

May 24–25, 2004 / Cincinnati

**NATIONAL
HEALTH
POLICY
FORUM**

Site Visit Report

The Economics of Quality: Changing Incentives in Cincinnati

THE GEORGE
WASHINGTON
UNIVERSITY

WASHINGTON DC

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Cincinnatians were also generous in sharing their time and expertise with Forum researchers planning the program and with site visitors during the trip. The Forum is grateful to those who served as speakers, as well as those who contributed behind the scenes. Lynn Olman of the Greater Cincinnati Health Council was particularly helpful with contacts and referrals and with elucidating the history of the Cincinnati market. The Forum thanks Michael Barber of Group Health Associates for hosting the group and for posing perhaps the visit’s most provocative policy conundrum. Uma Kotogal and Melissa Saladonis went to enormous effort to coordinate a rewarding morning at Cincinnati Children’s Hospital Medical Center.

As always, federal participants played a key role in the site visit’s success. This group of policymakers was particularly spirited in its collective curiosity, insight, and open-mindedness.

May 24–25, 2004 / Cincinnati

The Economics of Quality: Changing Incentives in Cincinnati

INTRODUCTION

How Does the Cincinnati Market Compare to National Trends?

Market forces alone have limited capacity to deliver efficient health care systems, according to a recent *Health Affairs* article that examined market dynamics in 12 communities across the country.¹ The study's conclusions provided a compelling formula by which to assess the Cincinnati market.

How does Cincinnati reflect the patterns that the authors of the *Health Affairs* article, researchers at the Center for Studying Health System Change, saw in its 12 community tracking sites? Rather well, it seems:

- **Pattern 1: Provider market power stems from the absence of effective substitutes.** The Cincinnati market is dominated by single-specialty groups. Its three hospital systems all seem to be included in all contracts.
- **Pattern 2: Absence of efficient delivery systems.** There is no integrated delivery system in Cincinnati. There are few multispecialty physician groups. Most practices, especially in primary care, are small. Most providers participate in most networks. The demise of capitation precludes focusing on a defined population.
- **Pattern 3: Employer failure to demand efficiency.** Although Cincinnati is home to large employers such as Procter & Gamble, General Electric, and Kroger, purchasers have not exerted enough collective muscle to demand efficient, high-quality care. Worker preference for broad networks and unrestricted access has weakened cost-containment strategies. Health plans say that employers will not back them in tough negotiations with providers or support payment differentials based on quality.
- **Pattern 4: Insufficient health plan competition.** Cincinnati's health plans are virtually indistinguishable. Preferred Provider Organization (PPO)-type networks have little leverage on provider practice, so quality improvement programs tend to be relatively shallow.

What's unique, or at least unusual, about Cincinnati?

Cincinnati has a strong community spirit. Health care stakeholders have created vehicles, such as the Health Improvement Collaborative, to enable them to work together to address market challenges, such as workforce shortages, information technology, and care of chronic illnesses.

A strong relationship exists between the medical community and the University of Cincinnati medical school; many medical students stay to practice in the Cincinnati area.

Cincinnati Children's Hospital Medical Center is well-funded, committed to quality, and clearly a regional leader. It is also essentially a monopoly, and so a difficult model to replicate.

Cincinnati voters approved and continue to support a county-level tax levy to fund indigent care in Hamilton County, which includes the center city (though not all of the metropolitan area).

Survey researchers at the University of Cincinnati say that the city reflects national attitudes and demographic trends consistently. "If you want to find a national average," they say, "look at Cincinnati."

PROGRAM

The site visit began the morning of May 24 with an overview of the Cincinnati health care market and how it has changed over the last decade or so. Stakeholder panels followed, in which employer, health plan, and hospital representatives gave their perspectives on competition, costs, and the driving forces in the market. After lunch, the group traveled to the offices of Group Health Associates, a large multispecialty practice, to talk with its physicians about their recent conversion from a capitated to a fee-for-service reimbursement model.

