Dean's Newsletter
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Trends in Healthcare: Some Forecasts from The Advisory Board and Related Reflections

The past year has been filled with forecasts of healthcare reform and its impact. As the Congress moves to its next phase of reconciliation and then a vote on its lumbering plan, we can begin to anticipate the many changes that will unfold over the next years. These will affect physician and provider workforces, physician compensation, the balance between specialty and primary care services, the graduate medical education pipeline, hospital services and the balance between inpatient and ambulatory care, hospital (and medical center) margins, and over time, cost controls. While the attention in the news has been on extending coverage and access to care, a focus on quality, information technology and the overall use of technology will continue to be major themes. The thorny but central issue of fee-for-service, when it is really addressed, will impact many of the current impasses– and the major constituencies who continue to lobby and press for sustaining the present (and past) rather than fully planning for the future.

The Advisory Board, a provider of comprehensive performance improvement services to the health care and education sectors, recently presented an interesting summary. While there are many views that will be at variance with their findings, some of the commentary is of interest and will likely be relevant to our own planning at Stanford Medicine. Among these is that 59% of institutions responding to a survey on patient volumes do not expect inpatient surgical growth in 2010. At the same time, many institutions believe that they have already made significant expense reductions in recent years – thus affecting their options on both the revenue and expense sides of the equation.

Overall, changes resulting from health care reform (although it is more uncertain at this moment about what is likely to happen this year) are likely to impact hospital margins that are sensitive to higher cost technical and procedural (including surgical) services. With changes in the economy as well as consumer education and overall costs, there could be more shifts away from surgical to medical or other treatment options – again affecting overall hospital revenues. Utilization management groups and decision support services that insurance companies are setting up to control expenditures will

likely influence these shifts in the locus and scope of care. The forecasts, taken as a whole, predict that these and other changes will decrease inpatient services across a wide spectrum of disciplines. Utilization may also decrease in outpatient services, although less than for inpatient volumes.

While these are general projections and their impact will surely differ in various regions and communities of the country, it is hard to escape the conclusion that some features will have a local impact. In part this expectation also relates to overall changes in national and institutional economic foundations that affect debt capacity, investment income, operating income and philanthropy. The economic downturn has influenced each of these factors and has resulted in a lower capital base against which to secure debt capacity or investment income. I have written about the effects of these changes on the university and medical school, and there is every reason to believe that they will also impact our healthcare facilities equally if not moreso.

At most academic medical centers – as well as medical centers in general – most projected growth is in Medicare, which has significant implications since Medicare reimbursements are significantly less than those of commercial payers. With an increasing chronic disease burden in the USA, costs will increase along with pressures to increase cost effectiveness and improve coordination – which clearly makes sense. This will be accompanied by a number of new accountability and bundling models of care – something that I hope we can impact as we establish, together with Stanford Hospital & Clinics (SHC), a new Center of Quality and Effectiveness later this year (with details to follow in a future newsletter). To control costs (or, in the new vernacular, "bend the cost curve") a better balance of in-patient and ambulatory services along with utilization of technology and higher cost practices and procedures will be sought – although like all of these changes, they will likely unfold over an extended timeline. On a local level, opportunities to improve care delivery, coordination, quality and cost will likely be fostered – and Innovation Zones have been advocated to stimulate these initiatives.

The Advisory Board (as noted above) has put forth some possible implications of the interplay between increasing the number of individuals in the USA covered with insurance together with payment innovation and delivery system reform. Again, these are still opinions but they should provoke critical thinking. They include the following:

1. The transition to outcomes –focused reimbursement will materially increase risks to revenue growth
2. Operating efficiency will challenge top-line growth as the driver of future inpatient profitability
3. Bundled payments and other reimbursement innovations will make specialty care more rare and less profitable
4. Rewards in primary care practice will evolve to focus on coordination, chronic disease management and population health
5. Total cost management will begin to supplant fee-for-service incentives in the health systems business model

6. All providers will maintain tighter and fewer affiliations across the delivery system
7. M&A (merger and acquisition) strategy will expand in scope to focus increasingly on (functional) vertical integration
8. Information-driven care, not simply information technology adoption, will ascend as a competitive differentiator
9. Consumer-driven health care will be driven (further) to the margins
10. New regulatory frameworks and entities will emerge

