

Dean's Newsletter

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A Discussion on Universal Health Insurance

On Monday evening, February 26th I was pleased to be invited by several of our Stanford medical student associations to join Professor Victor Fuchs in a dialogue on universal health insurance and on some of the recent state-based health care proposals that have emerged over the past year. Perhaps even more than the discussion itself, I was extremely gratified to see how many students participated in the seminar, which I saw as an indicator of the relevance and immediacy of this topic.

In a poll reported by the New York Times on March 2nd, “a majority of Americans say the federal government should guarantee health insurance to every American, especially children, and are willing to pay higher taxes to do it” (http://www.nytimes.com/2007/03/02/washington/02poll.html?_r=1&oref=slogin). But Professor Fuchs observes that other polls have also indicated that, while Americans want health care reform, this means many different things to different individuals, and there is not a consensus on whether this should be a government-based, insurance-based, market-based, etc. solution. Perhaps the only area of agreement is that what we have now – which is not a health care system at all – is not working very well. The costs of health care continue to rise along with the numbers who are uninsured, and dissatisfaction is becoming more and more the norm for both providers and consumers. Further, as I have indicated in previous commentaries, despite the fact that we spend more than any other nation on health care (now 17% of the GDP), we are not leading the world in important outcome metrics – except for how much we spend on administrative overhead, where we are clearly number one.

I readily acknowledge that I am by no means an expert in health care policy *per se*. But I have been part of the health care system for over three decades and have personally observed its continued deterioration – although I have to say that it never got off to a good start when the employee based system we have today was initiated as a wage and price control during the Second World War. Sadly, attempts both before and since then to develop an organized health care system in the USA have failed for a variety of reasons, not least of which have been countervailing pressures (largely economic) by doctors, the insurance industry, the pharmaceutical industry and others.

The attempts to correct the escalating costs of health care by market forces has, to a large extent, also failed, in my opinion, and the time has come for much more sweeping changes. But while the American public seems increasingly to support the need for change, the personal choices and likely sacrifices that will need to be made are hardly matters of consensus.

Because of the lack of a coordinated federal health care policy (although proposals are being configured rapidly by both Republican and Democratic presidential hopefuls in anticipation of the 2008 elections) several states have come forward with health care plans. In April, 2006, Massachusetts was among the first to announce a plan for universal coverage – although to date the plan has yet to be enacted and the costs are purported to be much higher than previously projected (see also the May 18 2006 issue of the *New England Journal of Medicine* entitled “*Can Massachusetts Lead the Way in Health Care Reform*” by SH Altman and M Doonan - <http://content.nejm.org/cgi/content/full/354/20/2093>). And of course, in California Governor Schwarzenegger announced a plan for universal health insurance in January, 2007. While these state plans are of interest – and demonstrate that the failure of a federal policy will result in local or state-based efforts – the fundamental issues remain unaddressed. For instance, they are still based on using market forces to contain cost. But at least these efforts heighten awareness and provoke further discussion – although unless the dialogue becomes really engaged and effective in creating a solution, a crisis point will occur, especially when the Medicare Trust Fund becomes bankrupt a decade from now.

While the methods for solution are problematic and may be difficult to enact, the general principles of the Schwarzenegger Health Care Proposal have merit. The Governor’s plan addresses the need – at least conceptually – to focus more on health promotion and wellness, recognizing as it does that we spend too much on the care of diseases whose root causes might be preventable if more resources were applied to addressing underlying problems. A good example, of course, is obesity and all the co-morbidities associated with it – just as tobacco use is unequivocally associated with serious disease. In addition, the Governor’s plan recognizes that 6.5 million Californians are uninsured and that a minimum level of coverage must be in place for all. The proposal addresses coverage of children below the federal poverty level (FPL) as well as uninsured legal residents and even uninsured individuals without a “green card.”

To meet these goals, the Governor’s plan requires all Californians to have health insurance coverage and indicates that this will be provided by a combination of Medi-Cal (proposed to be increased “almost” to Medicare levels) and Health Family Program Benefits. Further, there would be an employer mandate for those with >10 employees to either offer insurance or pay 4% of payroll into a subsidized purchasing pool to help cover individuals earning less than 250% of the FPL. Insurers would be expected to limit the percentage of premiums to administrative costs and profit to 15%. In addition, hospitals would be expected to contribute 4% of gross receipts and physicians 2% of gross receipts. While it is important to spread the responsibility, one can only be suspicious of how the politics of such a plan will play out in the efforts to enact it.