Site visitors spent the morning of May 25 at Cincinnati Children's Hospital Medical Center. CCHMC's board chair and other executives discussed the facility's original Pursuing Perfection grant from the Robert Wood Johnson Foundation and how it became the basis for refocusing the institution's goals and operations to make quality improvement central to care delivery. Involving families in care teams is an important part of the new approach. Site visitors then were paired with CCHMC physicians, accompanying them on clinical rotations that highlighted care programs in clinical areas such as cystic fibrosis and diabetes. Later, speakers discussed physician workforce issues, including recruitment, perceived shortages in some specialties, and the role of malpractice liability in choosing both a specialty and a practice location.

In the afternoon, site visitors talked with a panel of speakers about Bridges to Excellence (BTE), a pay-for-performance program that was

spearheaded by General Electric. Cincinnati is a BTE pilot site for improving diabetes care. The program concluded with a lively discussion among site visitors and a panel representing the Ohio Heart Health Center of the issues involved in establishing a specialty hospital.

IMPRESSIONS

Market Characteristics

- Rising health cost trends are driven by physician and hospital fee increases, as well as increased utilization, new technologies, and new uses for old technologies.
- Provider consolidation is a significant market driver. There are eight specialties in which two-thirds of physicians are in one single-specialty group. There is one large multispecialty group. Primary care practice, by contrast, remains small and fragmented. Hospitals have consolidated, going from 33 independent hospitals to three systems and one independent.
- Competition among hospital systems seems to be a matter of dividing up the market on the basis of geography and service emphasis (for example, cardiology or neonatal care). All three hospital systems contract with all three major health plans. Hospitals' practical (as opposed to social) mission is to grow admissions, build volume, and increase market share. System administrators are professional managers, whose priorities supercede local ties and loyalties. As businesses, hospitals are also big employers and engines of the local economy.
- The major health plans offer broad provider networks comprising essentially the same physicians and hospitals, so competition turns largely on relationships and service differentials.
- Relationships among health care stakeholder groups (employers, health plans, hospital systems, physicians) are marked by acrimony. Health care is the major issue at the bargaining table for some unions.
- Hamilton County, where Cincinnati is located, has a strong safety net, with funds for indigent care generated by a property tax levy. Because suburban counties in the metropolitan area (including those in Kentucky) do not have such a base to provide indigent services, city providers treat a significant number of nonresidents.
- Malpractice insurance rates for some specialties are notably higher than in similar cities in the region, particularly Indianapolis, and are perceived to offer a strong deterrent to setting up practice in the Cincinnati market.

Employer Strategies

- Health care managers in various sectors are united in a belief that consumer education must build in a wellness or prevention component in addition to making consumers more aware of the true magnitude of health care costs.

IMPRESSIONS

- Cincinnati employers are interested in the potential of consumer-directed health plans. Some already emphasize such plans in the choices they offer employees, but most employers have not been willing to steer employee choice through differential employer premium contributions.
- Health plan executives suggest that employers want them to be tough in negotiations with providers but are unwilling to back them up in eliminating high-cost providers from networks.
- Large employers feel a commitment to maintain retiree health benefits, but they do not intend to duplicate Medicare coverage. Small and medium-sized employers have generally terminated, if indeed they ever instituted, retiree health plans.

Quality

- Broad-based quality improvement (QI) programs, such as the Centers for Medicaid and Medicare Services's (CMS's) Premier demonstration, are rendered unappealing to providers where the investment required to participate is perceived to exceed the potential rewards for performance. A second disincentive to participation is a lack of agreement on common performance measures.
- Quality measurement to date is a "by-procedure" evaluation, where process measures and interim criteria (such as lower cholesterol) stand in for endpoints (for example, added years of life or better functionality). There is little grasp of total quality of care and how best to foster it.
- Some believe QI programs differentiate only between "the summas and the magnas." No sponsor of such programs (at the national, plan, or delivery system level) has been willing to isolate poor performers, in effect telling consumers to avoid certain providers.

