that "beneficiary access to high-quality primary care is essential for a well-functioning health care delivery system," but it noted that because these services are undervalued, they are at risk of "being underprovided to the Medicare population."[2] The commissioners signaled their interest in tying future federal support of GME to training in particular specialties when they suggested in their latest report that

> policymakers could consider ways to use some of these [Medicare] GME and [indirect medical education] subsidies toward promoting training in primary care. For example, a portion could be targeted specifically to support medical residency positions in primary care. Similarly, allocating shares toward nurse practitioners and physician assistants — integral partners in managing patients' chronic conditions — could be useful for promoting primary care services.

The commissioners were critical of the growing emphasis on specialty care, asserting that "areas with more specialist-oriented patterns are associated with higher spending, but not improved access to care, higher quality, better outcomes, or greater patient satisfaction." To reach its conclusions, the commission relied heavily on the findings of researchers at Dartmouth Medical School,[32-34] who have conducted studies that have also influenced the Congressional Budget Office.[35]

MEDPAC RECOMMENDATIONS PROMOTING PRIMARY CARE

On the basis of these views, MedPAC made two recommendations to Congress in its new report. First, legislators should make an upward adjustment of Medicare fees for primary care services such as office and home visits, which are billed under the physician fee schedule. The adjustment would also increase payments for services when they are furnished by physicians, advanced practice nurses, and physician assistants who have focused their practices on primary care. Second, Congress should initiate a pilot project designed to determine the value that a "medical home" could provide to Medicare beneficiaries. It should also provide the program with an opportunity to structure payment incentives for primary care activities such as care coordination, which are sorely needed by many patients[36] and called for by professional associations.[37]

For purposes of this article, the most important of these recommendations would adjust upward Medicare fees for primary care services because the effect of this adjustment would be more immediate. If enacted, the adjustment would be instituted on a budget-neutral basis; thus, it would come at the expense of specialists' fees. Providers could receive the adjustment if primary care ser-

vices, as a percentage of their practices, met a certain threshold. The commission considered thresholds in a range of 40 to 75% of a primary care practice and payment adjustments of 5% and 10%. For example, allowed charges for an eligible physician would increase by at least 5.6% with an adjustment of 10% and a threshold of 60%. Physicians in geriatric medicine and family practice would most likely be the major beneficiaries of the fee adjustment because, on average, they devote the largest percentage of their practice time to primary care. Although these payment adjustments would be an improvement in the fees paid to physicians who deliver primary care services, their incomes would still be well below those of doctors who perform procedures (Fig. 1).

CALLS FOR GME REFORM AND GREATER ACCOUNTABILITY

With virtually no staff to call on, members of the COGME have had to write their own reports.[39,40] However, because most of its members are practitioners of one kind or another — specialists, family physicians, and leaders of academic medical centers and nonprofit health systems — rather than strictly policy analysts, they bring some credibility to the reports that derives from their operational experiences. Dr. Russell G. Robertson, chairman of the Department of Family Medicine at Northwestern University, presides over the council. In one of its recent reports, the council recommended an increase of 15% in the number of Medicare-supported GME positions.[40] (MedPAC has not adopted a position on that issue.) At the same time, COGME urged Congress to broaden the definition of an eligible "training venue" beyond that of the inpatient setting, pointing out that

> GME funds are tied to inpatient, hospital-based care, while medical practice and education are shifting more to the ambulatory setting for both primary care and specialty care services. . . . The future practice of medicine, and therefore training, should be coordinated, interdisciplinary, and patient-centered, rather than fragmented among multiple unrelated providers and settings of care. Unfortunately, the current GME funding streams continue to perpetuate an outmoded style of medicine.

The COGME and MedPAC have also recommended that teaching hospitals be held to greater accountability for the public monies they spend on training new physicians. Underscoring this