Other facets of the plan focus on information technology, quality and efficiency. These too are important since the costs for new technologies and the lack of attention to lower cost solutions serve as serious health cost drivers. Equally notable, to a large extent the Governor's plan is still built on market-based solutions, and it ignores the fact that the legislature voted for (but the Governor vetoed) the single payer California Health Insurance Reliability Act sponsored by Senator Kuehl last year. Ironically the plan to enhance Medicaid funding also comes at a time when the President's budget is seeking to reduce the investment in Medicaid.

I have previously commented that I remain partial to many of the principles of a single payer system, although I fully recognize the complexities of enacting such a system in the USA in the foreseeable future. In our discussion with the medical students, however, Professor Fuchs and I were united in our view that the current employer based system is not tenable over time. I have also previously commented on the health care voucher system proposed by EJ Emmanuel and VR Fuchs (see *N Engl J Med* 2005; 352:1255-1260), which I view as a viable alternative. It includes ten basic components: 1) Universality, in which every American under 65 years would receive a voucher guaranteeing health care services from a qualified insurance company or health plan; 2) Free Choice of Health Plan; 3) Freedom to Purchase Additional Services using personal after-tax dollars; 4) Funding by an Earmarked Value-Added Tax based on personal consumption; 5) Reliance on a Private Delivery System; 6) End of Employer-Based Insurance – which would be phased out; 7) Elimination of Medicaid and other Means Tested Programs; 8) Phasing Out of Medicare – which would be replaced in time by the voucher system; 9) Administration – wherein management and oversight would be done by a Federal Health Board that would review and modify benefits through regional boards; and 10) Assessment of Technology and Outcomes through an independent Institute for Technology and Outcomes Assessment. While still sustaining the current insurance based models, a system like the one proposed by Emmanuel and Fuchs has considerable merit.

It seems clear that over the next couple of years a number of health care proposals will come forward. There does appear to be an increasing convergence between public dissatisfaction with the current “non-system,” rising costs, lack of coverage and the lack of time available to consumers by health care providers. But most of the solutions will be at the margin and few will address the underlying problems – which is unfortunate, since the crisis will surely loom to even greater proportions in the next decade, when Medicare funding becomes threatened. But perhaps by then our nation will be ready for the changes that inevitably need to come forward if we are to have a fair and more reliable health care system in the United States of America. In the meantime, I am pleased that our students are concerned, interested and engaged in these issues and hope that each in his or her own way will become leaders and advocates for health care reform – and that some actually play a truly transformational role in the future.

A Bright Light Focus on Quality

For all the right reasons, a focus on providing the highest quality clinical services (as judged by various external metrics) along with the best patient service and most advanced and compassionate medical care must be among our most important goals and objectives. And as I have noted previously, and you are likely well aware, quality metrics are rapidly becoming the yardsticks to compare and contrast clinical programs at hospitals and medical centers. They will increasingly be used to guide payments to doctors and to hospitals – through Medicare and private insurers. And they will become publicly available standards that patients will use to determine where to seek their personal medical care. While there are many concerns that can be expressed about which metrics to use or how they compare to community versus academic institutions, the reality is that some quality metrics are already being used and will be increasingly used in the years ahead. It is certainly important to perform well in whatever comparative assessments are made – but it is equally if not more important to strive to achieve the highest quality performance simply because that is the right thing to do.

Already various institutions are posting their internal results and outcomes. And some external metrics are now posted – including the results of the Child Health Corporation of America (CHCA) – which “is driving children's hospitals to the highest level of performance by creating cultures of improvement and a data-driven foundation for safe, waste-free, error-free care” (see: http://www.chca.com/company_profile/pi/index.html). It is notable that among the 41 children's hospitals sharing data and performance results through CHCA, our Lucile Packard Children's Hospital has fared among the very best. Thanks to the efforts of numerous faculty and staff, and with the support and leadership of LPCH administration and the Board of Directors, a culture of quality performance has been developed over the past several years that is winning national acclaim. Most recently LPCH won the “Race for Results” award for its “Rapid Response Team” project – an award given to only two children's hospitals each year (an honor made even more significant by the fact that LPCH also won this award in 2005!). This is just one of a panoply of quality driven goals and objectives that have been established under the leadership of Dr. Paul Sharek, Assistant Professor of Pediatrics and Medical Director of Quality Management and his excellent staff.