Bridges to Excellence (BTE), spearheaded by General Electric and funded in part by the Robert Wood Johnson Foundation, is a multistakeholder approach to quality incentives. Employers, health plans, consumers, physicians, and group practices seek to improve quality through rewards and incentives that encourage providers to deliver optimal care as well as encourage patients to seek evidence-based care and self-manage their own conditions. In Cincinnati, where BTE has focused on diabetes care, physicians are required to (a) qualify for participation on the basis of eligible-patient volume (specifically, patients employed by a BTE employer, or their family members) and (b) demonstrate superior performance on the basis of measures developed by the National Committee for Quality Assurance. Those who succeed receive bonuses of \$100 per eligible diabetes patient. Participating employers let their employees know which physicians have been recognized as high-quality providers.

- Attempts to change physician behavior are more successful when they focus on outcomes rather than specifying process and when their incentives involve "real" money. Physicians' resistance to being managed or evaluated may be overcome, but only slowly.
- General Electric's Bridges to Excellence program (see sidebar) shows promise, but progress has been slow and painful. Physician buy-in and acceptance of the pay-for-performance model is hard-won, though some reluctance may be attributable to eligible-patient levels too low to justify the effort to qualify.

- Children’s Hospital has leveraged a Robert Wood Johnson Foundation Pursuing Perfection grant (see sidebar) into an ongoing transformation of care delivery. Family members are now routinely incorporated into core care teams. QI is premised on promises as well as measures. Care transformation is linked to organizational business strategy. However, all are agreed that there is still a long way to go, particularly in view of the fact that a hospital-wide (as opposed to departmental) medical record system has yet to be put in place.

Pursuing Perfection is a major initiative of the Robert Wood Johnson Foundation. Cincinnati Children’s Hospital Medical Center served as one of the first pilot projects, which focused on establishing a comprehensive delivery system for children with chronic illnesses, with an initial emphasis on patients with cystic fibrosis. The program is now focused on large-scale, organizational transformation, not just a series of incremental performance improvement projects. The new criteria include:

- Emphasizing internal/external transparency.
- Linking organizational strategic plans and objectives.
- Encouraging clinical and business leaders to lead change efforts.
- Placing patients and/or parents on design teams.
- Establishing commitment of resources and/or leadership.

Physician Issues

- Physicians assert that no one is willing to raise reimbursement levels for superior performance. In the transition from capitation to a fee-for-service environment, one physician group had to eliminate ancillary services that are not reimbursable, such as counseling patients on nutrition and self-management of chronic disease.
- Group Health Associates (see sidebar) demonstrates that getting physicians to change their behavior—commonly regarded as a serious challenge—can be accomplished quickly and dramatically by changing financial incentives. Physicians react strongly to fear of economic hardship, suggesting that sticks are more powerful than carrots. Physicians cannot be blamed for responding to the incentives constructed for them.
- Though hospitals and physicians seem quite concerned about shortages in some physician specialties, there is no objective standard by which to judge the severity of shortages. Comparisons with similar cities, presented as evidence of shortages in Cincinnati, could mean that Columbus or Louisville has a surplus. Site visitors raised the question whether, in the supply-driven health care system, all shortages are necessarily bad.

Changes in the marketplace forced **Group Health Associates**—Cincinnati’s only multi-specialty physician group practice—to switch to fee-for-service (FFS) reimbursement after nearly 30 years as a capitation-based medical group. A medical culture that stressed prevention and conservative medical management found that it needed to change its practice patterns in order to stay in business. Departments that were not reimbursed under FFS (mental health, eye care, and dietary counseling) were eliminated. Practices and clinicians who were not able to generate performance to break even or better were closed or let go. The practice improved the profitability of its reimbursable ancillary services and added other profitable services.