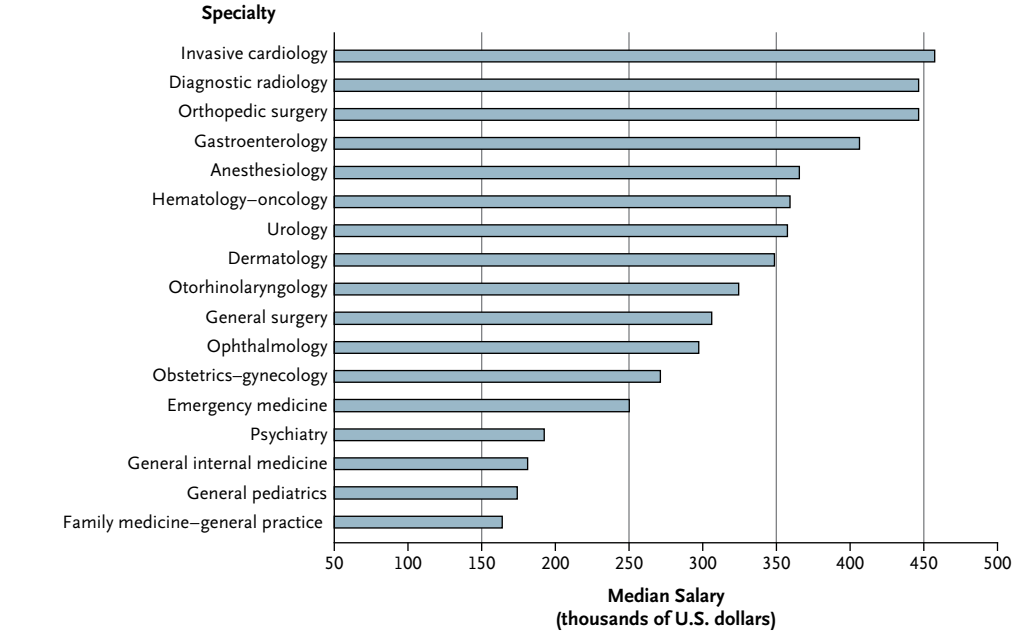

Figure 1. Median Salary According to Medical Specialty, 2006.
Data are from the Medical Group Management Association.[38]

view, the chairman of MedPAC for 8 years, Glenn Hackbarth, said at its public meeting in January 2007 that he had the "utmost respect" for teaching hospitals, but he added, "my perennial concern . . . has been that the current [indirect medical education] system is problematic . . . because there is no accountability for what's produced . . . I would like to see . . . appropriate funding for these important institutions coupled with more accountability."[41]

NEW ADVOCATES FOR PRIMARY CARE

Given the overriding emphasis on specialization and the beleaguered state of primary care, a variety of concerned persons and organizations have launched efforts to resurrect the role of the generalist physician in the medical workforce. A coalition of large employers, consumer groups, professional associations, and other stakeholders, spearheaded by IBM and organized as the "patient-centered primary care collaborative," has coalesced around the model of the medical home as its preferred way of promoting primary care.[42,43] In describing its intent, the collaborative said,

> Employers that subsidize health care coverage want to provide access to care that delivers excellent outcomes, creates patient confidence and satisfaction and is affordable for all who pay — a challenge we have yet to meet. . . . Research studies in countries where patient–physician relations focus on primary care consistently show that people live longer, populations are healthier, patients are more satisfied with their care and everyone pays less.[44]

The coalition has persuaded the presumptive Republican and Democratic presidential nominees to endorse the concept of a medical home (Grundy P: personal communication).

The AARP has begun to express its concerns over the decline of primary care on behalf of its membership of 39 million people who are 50 years of age or older. John Rother, group executive officer of policy and strategy for AARP, said in an interview that I conducted, "Primary care is key to more effective and efficient delivery of services, especially for individuals with multiple chronic conditions. We support changes in physician reimbursement that will generate a more appropriate mix of physicians going forward." In another recent interview, Mark B. McClellan, administrator of the Centers for Medicare and Medicaid Services from 2004 to 2006, said,

> There are increasing calls for GME reform but that has not translated into broad support for changes that could save some money and provide better support for training physicians in innovative approaches to coordinate care, enhance care for disadvantaged populations and develop better models of translational research. These are vital goals that need further development as soon as possible.

CONCLUSIONS

The new expressions of concern over the composition and size of the physician workforce, mixed with the prospect of a new era of discussions about health care reform, could renew the debate about medical specialties and about how many doctors are enough. Should this debate develop, policies designed to encourage more medical-school graduates to pursue careers in primary care will, in all likelihood, focus on financial incentives rather than (as it did 15 years ago) on the creation of a national commission that would allocate residency positions among specialties.[45] However, this impulse is a long way from fruition given the large differential in fees that separates generalists and specialists, the American preference for private decision making, and the reluctance of government to wade into this complex arena that could deteriorate into a pitched battle between physicians with conflicting economic interests.

Advocates of primary care practitioners believe that nothing short of a major overhaul of economic incentives would attract more medical-school graduates to pursue careers as generalist physicians. But to achieve this goal will take nothing less than a vigorous public uprising that compels policymakers and private stakeholders alike to acknowledge the value of making primary care a centerpiece of a restructured health care system, as is the case in most other industrialized nations, and acting accordingly. That kind of commitment on behalf of primary care may emerge in the future, but it is not on the American horizon today.

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Health Goals 2010

Innovate and simplify . . .

. . . to deliver best health.