I share these observations more to provoke discussion than to provide a specific set of predictions. As I stated at the outset, a lot of pundits have offered forecasts about healthcare reform. That said, now more than a year into the debate and political and legislative process, some things are becoming clearer and more likely. At a minimum they compel us to think creatively about how to lead rather than wait for change to emerge or be instituted and to think more broadly across the domains of inpatient and ambulatory care to develop ways of improving the health of local and regional communities. There will not be a single solution but there will be lots of opportunities for change and evolution. Like all evolutionary processes a lack of adaptation to a new landscape can have serious consequences for individuals and institutions. And since healthcare systems are likely to change over the next decade, the need to be thoughtful and creative is an imperative for all of us.

Human Tragedy Comes on Different Scales But Is Always Painful

It is natural that we feel the loss of individuals who are members of our family and community. On December 17th Dr. Brant Walton, a young and promising faculty member in the Department of Anesthesia, died of colon cancer, leaving his wife Melissa and 3-year old son Will. His friends and colleagues felt his loss deeply and acknowledged his life in a ceremony at Memorial Church on January 19th.

On January 7th, Dan Begovich, husband of Stanford University Board Member Mariann Byerwalter, died unexpectedly, leaving behind his wife and three young boys – Joseph, Daniel and Neal. Hundreds of members of the Stanford, Bay Area and global communities shared his loss and celebrated his life in an exceptionally moving and meaningful memorial service at St. Catherine of Siena Catholic Church on January 14th – also Dan's birthday.

Death is part of the human condition and something we all will face. As a pediatric oncologist and AIDS specialist for children, I have witnessed the death of children over a number of decades. Even when death comes as an end to suffering, it creates a deep void in those left behind – especially family, friends and community. This void runs even deeper when death occurs suddenly and unexpectedly or at a young age and for those leaving behind young families. And it can impact our collective human consciousness, as it did with the recent tragedy in Haiti. The catastrophic events that have transpired in Haiti over the past nearly two weeks is beyond words. Many have reached out to help as best as they can, including a dedicated group of physicians and nurses from

the Stanford Emergency Department (see: http://med.stanford.edu/ism/2010/january/haiti-team.html). They deserve our deep admiration and respect.

I also want to thank the Stanford community for contributing to the relief efforts in Haiti. One of the many forms this is taking is a challenge grant program from the Stanford Medical Center (including departments, Stanford Hospital and Clinics) and the President and Provost's office. To date more than 1000 individuals have made personal contributions totaling over $118,000. The money will go to support operations at the Hospital Albert Schweitzer, which is located near Port-au-Prince. I thank Dr. Michele Barry, Senior Associate Dean for Global Health, for initiating this match program (see: http://med.stanford.edu/ism/2010/january/haiti.html for details on how to give to the challenge grant). I also thank the wonderful Stanford community for their support.

These personal and global tragedies are devastating – especially for the individuals and families directly and immediately affected. Our hearts go out to them. But these events are also reminders of our human fragility and of why it is important to support each other, not only at times of crisis and loss – but throughout our lives as well.

Continued Work on Faculty Development and Leadership

Faculty diversity, leadership, development and satisfaction are enormously high priorities for me and for the School of Medicine. In numerous ways we have worked diligently to enrich diversity, promote leadership, foster faculty development and enhance career satisfaction. According to Senior Associate Dean Dr. Hannah Valantine, who updated our Executive Committee on January 15th, we have made progress in the past several years, especially since the Office of Diversity and Leadership that she leads was founded in November 2004.

In the November 23, 2009 Dean's Newsletter I provided updated results from the AAMC COACHE Survey, which assesses faculty satisfaction. Recognizing that every survey has its limitations, this follow-up study demonstrated that, among the participating institutions, Stanford faculty had the highest score among the subset designated as our peers as well as among all participating institutions on the two measures of "global satisfaction." Specifically, overall, more than three-quarters of those responding indicated that they are "satisfied or very satisfied" with Stanford as a place to work and (separately) that if they had to do it over again, they would still choose academia and Stanford as the place to be. This is good news and for many would be sufficient to say that we are doing well by our faculty. And while I do believe that we are trying to be as supportive as possible, neither I, nor Dr Valantine nor others in leadership positions believe that we have achieved all that we can or should.