IMPRESSIONS

- New physicians coming into the system seem to want more “normal” lives and working hours while having the same target incomes as their overburdened predecessors.

Reimbursement

- Medicare’s prospective payment system, perceived as favoring “high-tech” procedures, provides a powerful incentive to deliver more of such procedures. Thus every hospital wants an open-heart surgery program, whereas resources are withdrawn from other services. In particular, mental health care has been all but abandoned.
- It is commonly accepted that care coordination saves money and improves care, but no one is willing to pay for it. Fee-for-service, as currently constituted in both Medicare and the private insurance that follows its lead, rewards procedures rather than time and planning.
- In a time of out-of-control health costs and with a prevailing attitude of “I’m not doing anything I don’t get paid for,” pay-for-quality advocates don’t seem to have enough to offer. The rhetoric is there, but the money is not.

Specialty Hospitals

- The growth of specialty hospitals and ambulatory surgery centers is fueled by consolidation of physician practices, physician access to capital, the repeal of Ohio’s certificate-of-need statute, and the perceived opportunity for profit and control.
- Specialty hospital proponents argue that quality is served by a high-volume, high-skill facility that concentrates on one type of service, such as cardiac care. Some physicians and even some health plan executives agree that a specialized facility serving as a regional center of excellence could benefit the community, in part by driving out marginal, duplicative programs in community hospitals. Opponents invoke the potential loss to the community of services, such as trauma centers, that would be difficult to sustain without the institutional cross-subsidies made possible by highly reimbursed and potentially more profitable service lines.
- Support of or opposition to specialty hospitals is also an issue of control, a question of whether hospital administrators or physicians should ultimately be in charge of the care process and its quality.
- Specialty hospitals tend to be built or planned when the procedures in question appear to command high profits. If Medicare were to cut back on what it pays for cardiac or orthopedic procedures, for example, enthusiasm for specialty facilities might wane.

Enduring Questions

One summary impression applies in some measure to all site visits: one cannot grasp a market in a matter of two or three days. Site visitors hear presentations from various viewpoints and must assess on the fly how they fit together and

what the fundamental issues really are. The Cincinnati visit inevitably raised questions that go beyond a single market or an easy breakout of alternatives.

- While competition among doctors and among hospitals—especially with fee-for-service incentives in place for both—favors maximizing the volume of health care services delivered, how can health care leaders address overall efficiency or the good of an entire population?
- Similarly, when physicians and hospitals are able to drive the volume of care delivered, how can sufficiency or shortage of physicians be objectively determined? How many specialists are enough?
- Providers behave rationally in responding to the incentives they are given. Are there ways to turn current incentives more in the direction of quality improvement?
- Prepaid group practice can facilitate preventive care, investment in information technology, and quality improvement. What contributes to the erosion of this model, and what might increase its prevalence?
- Policymakers have come to recognize that care of chronic illness is where planning and resources need to be focused. Does existing infrastructure need to be strengthened to support such care? How might this be accomplished?
- Given a general recognition that care coordination can save money, improve care, and raise patient satisfaction, how do we ensure that those willing to pay for coordination reap its rewards?
- When competing health plan networks all include the same providers, can a consumer (however well-informed) make a choice based on anything but price?
- Will employers retreat from health benefit management by moving to consumer-directed plans?
- How does shifting more of the health care cost burden to consumers impact the cyclical battle between providers and insurers?

IMPRESSIONS

ENDNOTE

1. Len M. Nichols, Paul B. Ginsburg, Robert A. Berenson, Jon Christianson, and Robert E. Hurley, "Are Market Forces Strong Enough? Confidence is Waning," *Health Affairs*, 23, no. 2, (March/April 2004): 8–20; and presentation by Len M. Nichols, Center for Studying Health System Change, "The Power and Limits of Market-based Strategies in Health Care," National Health Policy Forum pre-site visit briefing, May 19, 2004.