Safe | Equitable | Efficient | Effective | Timely | Patient/Member-Centered | Six Aims

1. **Customers receive amazingly easy-to-use care, coverage and service.**
   - A. By 2010, HealthPartners health plan will score in the 90th percentile in each of the 10 key results for commercial CAHPS.
   - B. By 2010, the HealthPartners dental group will achieve top decile performance for patients' willingness to recommend.
   - C. By 2010, HPMG will achieve top decile performance for patients' willingness to recommend.
   - D. By 2008, HealthPartners will define measures of access satisfaction that are inclusive of emerging alternatives to face-to-face visits.
   - E. By 2008, HealthPartners will define measures of satisfaction reflecting efficient path to recovery from illness and will establish a goal for improvement.
   - F. By 2010, Regions hospital will achieve top quartile performance among medical/surgical inpatients on willingness to recommend.
2. **Customers receive maximum quality and affordability in health and care.**
   - A. By 2010, HealthPartners health plan will achieve top decile performance on key HEDIS & CAHPS results.
   - B. By 2010, HPMG will perform at the 90th percentile on HealthPartners quality of care index, and in the most favorable tier of providers in the Total Cost Index for tiered specialties.
   - C. By 2010, Regions hospital will perform at the 90th percentile for HealthPartners hospital quality of care index, and in the most favorable tier of hospitals based on Total Cost of Care
   - D. By 2010, HealthPartners in partnership with other stakeholders will develop an index of affordability and costs which is benchmarked to a multiple of the federal poverty level, or another publicly available benchmark.
   - E. By 2007, HealthPartners will have a strategic approach to eliminate unwarranted variation in supply sensitive services.
3. **Patients and members receive equitable care and service.**
   - A. By 2006, we will measure disparities in experience, preventive services and diabetes by race and financial class.
   - B. By 2008, we will measure disparities in vascular disease care, pregnancy and asthma by race and financial class.
   - C. By 2010, we will cut identified disparities by 75%.
4. **Customers feel they are treated as individuals.**
   - A. By 2010, 90% of commercial members will say HealthPartners' customer service always treated them with courtesy and respect.
   - B. By 2010, HealthPartners dental group will achieve top decile performance in patient's reporting that their dentist treated them with respect and dignity.
   - C. By 2010, HPMG will achieve top decile performance in patients reporting that their health care provider treated them with respect and dignity.
   - D. By 2010, Regions Hospital will achieve top quartile performance among medical/surgical inpatients reporting being treated with courtesy and respect.
5. **Patients and members have and understand the information they need to be effective decision-makers.**
   - A. By 2010, 75% of CAHPS survey respondents will give an excellent rating to HealthPartners for how well the plan provided information and support to help make decisions about their health care.
   - B. By 2010, HealthPartners dental group will achieve top decile performance in patients reporting their dental clinic provided them with information to make better decisions about their oral health.
   - C. By 2010, HealthPartners dental group will achieve top decile performance with patient agreement that this information helped to make better decisions about your oral health and care.
   - D. By 2006, HealthPartners will outline a formal process for supporting patient-decision making and health literacy.
   - E. In 2008, the OB/GYN and Breast Cancer departments will implement patient decision making tools for those patients with benign uterine disease or breast cancer.
6. **Customers are incented and supported for self care and healthy behaviors.**
   - A. By 2010, we will offer a Health Assessment to every adult member and medical group patient and we will have a 75% adult participation rate.
   - B. By 2010, we will have 100% improvement in the comprehensive lifestyle behavior measure reported by our members and patients.
7. **Customers experience perfect transitions among clinicians, patients, family, payers and community support.**
   - A. By 2010, HealthPartners medical & dental groups will achieve 75% of patients who strongly agree (top box) their care was coordinated well.
   - B. By 2010, Regions hospital will achieve top quartile performance on satisfaction with transition of care questions.
   - C. By 2010, HealthPartners plan will achieve 75% of patients who are very satisfied (top box) with how well specialty care and hospital care are coordinated with their personal physician.
   - D. By 2010, HealthPartners will achieve __% performance for frail elderly/MSHO patients who experience nonelective rehospitalization for the same condition that prompted their index hospitalization.
8. **Customers receive evidence-based care, creating an efficient path to recovery.**
   - A. By 2010, HealthPartners will achieve 60% performance on diabetes optimal care outcome measures and 75% performance on vascular optimal care outcome measures.
   - B. By 2010, HealthPartners will achieve 90% performance on all optimal care process measures. [preventive services, community acquired pneumonia (CAP), congestive heart failure (CHF), acute myocardial infarction (AMI), ventilator associated pneumonia (VAP), central line (CLI) & surgical site infections (SSI), depression, and pressure ulcer prevention].
   - C. By 2010, double or triple the percent of health care costs and episodes assessed with optimal care approach.
   - D. By 2007, HealthPartners will develop a strategic approach to reducing variation in supply sensitive services and create stretch performance targets for improvement.