Indeed, we believe we have work to do in creating the correct sense of value among those engaged in missions of education, research and patient care – especially education and patient care. We believe we have work to do in improving the services and resources to support faculty at all stages of career development, especially at the

department and division level, in promoting an environment that fosters better balance between home and work, that addresses perceptions or realities of opportunities based on gender and ethnicity, and that does a better job in mentoring and guiding faculty through their career development. These are not new topics or issues, but they are ones that require additional effort. In fact they are themes we will be discussing further at the Annual School of Medicine Leadership Retreat on February 5th.

One initiative that has achieved unquestioned success and broad respect is the Faculty Fellows Program, which graduated its fourth class on January 20th. This program brings together faculty from clinical and basic science departments and creates small communities guided by a faculty mentor along with community sessions that explore the careers and life journeys of Stanford leaders. I had the opportunity to speak to this group last year along with the President, Provost and others from the medical center and university. At the graduation dinner the fellows reflected on how the program benefited them individually and even collectively. Among the most important lessons I learned from their comments is the importance of community and how their experience as Faculty Fellows connects them in a significant way with each other, the medical school and the university. They have the opportunity to learn about leadership through the stories and experiences of others and from each other. And their personal assessments, reflected through the eyes of Julie Moseley, Director of Organizational Effectiveness, provides each of them with new and invaluable insights for self reflection.

I offer my commendations and congratulations to the 2009 Faculty Fellows and look forward to working with them in the years ahead. This year's Fellows include:

Timothy Angelotti	*Associate Professor of Anesthesia*
Juliana Barr	*Associate Professor of Anesthesia*
Preetha Basaviah	*Clinical Associate Professor of Medicine*
Helen Bronte-Stewart	*Associate Professor of Neurology*
Kay Chang	*Associate Professor of Otolaryngology*
Waldo Conception	*Associate Professor of Surgery*
Firdaus Dhabhar	*Associate Professor of Psychiatry*
James Fann	*Associate Professor of CT Surgery*
Lauren Gerson	*Associate Professor of Medicine*
Geoffrey Gurtner	*Professor of Surgery*
Peter Kao	*Associate Professor of Medicine*
Anna Messner	*Professor of Otolaryngology*
Ruth O'Hara	*Associate Professor of Psychiatry*
Steve Roth	*Associate Professor of Pediatrics*
Richard Shaw	*Professor of Psychiatry*
Gavin Sherlock	*Assistant Professor of Genetics*
Rebecca Smith-Coggins	*Associate Professor of Surgery*
Julie Theriot	*Associate Professor of Biochemistry*
P.J. Utz	*Associate Professor of Medicine*

In addition to congratulating our 2009 Faculty Fellows I also want to thank the incredible contributions of this year's Faculty Mentors. They really helped to make the program the success it turned out to be and we are deeply indebted to them. They included:

Linda Boxer	*Professor of Medicine and Chief, Division of Hematology, Department of Medicine*
Al Lane	*Professor of Dermatology and Chair, Department of Dermatology*
Stephen Galli	*Mary Hewitt Loveless Professor of Pathology and Chair, Department of Pathology and of Microbiology & Immunology*
David Stevenson	*Vice Dean and Senior Associate Dean for Academic Affairs, Harold K Faber Professor of Pediatrics*

Special thanks must go to Dr. Hannah Valantine for her dedication and wonderful leadership of this and related programs. I also want to thank Jennifer Scanlin, the Program Manager for the Office of Diversity and Leadership, along with Lydia Espinosa, Administrative Associate, for their many contributions.