Serious efforts are also underway at Stanford Hospital & Clinics (SHC) to be a leader in the quality of care. To further enhance these efforts Martha Marsh, President and CEO of SHC, and I charged a working group led by Dr. Norm Rizk, Berthold and Belle N. Guggenhime Professor of Medicine and Senior Associate Dean for Clinical Affairs, and Dr. Kevin Tabb, Chief Quality and Medical Information Officer at SHC. The working group includes clinical department chairs, medical staff and patient care service representatives, among others. The goal of this working group is to develop the mechanisms and cultural transformations necessary to enable SHC to become a “top 10” institution in quality of care. This goal will translate into actions that will take place at the clinical department or division level and that will result in both short term measures of success as well as the long term changes necessary to sustain high quality programs.

The group is working diligently and will be making its report by April, 2007. The results of their work will lead to changes at both the individual faculty and physician level and at the levels of departments, the school, and the hospital. We are intent on making the necessary changes – and being accountable for them – since this is an area where we must do as well as possible even though we recognize that there is a considerable amount of work and effort required to do so. As in all process changes, these will require cultural changes in tandem with serious attention to defined quality metrics – but this is essential if we are to be a leading academic medical center. More will follow on this important topic in subsequent Newsletters.

The Stanford Challenge and Stanford Medicine

I have previously written about the Stanford Challenge, the \$4.3B campaign launched in October 2006 around a series of major themes, including, among others, the Initiative on Human Health, Energy and the Environment, International Initiatives, and Educating Leaders. In recent weeks we have had the pleasure of announcing several major gifts as part of the Stanford Challenge: a \$5M contribution from Akiko Yamazaki and Jerry Yang for the Learning and Knowledge Center and a \$33M gift from Lorry Lokey for the Stanford Institutes of Medicine 1, which will focus on Stem Cell Biology and Regenerative Medicine. These are wonderful contributions, and they join many others we have been fortunate to receive in recent months and over the past several years. They are all critical to helping Stanford Medicine become the transformational leader of the 21st century that it can – and must - become.

But we have a very long way to go, given the scope and depth of our plans. Among these is the bold and ambitious reconstruction of the medical center – including the School of Medicine, Stanford Hospital and Clinics and the Lucile Packard Children's Hospital. Indeed I presented the range of facilities projects that will unfold during the next 10-20 years in my December 4, 2006 Newsletter on Planning the Future of the Medical Center. Importantly, this plan transcends bricks and mortar – although it certainly requires new foundations. Now that it has been nearly 50 years since the School of Medicine moved to Palo Alto and reshaped the face of biomedical research and academic medicine, we have the opportunity to plan for the next fifty years and beyond. And we are uniquely poised to do so.

During the past 50 years, Stanford Medicine has achieved national and international prominence. And importantly, we are now a medical center that is seen by our peers to be “on the move.” We have intentionally aligned our missions in education, research and patient care. Building on our rich history of excellence in discovery science, we are putting into place additional plans to further enhance and develop our foundations in research. We are also defining the future of medical and graduate education and the facilities that will support and develop them. Bringing basic and clinical scientists together is a key theme in the Stanford Institutes of Medicine, and we will be developing new integrating cross-connections with genomics and human genetics, molecular imaging and informatics. Equally importantly, we are linking our efforts to translate discoveries with our clinical partners at SHC and LPCH.

To help facilitate these connections and, more importantly, to further enrich them, we have formed a Campaign Executive Committee that links medical development opportunities between the School and SHC. We have done this separately with LPCH but ultimately need to bring all into alignment. The new Executive Committee held its first meeting on Tuesday, February 27th and will meet biweekly hereafter. The Committee includes, Martha Marsh, Doug Stewart, Barbara Clemmons, Amelia Alverson, John Ford, Denise O’Leary, John Freidenrich, and myself. We anticipate that, by combining medical school and hospital leaders with medical center and university development leaders and trustee volunteers, we can coordinate and address the critically important challenges that lie ahead. The tasks are daunting but, taken one piece at a time, are achievable – as long as we stay connected and keep focused on the important mission that stands before us.

In tandem with the Campaign Executive Committee, which will provide an overarching focus, we have defined key initiatives that focus on the interconnections between our academic and clinical programs. Each of these will have Campaign Council and two of them, the Leadership Council on the Learning and Knowledge Center and the Leadership Council on the Cardiovascular Institute, met this past week. Both of these groups have assembled outstanding community volunteers who will work with Institute Directors, clinical leaders and medical development staff to move our important initiatives forward.