Lasted Updated: 3/11/2008

Mission — **To improve the health of our members, our patients and the community.**

Vision — **To be the best and most trusted provider of health care, health promotion, health care financing and health care administration in the country. We will transform health care by delivering outstanding care and service based on the six aims: Patient/member centered, Timely, Effective, Efficient, Equitable, Safe**

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Innovate and simplify . . .

. . . to deliver best health.

Safe
Equitable
Efficient
Effective
Timely
Patient/Member-Centered

Six Aims

9. Members and patients will have help to be healthy

Optimal Lifestyle
- Tobacco use and exposure
- Nutrition
- Obesity/weight management
- Substance Abuse
- Physical Activity

A. By 2006, we will include Nutrition & Substance Abuse components into our Optimal Lifestyle measurement.
B. By 2010, we will achieve 100% improvement in the Optimal Lifestyle behaviors measure reported by our patients & members.

10. Members and patients will have help with health/life transitions

Pregnancy and childbirth

A. By 2010, we will cut identified disparities in pregnancy treatment and outcomes by 75%.

Palliative care

B. By 2010, 80% of HealthPartners members enrolled in complex case management programs, MSHO community based patients, HPMG stage IV CHF, and oncology patients engaged in disease management programs will have advanced directives.

11. Members and patients will live well with acute and chronic illness and disease

Diabetes care

A. By 2010, HPMG total cost of care for patients with diabetes will be in the best 1/3 of providers.

Vascular disease care

B. By 2007, HealthPartners will expand its Heart Disease programs to include other vascular conditions for which Optimal Care guidelines create improved care & health.
C. By 2010, HealthPartners will achieve 75% performance on Optimal Vascular Disease Care.
D. By 2010, HPMG total cost of care for patients with vascular care needs will be in the best 1/3 of providers.

Cancer care

E. By 2010, HealthPartners will define measures of optimal cancer care and develop a benchmark for improvement.
F. By 2010, HealthPartners Cancer Disease Management Program will achieve an engagement rate of 70% for high severity commercial members.
G. By 2010, Regions Hospital will achieve top quartile performance among oncology inpatients reporting during their hospital stay, the doctors explained things in a way they understood.
H. By 2010, HPMG will achieve top decile performance with oncology/hematology and breast center patients reporting they received as much information about their condition and treatment as they needed from their provider to make informed decisions.

Bone and joint disease care

I. By 2007, HealthPartners will develop optimal care measures for supply sensitive services, and create stretch performance targets for improvement.
J. By 2010, HPMG total cost of care for bone & joint disease care will be in the best 1/3 of providers.

Depression care

K. By 2010, 50% of newly diagnosed patients & members will have a 50% improvement in their symptoms as measured via PHQ9.

Asthma care

L. By 2010, 90% of patients with persistent asthma will be on anti-inflammatory therapy.

12. Members and patients will be safe

Rapid response teams

A. By 2010, HealthPartners will reduce code II calls per 1000 patient discharges by 50%.

Medication reconciliation

B. By 2010, HealthPartners will decrease adverse drug events associated with harm by 75%.

Hospital acquired infections

C. By 2010, HealthPartners will eliminate occurrences of hospital acquired infection related to Ventilator Associated Pneumonia (VAP), Surgical Site Infections (SSI) and Central Line Infections (CLI).

Reduced harm in hospital and clinic settings

D. By 2007, HealthPartners will identify measures of clinic and hospital safety and develop stretch targets for clinic and hospital.

E. By 2010, the Regions Hospital Standardized Mortality Rate (HSMR) will be at or better than the actual to expected rate of 100% (e.g. lower than 100%).

Lasted Updated: 3/11/2008

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People	Health	Experience	Stewardship
Live the HealthPartners values	***Be the best at improving health***	***Deliver an exceptional experience that customers want and deserve at an affordable cost***	***Deliver greater value, growth, and financial results***

Regions Hospital Focus for 2009

People

- Provide resources and support for employees to be successful in Expansion 2009 planning and implementation
- Create a culture of partnership to improve employee well-being
  - Demonstrate and cultivate respect
  - Effectively communicate the link between day to day work and our annual goals
  - Recognize and reward great performance
  - Inspire people to serve our customers as the top priority
  - Support employees in their goals for health improvement
- Foster a culture of accountability to achieve performance excellence (Manager Expectations Plan)
- Increase the diversity of our workforce in leaders, professional and technical, and skilled craft categories

Health

- Patient and Family involved in care and driving decision making
- Measurably improve results to achieve our Health Goals 2010 by:
  - Focused interdisciplinary Performance Improvement teams
  - Clearly defined accountability structure and incremental goals established
- Further commitment to a Culture of Safety through
  - Implementing and supporting highly reliable systems
  - Maintaining Effective Care Teams
  - Standardized systematic approaches to performance improvement
- Reduce health disparities based on race and language
- Continued work on behavioral health including the care model and facility planning