The Potential of an Evolving Role of the MCAT in the Evaluation of Medical School Applicants

One of the key milestones to gaining entrance to medical school is the Medical College Admissions Test (MCAT) – some version of which has been around since 1922, twelve years after the Flexner Report on Medical Education. Over the past 88 years, the format of the MCAT exam has been reviewed some five times – the last review was nearly two decades ago, even though there have been regular updates in content. Two years ago the Association of American Medical Colleges (AAMC) appointed a 22 member task force led by Dr. Steve Gabbe, Senior Vice President for Health Sciences and CEO of the Ohio State University Medical Center, to critically examine the future of the MCAT. Called the MR5 committee, it is comprised of experts and leaders from academic medicine, including deans, admissions officers, representatives from student and educational affairs and diversity offices, and basic and clinical faculty along with other college faculty and leaders and medical students.

The MCAT has largely focused on knowledge content and aptitude for science and medicine. The MR5 committee has already reached out to over 1200 medical school faculty, residents and students about how the current MCAT format predicts success in medical school – or more broadly, in medicine. An important and unresolved issue is whether medical schools do enough to examine the personal and professional attributes of applicants and how those correlate with outcomes in medicine.

Whether an exam can and should seek to define the personality profile that characterizes a doctor is a matter for serious discussion and debate. Dr. Pauline Chen began addressing this topic in an opinion piece entitled "Do You Have the 'Right Stuff' to be a Doctor" in the January 15th issue of the New York Times (see:

http://www.nytimes.com/2010/01/15/health/14chen.html?scp=3&sq=pauline%20chen&st=cse). Dr. Chen notes that some medical schools have begun administering personality tests and have noted some correlation with success in medical school and beyond. Whether this should become a feature of the MCATs is one of the key issues that the MR5 committee will be grappling with over the next two years.

Combining scales and measures to evaluate both the skills to learn and practice medicine and the personality features that define a potential for professionalism and excellence in medicine is important but also challenging. Success in medicine comes in many forms, since career opportunities are highly variegated and can evolve over time. Significant caution needs to be exercised in making sure that personality tests, if used, do not become too proscribed, monotonic or limiting. What defines the personality profile of an MD who discovers new ways of understanding human biology or new ways to treat or prevent disease is likely quite different from metrics that might define a primary caregiver. My guess is that there will be some significant overlap, especially since within the life of a physician careers as an investigator, healthcare provider and administrator can unfold over time or even concurrently. The more important goal would be to delineate personality metrics that might predict adverse outcomes or unsuitability for medicine.

These are important issues, and I suspect that many of you are unaware that these discussions are even taking place – much less possibly moving toward recommendations in the next couple of years. I will certainly do my best to keep you apprised as information unfolds. Certainly feel free to share your thoughts and I will make sure they get to the MR5 committee.

Stanford Mini-Med School: Take Two

On January 12th we welcomed a new class to the second quarter of our highly successful Mini-Med School. As with our Fall Quarter, the Winter Quarter was filled to capacity (250 participants and a long waiting list). The course remains the most popular among all Stanford Continuing Studies programs. The first session set the bar quite high for all future presentations. Dr. Geoff Rubin, Professor of Radiology, gave a tour de force lecture entitled "Inside Out: How Imaging Technology Offers a Portal to Human Anatomy and Disease" that reviewed the history and current as well as future applications of radiography, CT imaging, ultrasonography, MR imaging and nuclear imaging. And Dr. Dan Bernstein, Alfred Woodley Salter and Mabel Smith Salter Endowed Professor in Pediatrics, delivered the January 19th lecture on "The Developing Heart in Health and Disease". Future programs will include presentations on vascular disorders of the nervous system, vision in health and disease and a number of other exciting topics.

The programs from the Fall Quarter have started to be available at Stanford on iTunes U. (IRT: please insert URL that goes directly to Mini Med School, Stanford iTunes U). In addition, the School of Medicine will launch a dedicated web site in early February for the lectures. We will let you know when it is available for viewing.

Awards and Honors

- ***The Kidney Transplant Team*** has once again been cited by the Scientific Registry of Transplant Recipients as the best in the nation in exceeding higher than expected results in both patient and graft survival at one and three years following transplantation. Thanks to the leadership of Drs. Stephan Busque and John Scandling and an outstanding transplant team, this service continues as one of the very best anywhere. Thanks and congratulations to an outstanding clinical service.