Updates on the Faculty Appointment and Promotion Process

At the March 2nd meeting of the School’s Executive Committee, Dr. David Stevenson, Vice Dean and Senior Associate Dean for Academic Affairs, presented an update on activities in the Office of Academic Affairs (OAA). I was unable to attend this meeting due to illness and so this report comes from Dr. Stevenson and Judith Cain, Assistant Dean for Academic Affairs.

Dr. Stevenson began by reporting on the progress that has been made in implementing recommendations from the School-wide Task Force on Appointments and Promotions, which was chaired by Dr. Robert Jackler from 2004 to 2006. Charged with streamlining as much of the excessive bureaucracy as possible while preserving the integrity of appointment and promotion policies and processes, the Task Force targeted several areas for improvement. These included the completion of all reappointment and promotion actions in as short a time as possible and a reduction in the need for and length of interim appointments. The goal is to have the candidate’s appointment process completed *prior* to his/her official start date at Stanford. The Task Force also recommended the creation of a web-based system to manage the preparation of, and collection materials for, the appointment forms used to recommend professorial appointments, reappointments and promotions.

Dr. Stevenson said that his office has concentrated most of its efforts on improving on-time performance rates for reappointments and promotions. Toward that end, each candidate coming up for reappointment or promotion now receives notification

from Academic Affairs confirming initiation of the review one year in advance of the conclusion of the current appointment date. The Office of Academic Affairs has also developed and communicated month-by-month timelines to departments, which is proving to be an important tool in completing these reviews on time. In addition, Academic Affairs now checks in with departments at two, four and six-month intervals to monitor the progress of the reviews, which allows early intervention when problems arise. Dr. Stevenson noted that this investment of time and energy is beginning to yield positive results. Beginning at the low 2003-04 benchmark of 12%, the on-time rate has now more than tripled and continued steady progress is anticipated.

With respect to appointments requiring interim arrangements while awaiting long form preparation and approval, the actual number (approximately 75% of all new appointments) has remained high over the last three years. However, the duration of these appointments has decreased from nine to six months. Through closer management and oversight, Academic Affairs is redoubling its efforts to make further inroads in achieving the Task Force's recommendation to reduce the number and length of interim appointments.

A centerpiece of the Task Force's recommendations was the creation of a web-based system to manage the preparation of, and collect materials for, the appointment forms used to recommend professorial appointments, reappointments and promotions. Dr. Stevenson introduced Phil Constantinou, Associate Chief Information Officer in the Office of Information Resources and Technology, who presented a demonstration of FAST/FAC, which is poised to streamline and transform the way that these actions are carried out. The first phase of the project, which will allow departments to view individual appointment and leave history, manage long form preparation and process and generate automatic deadline notifications, is set for release during the summer of 2007.

Dr. Stevenson also announced that he has formed a Task Force on the Medical Center Line Professoriate to review the current status of the line and make recommendations to further clarify expectations for their faculty. Chaired by Dr. Stevenson, members of the Task Force are Maurice Druzin, Obstetrics and Gynecology and Associate Dean for Academic Affairs; Ann Leung, Radiology; Frank Longo, Chair, Neurology and Neurological Sciences; Stephen Roth, Pediatrics; Geoffrey Rubin, Radiology; Stephen Ruoss, Medicine; Sherry Wren, Surgery; and Paul Yock, Medicine and Bioengineering.

He also reported that a committee has been established to review appointments, reappointments and promotions in the Clinician/Educator line. Patterned after advisory groups that evaluate similar actions in the professorial lines, the new Clinician/Educator Appointments and Promotions Committee is chaired by Dr. Druzin and its members include the following five clinical professors: Ronald Cohen (Pediatrics), Peter Moskowitz (Radiology), Janice Lowe (Pediatrics), Dean Winslow (Medicine), and Nancy Morioka-Douglas (Medicine.)

I want to thank Dr. Stevenson and the Office of Academic Affairs staff for their many efforts to improve the faculty appointments and promotions processes. The progress to date is very encouraging, and I look forward to further updates in the months ahead.

Carla Shatz Will Join Stanford as Next Director of Bio-X

I am very pleased that Dr. Carla Shatz, currently the Nathan Marsh Pusey Professor and Head of the Department of Neurobiology at Harvard Medical School, will be rejoining Stanford University as the Director of Bio-X, where she will also be a faculty member in Biological Sciences and Neurobiology. We have also been pleased to have Dr. Shatz as a member of the School of Medicine's National Advisory Council – where she has served with distinction – and where she will be surely missed!