Experience

- Achieve a welcoming environment with a unified approach across the Regions Hospital campus
- Measurably improve our customers' experience (Patient Satisfaction Improvement)
- Reinforce ownership and enthusiasm for service excellence with every employee and leverage technology to improve customer experience
- Improve key throughput processes that impact the customer experience (Access and Flow Measures)

Stewardship

- Achieve staff and provider efficiency targets established in Expansion 2009 assumptions
- Improve cost structure in our hospital and service lines to reduce cost of care
- Generate required net income ($9 million)
- Achieve growth targets
- Cross utilize and market our care delivery system (Group Practice Building)
- Participate in pilot package pricing
- Pursue public policy change to address DSH decreases so as to insure the viability of safety net hospitals
- Development of financial models which support behavior health facility improvements

What is different?

People

- Regions Expansion 2009 opening with significant time and work dedicated to planning and implementation
- Improvement in pulse survey participation rates and outcomes
- Manager performance expectations clearly defined and understood
- Communication tools continue to support performance and culture goals - these include Daily Huddles, Employee Forums, Recognition Programs, etc.
- Expanded competencies required for leaders and direct line staff

Health

- Regions Expansion 2009 opens, requiring broad involvement for units/departments in care system design implementation including a new management structure to support larger units
- Broad awareness of Health Goals 2010 throughout Regions Hospital
- Continued top decile performance in publicly reported quality measures
- Reliable patient race and language data collection systems/methodologies

Experience

- Expansion 2009 opens which will create a physical environment for our patients/families that is differentiable and market leading
- Improving patient satisfaction scores in 2008
- Hardwiring BCBE systems at all levels – more specific targeted pilots and interventions at focused unit levels
- Manager Expectations Plan fully implemented
- Improvements in Access and Flow
- Real time capacity data automated and available

Stewardship

- Efficiency plans developed across hospital departments using financial targets and benchmarks
- Continued progress in Group Practice Building
- Improving access and use of capacity to meet/exceed occupancy targets
- Increasing collaboration and shared accountability to drive growth in all areas critical to Expansion 2009
- Successful Regions Direct Revitalization for all referring providers for direct admissions to Regions Hospital
- Package pricing for Orthopedics and Cardiology

How will we make this happen?

People

EMPLOYEE

- Promote the importance of employee survey participation at all levels
- Each staff member will continue to receive timely feedback on performance and annual performance reviews
- Successful training for Expansion 2009 expanded competencies

LEADER

- Budget staff training and education for Expansion 2009
- Include pulse survey participation targets in manager expectations plan
- Follow structured plan when manager expectations are not met
- Implement effective recruiting approaches and retain a diverse leadership team and workforce
- Implement selection process to attract, select, and retain employees who will contribute to improved patient experience
- Pilot Just Culture structure in surgical services

Health

- Promises emphasis to implement an integrated 2009 patient-centered work plan led by BCBE (including, but not limited to, Tri-care, AIDET, Interdisciplinary Rounds, SBAR, Visiting Policy)
- Partner with patients and families to achieve health goals
- Implement integrated strategies across Hospital and Medical Group to achieve our Health Goals 2010
  - Use Health Goals priorities as an input to the divisional 2009 plans
  - Monitor progress against the goals
- Test and measure effectiveness of new approaches with a common set of measures across the organization
- Leverage technology to improve health (Epic Optimization and support plan)
- Successful recruitment of key physicians
- Improve awareness of clinical health data at staff level through Huddles, BCBE boards, and HBI utilization
- Identify and reduce health disparities related to Equitable Care
- Continued development of innovative care model strategies
- Development of a behavior health facility plan
- Care management model of behavioral health patients to improve care and affordability for this population
- Prevent unnecessary readmissions by standardizing processes using best evidence care to improve individual outcomes and system affordability

Experience

- Systematic reinforcement of tool implementation through Manager Expectations Plan
- BCBE tools fully implemented: patient rounding, staff rounding, AIDET, Questions About My Care, and Who's My Doc
- Implement campus naming, signage & way finding through Regions Hospital campus
- Expand Access and Flow technology capabilities
- Implementation of Emergency Department Lean Teams focused on ED Flow
- Physician Model of Care work focused on communication with physicians
- Identify and reduce experience disparities for Equitable Care
- Optimize electronic tools for improved patient and visitor experience
- Implement welcoming and departure strategies including leadership and department structure
- Ancillary and support departments will have the same service and improvement objectives as the clinical care providers
- Focus on improving end of life care by appropriately expanding the use of inpatient palliative care and advance care planning for patients with congestive heart failure

Stewardship

- Commitment to improve resource utilization and support supply cost reductions
- Achieve increased throughput and capacity goals in inpatient, ED and OR
- Develop and market plans and services for growth in the East Metro & Western Wisconsin in Cardiovascular, Neurology, Orthopaedics, Urology, and other key service lines
- Continue integrated focus on Group Practice Building
- Navigate State of MN and CMS changes to Medicare payments with focused efforts to ensure accurate documentation, coding, and reimbursement
- Communicate the community benefit investment made by Regions Hospital
- Expand package pricing work to support continued innovation in clinical and business models addressing the need to make healthcare more affordable
- Implement more robust VAT (Value Analysis Team) process to achieve targeted savings/cost reduction and manage appropriate technology utilization
- Improve resource utilization with a focus on supplies, lab and pharmacy

How will we know it happened?

People

- Achieve specialization to patient type in OR, ED, and patient aggregation for South/Central Sections
- Improved Pulse Survey Scores in "At HealthPartners/Regions Hospital the people with whom I work treat each other with respect" from 63% to 65%
- Improved employee survey scores in "Would you recommend Regions" from 77% to 84%
- Achieve EEOC diversity targets in the Officers and Managers categories - increase by 10%

Health

- Achieve Hand Washing Compliance of 90%
- Execute to achieve HealthGoals 2010
  - CAP Perfect Care to 91%
  - SSI Perfect Care to 90%

Experience

- Improved experience measures
  HCAHPS top quartile performance in:
  - Would You Recommend to 74% (RN Communication to 74%, MD Communication to 80% and Pain Control to 68%)
- Reduce Regions Direct med/surg patient diverts to 0.5% or less
- Improve discharge before noon to 35% for med/surg and behavioral health patients

Stewardship

- Achieve budgeted net income of $9 million
- Ensure HPMG Tier 1 and NSP utilization of HPMG Specialties
  - Improve utilization percentage to 80%
- Expansion 2009 on time on budget

Our mission **is to improve the health of our patients and community by providing high quality health care which meets the needs of all people.**
Our values: **Passion Integrity Teamwork Respect**

HealthPartners®

2010 ANNUAL PLAN

Confidential

Our vision: **Through our innovative solutions that improve health and offer consistently exceptional experience at an affordable cost, we will transform healthcare. We will be the best and most trusted provider in health care, health promotion and health plan services in the country.**

	Success	What drives our success?	How will we make success happen?
People	***A highly engaged and committed workforce as measured by:*** • Improved employee well-being • Increased workforce diversity • Alignment with our mission and values across HealthPartners	Build on our culture of **partnership** • Respect • Accountability for excellence (go above and beyond) • Reward and recognition • Involvement and engagement	• Be reliable and follow through on responsibilities • Emphasize the importance of positive attitude • Set clear expectations and priorities for every employee • Leaders will regularly use methods that involve and engage staff to improve all we do • Intentionally show appreciation for individual and team contributions • Work effectively with organized labor to achieve our market objectives
		Foster simple, clear and concise **communications**	• Be transparent – share our direction, successes and challenges • Seek to understand and listen • Redesign ERIC to meet employee needs and business goals
		Cultivate an environment where people can **thrive and grow** • Build FUN in all we do	• Support personal health goals by using HealthPartners tools and resources • Encourage individual professional development • Continue to provide tools and training that strengthens our leaders' skills • Provide regular feedback and valuable, timely annual performance reviews
		Expand **diversity and inclusion** work within the organization	• Retain and develop diverse employees • Target recruitment of diverse candidates • Support initiatives that foster an inclusive environment and opportunities for growth
Health	***Improved health for our patients, members and community as measured by:*** • Improved health outcomes • Improved coordination of care that lower costs and improves experience • Improved optimal healthy behaviors	Every division **achieves health goals in 2010** using capabilities from across the organization	• Use Health Goals 2010 as a guide to set each division and departmental annual plan • Work with partners to maximize results and deliver unique health solutions
		• Measurable improvement in **HEDIS** best in class results • **Reduction in disparities** based on race and economic status in our hospitals and clinics	Design and implement interventions focused on results improvement
		Effective pilots for **medical home/primary care redesign** within HPMG and contracted partners	Focus on access and communication, care coordination, affordability, patient self management and registry development
		Assure that **patient preference** guides care	Implement and spread decision support for specific health conditions and end of life care
		Provide **support for living well** with acute and chronic illness and disease	Interventions focused on improved patient care transitions
		Focus on **affordability** in all we do	• Strategically target improvement initiatives that optimize health, experience and affordability • Implement alternative methods for care delivery (e.g., phone, e-visits, etc) • Continue to develop payment and measurement methods that incent value
		Increase consumer knowledge and adoption of **healthy behaviors**	Interventions and tools to help members and patients achieve optimal lifestyle
Experience	***Deliver an exceptional experience that customers want and deserve at an affordable cost as measured by:*** • Improved customer experience • Enhanced respect and trust by patients and members • Customer recognition of the value of our care and services • Engaged and informed patients and members	Offer patients and members improved approaches to manage their health care **costs**	• Equip employees to assist patients and members in ways to better manage their health care costs • Enhance cost and quality information to respond to customer needs
		Communicate more effectively with patients/members	• Establish a "members like me" experience tool • Reinforce cultural competency work • Simplify patient/member materials • Ensure patients and members have the information needed/problem addressed • Focus on provider communication skills with patients • Continue work on health literacy
		Improve **access** to care and services; make us amazingly easy to use	• Expand choices for receiving care and services based on customers' preferences; increase use of web tools and e-care • Increase awareness of services/care we offer
		Provide more **customized** personal care and services	• Use member/patient preferences to communicate • Expand decision support capabilities
Stewardship	***Deliver greater value, growth, and financial results as measured by:*** • Growth in members and patients • More affordable care and coverage • Leadership in providing community benefit • State and federal reform that furthers our mission • Achieving net income target	**Grow** • Increase medical and dental membership • Increase patients in our clinics and hospitals • Increase our health and wellness customers	• Focus on member and patient retention strategies • Execute on marketing and sales strategies • Continue on group practice building strategies
		Improve **affordability** of healthcare • Reduce cost trends • Design contracted network payment to reward affordability • Maintain low administrative costs • Reduce the cost of care in our own care delivery system	• Introduce new Total Cost of Care payment strategies and decrease price trends • Implement strategies to address over-use, under-use, and misuse of healthcare • Introduce more cost effective care options • Expand use of Lean and other tools to improve efficiency • Provide purchasers with approaches to support employee health and reduce health care costs
		Foster a culture of **compliance**	• Systematic training and reinforcement on new laws and privacy and ethical business practices
		Provide **community benefit** and influence development of standards	• Coordinate and compile our community benefit work enterprise-wide • Shape discussions on community benefit at state and federal levels
		Engage in **healthcare reform** that supports our public policy platform	• Advocate reform platform with policymakers, regulators and community partners • Prioritize and participate in reform development and implementation • Engage stakeholders, including employees, in our reform efforts