Dr. Shatz will be replacing Dr. Matt Scott, who has served as the Chair of the Bio-X Scientific Leadership Council during the past several years. During that time Bio-X has evolved as one of the signature programs of interdisciplinary research and education at Stanford – as well as nationally. And the Clark Center, home of Bio-X, stands as a model of excellence in fostering novel programs in research among the biological, physical and engineering sciences. Professor Scott and his colleagues have done an excellent job in fostering opportunities for new innovations –among both trainees and faculty – and, consequently, Bio-X has become one of the central pillars in the Initiative on Human Health. On behalf of the School of Medicine, I want to offer my praise and appreciation to Dr. Scott for his many wonderful achievements – both for his leadership of Bio-X as well as in his role as an outstanding faculty member.

Dr. Shatz will further the efforts of Bio-X and will also continue her own excellent research as a neuroscientist, which has been focused on how the patterns of precise and orderly connections found in the adult central nervous system are achieved during development. Her return to Stanford is being met with considerable enthusiasm throughout her community, and we are all pleased to be welcoming her back to a new role – and to wonderfully exciting opportunities.

Honoring and Celebrating the Life of Dr. Larry Mathers

In the last issue of the Dean's Newsletter I told you about the tragic loss of our beloved teacher, scholar, clinician, colleague and friend, Dr. Larry Mathers. On Friday, March 9th several hundred of Dr. Mathers' students, colleagues, family and friends gathered in the Arrillaga Alumni Center to honor and celebrate his life in its many dimensions and remarkable contributions. We had an opportunity to see the roots of Larry's love of music, leadership, and scholarship – and of Stanford - emerge from his childhood days. We had the privilege of witnessing the impact of his teaching, mentoring, and dedication in the words of his students and colleagues. And we had the pleasure of listening to music from friends and colleagues who sang with Larry and also to hear Larry's own voice and music and, in doing so, be reassured that his spirit lives on. We will miss Larry deeply and recognize that an individual as kind, deep, humble and

variegated as he was will never be replaced. But we are all better for having known and worked with him or for having been mentored and guided by him – and that will sustain, along with his memory and the sounds of his voice and piano.

If you wish to make a contribution in Larry Mathers' name you can do so to any of the following organizations (please note on check that it is in memory of Dr. Larry Mathers):

- Emerald Glen Home – a residence facility for developmentally disabled adults
1101 Walpert Street
Hayward, CA 94541
- Stanford Department of Anatomy Gift Fund
326 Galvez Street
Stanford, CA 94305-6105
- Stanford Pediatric Intensive Care Unit Gift Fund
326 Galvez Street
Stanford, CA 94305-6105

Awards and Honors

- ***Dr. Pat Basu and Dr. Roni Katz*** have just been awarded the AMA Excellence in Medicine Awards for Leadership. Congratulations!
- ***Dr. Michael Longaker*** has been selected by Michigan State University (his alma mater) to receive the Distinguished Alumnus Award from the Michigan State University Men's Basketball Program. Dr. Longaker was a member of the Varsity Basketball Team from 1976 to 1980, and a member of the 1979 NCAA Men's Championship Basketball Team. Congratulations!
- ***Dr. Craig Albanese*** was installed as the first John A. and Cynthia Fry Gunn Director of Pediatric Surgical Services at the Lucile Salter Packard Children's Hospital on Wednesday evening, February 28th. This wonderful gift from John and Cynthia Fry Gunn continues their legacy of remarkable support for the University, Medical School and LPCH. It is most fitting that Craig Albanese is the first incumbent of this new Directorship. Craig is an internationally recognized leader in pediatric surgery and especially minimally-invasive and fetal surgery. He joined the Stanford community in 2002 and has quickly become established as one of the true leaders of Stanford Medicine and LPCH. Please join me in congratulating Dr. Albanese for this honor and in thanking John and Cynthia Fry Gunn for making the Directorship a reality.
- On Monday evening, March 5th, Stanford Hospital and Clinics and the School of Medicine honored three outstanding individuals for their contributions to patient care and SHC. The three individuals included:
 - ***Martin I. Bronk, MD*** for his services as a Member of the SHC Board of Directors – which he did with true excellence

- ***Bruce D. Feldstein, MD*** as the first recipient of the *Isaac Stein Award for Compassionate Care*
- ***Norman W. Rizk, MD*** as the first recipient of the *Denise O'Leary Award for Excellence*

Please join Martha Marsh and me in congratulating these three outstanding physicians.

Appointments and Promotions

- ***Joachim F. Hallmeyer*** has been appointed to Associate Professor of psychiatry and Behavioral Sciences, effective 3/01/07.