Our mission: **To improve the health of our members, our patients and the community.**

Our values: **Passion Integrity Teamwork Respect**

Regions Hospital®

2010 DIVISION/DEPARTMENT ANNUAL PLAN

Confidential

Our vision: **Our vision is to be the patient-centered hospital of choice for our community.**

	Success	What drives our success?	How will we make success happen?
People	***A highly engaged and committed workforce as measured by:*** • Improved employee well-being ➢ Pulse "I am involved in making changes that improve care, service and efficiency" ➢ Pulse "The people with whom I work treat each other with respect" • Increased workforce diversity ➢ Increase Diversity for Officers and Managers • Alignment with our mission and values across HealthPartners ➢ Pulse "I would recommend my company to my friends and family as a place to receive care and service"	Build on our culture of **partnership** • Respect • Accountability for excellence (go above and beyond) • Reward and recognition • Involvement and engagement	• Set clear expectations and priorities for every employee, actively manage underperformers • Help employees focus on improvements and achieving outcomes in an uncertain/challenging time • Support culture change by implementing key strategies in the people dimension that address accountability • Continue use of Regions Manager Expectations Plan (90 day action plan)
		Foster simple, clear and concise **communications**	Clear, concise communication delivered through employee forums, huddles and e-messaging to staff
		Cultivate an environment where people can **thrive and grow** • Build FUN in all we do	• Continue to provide tools and training that strengthens our leaders' skills • Provide regular feedback and valuable, timely annual performance reviews • Maintain positive momentum – success increases the likelihood of future success • Leverage workforce efficiency and effectiveness • Support staff transition through Expansion 09
		Expand **diversity and inclusion** work within the organization	• Retain and develop diverse employees • Target recruitment of diverse candidates
		Meet/Exceed Expansion 2009 People Goals	• Improve Pulse Survey Results "group works effectively as a team" • Improve Pulse Survey Results "access to training & development"
Health	***Improved health for our patients, members and community as measured by:*** • Improved health outcomes ➢ Top performance in CAP, SCIP, AMI and CHF core measures as designated by plus (+) performance by JCAHO/CMS • Improved coordination of care that lower costs and improves experience ➢ Decreased readmission rates ➢ Percentage of bed placement by primary patient populations • Improved optimal healthy behaviors	Every division **achieves health goals in 2010** using capabilities from across the organization	• Core Measure performance • AHRQ performance • HealthGrade performance • Leapfrog performance
		• Measurable improvement in **HEDIS** best in class results • **Reduction in disparities** based on race and economic status in our hospitals and clinics	Continued analysis and improvement to reduce identified disparities in core measure and OB care processes
		Effective pilots for **medical home/primary care redesign** within HPMG and contracted partners	Focus on communication, transitions and care coordination
		Assure that **patient preference** guides care	Continued development of Palliative Care and End of Life care as patient preference care
		Provide **support for living well** with acute and chronic illness and disease	Interventions focused on improved patient care transitions and reduced readmissions
		Focus on **affordability** in all we do	• Achieve readmission targets • Achieve aggregation targets
		Increase consumer knowledge and adoption of **healthy behaviors**	Interventions and tools to help patients achieve optimal lifestyle
		Meet/Exceed Expansion 2009 Health Goals	• Increase bed placement by primary patient population • Reduce same level of care patient transfers • Reduce patient falls • Increase cases with Specialized Care Teams in the operating room • Achieve Ancillary Services Health Goals (improve lab stat, radiology stat test, and pharmacy stat medication turnaround times)

Experience	***Deliver an exceptional experience that customers want and deserve at an affordable cost as measured by:***
	• Improved customer experience
	  ➢ Achieve top decile performance in patient satisfaction "Would you recommend" scores
	  ➢ Achieve top decile performance in patient "pain" scores
	  ➢ Achieve access and flow metrics
	• Enhanced respect and trust by patients and members
	  ➢ Achieve top decile performance in patient satisfaction "provider communication" scores
	• Customer recognition of the value of our care and services
	• Engaged and informed patients and members
		Offer patients and members improved approaches to manage their health care **costs**	• Enhance cost and quality information to respond to customer needs

		Communicate more effectively with patients/members	• Reinforce cultural competency work • Achieve top decile performance in MD and Nurse Communication (Picker/HCAHPS) • Consistently and reliably deliver Best Care Best Experience • Improvement in listening to our patients

		Improve **access** to care and services; make us amazingly easy to use	• Increase awareness of services/care we offer – cross marketing
			• Decrease left without being seen in ED
			• Decrease LOS of ED to inpatient patients and ED to discharge
			• Achieve access and flow efficiencies
			  • Reduce patient diverts
			  • Increase the number of patients discharged before noon
			• Achieve OR smoothing

		Provide more **customized** personal care and services	• Expand decision support capabilities • Increased success in pain control • Capitalize on South Section and increased percentage of private rooms to provide excellence in experience • Patients/families experience increased personal attention upon arrival and departure (see guest services work plan)
		Meet/Exceed Expansion 2009 Experience Goals	• Reduce negative way finding comments on patient surveys • Achieve Emergency Department Experience Goals (increase Fast Track Utilization, reduce patients left without being seen, reduce wait times) • Achieve Ancillary Services Experience Goals (improve cleanliness of environment, transport response time, pharmacy discharge medication timeliness)

Stewardship	***Deliver greater value, growth, and financial results as measured by:***
	• Growth in members and patients
	  ➢ Achieve volume targets
	• More affordable care and coverage
	• Leadership in providing community benefit
	• State and federal reform that furthers our mission
	  ➢ Successfully deliver a re-structured GAMC program
	• Achieve net income target
		Grow
		• Increase medical and dental membership
		• Increase patients in our clinics and hospitals
		• Increase our health and wellness customers
			• Execute marketing strategies (Take Me to Regions)
			• Continue group practice building strategies to achieve capture rate targets

		Improve **affordability** of healthcare • Reduce cost trends • Design contracted network payment to reward affordability • Maintain low administrative costs • Reduce the cost of care in our own care delivery system	• Implement strategies to address present on admission and readmissions • Introduce more cost effective care options and lab and pharmacy utilization • Expand use of Lean and other tools to improve efficiency • Successfully mitigate reimbursement rate cuts at the state and federal levels • Consider radical care model changes with respect to business survival
		Foster a culture of **compliance**	• Support the culture of patient privacy and compliance
		Provide **community benefit** and influence development of standards	• Shape discussions on community benefit at state and federal levels • Restore GAMC funding in some form • Implement financial plan that incorporates reimbursement cuts from the state and federal levels • Continue to expand philanthropic support for key hospital programs and needs
		Engage in **healthcare reform** that supports our public policy platform	• Advocate reform platform with policymakers, regulators and community partners • Engage stakeholders, including employees, in our reform efforts • Strong partnership and work with legislature
		Meet/Exceed Expansion 2009 Stewardship Goals	• Achieve unit occupancy targets • Achieve OR Efficiency Targets (OR Time Utilization, Procedure Card Standardization) • Achieve salaries as percent of net revenue targets • Achieve WHPPD staffing efficiencies (including acuity adjustable bed targets)

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Our values: **Passion Integrity Teamwork Respect**

Updated 10/19/09