AGENDA

Sunday, May 23

8:00 pm Dinner (optional) [*Bella Restaurant, 600 Walnut Street*]

Monday, May 24

9:30 am MARKET EVOLUTION [*McKinley Room, Westin Hotel, 21 E. 5th Street*]

Alfred J. Tuchfarber, PhD, *Director Emeritus*, Institute for Health Policy and Health Services Research, University of Cincinnati

Lynn Olman, *President*, Greater Cincinnati Health Council

Larry Savage, *President and Chief Executive Officer*, Humana Health Plan of Ohio

- What forces and responses have made the Cincinnati market what it is today? What shifts in market power have occurred in the local health environment over the past few years? Did the market evolve as you expected, or are you surprised by how events played out?
- What are Cincinnati's distinguishing demographic, political, employment, and health system characteristics? How does it compare with similar metropolitan areas?
- What is the market share of each of the major health plans? hospital-based systems? How distinguishable are the health plan options being offered in the market today? How broad are the provider networks?
- What is the current state of relations among physicians, hospitals, health plans, employers, and consumers? Are there particular tensions or alliances among any of the parties?
- Why were earlier attempts to monitor and report on cost and quality (the Iameter project) ultimately unsuccessful? What has been the legacy of these efforts?

10:45 am HOLDING THE PURSE STRINGS:
PURCHASER COST AND QUALITY STRATEGIES

Gerald J. Domis, *Manager, Corporate Health Care Benefits*, Procter & Gamble

Cookie McDonough, *Director, Compensation and Benefits*, Frisch's Restaurants

James D. Smith, *Grand Lodge Representative*, International Association of Machinists and Aerospace Workers

- What has been the influence of large employers on the Cincinnati market?

AGENDA

Monday, May 24, 2004 *(continued)*

- What trends are occurring regarding benefits and costs? Do most employers offer a choice of plans? How have these options changed over the past several years? Are employers considering moving toward consumer-directed health plans?
- What are employees' priorities and concerns around health benefits?
- What obligations do Cincinnati employers have to their retirees? Will the new subsidies in the Medicare Modernization Act change employer strategies regarding retirees?
- What barriers exist to improving efficiency and outcomes in health systems? How does cost compare to quality in the value equation?

11:45 am Buffet luncheon

12:15 pm SHOWDOWN IN THE QUEEN CITY: CONTRACT NEGOTIATIONS FROM THE HEALTH PLAN PERSPECTIVE

Paul Beckman, *Vice President, Southern Ohio Health Service Area, Anthem Blue Cross and Blue Shield*

- How has competition among health plans changed recently in the Cincinnati market? Has ownership by national firms, as opposed to local, changed the culture around negotiations with providers?
- How have Anthem's product offerings changed over the past several years?
- In the most recent round of contract negotiations with providers and employers, what issues were the major sticking points?
- Is there a trend toward or away from physician practice consolidation?
- What are the incentives and disincentives for a health plan to pay providers differentially on the basis of quality?

1:00 pm PROVIDER PUSH-BACK IN A POST-MANAGED CARE ERA

Ken Hanover, *President and Chief Executive Officer, The Health Alliance*

John S. Prout, *President and Chief Executive Officer, TriHealth, Inc.*

Thomas Urban, *President and Chief Executive Officer, Mercy Health Partners*

- How have hospital-based systems changed their negotiating strategies? Have profit margins improved? Are these strategies sustainable over the long term?
- How have hospitals and physician associations been merged and/or consolidated over the past few years? What do such changes mean to patients?

AGENDA

Monday, May 24, 2004 (*continued*)

- How do payment rates (especially Medicare's) influence decisions about which lines of business to promote or diminish (for example, orthopedics versus psychiatry)?
- What are your capital investment priorities (for example, physical plant upgrades, new facilities, information technology)?
- Do your hospitals participate in the Centers for Medicare and Medicaid Services (CMS)-sponsored voluntary hospital reporting initiative? How much did the promised increases in market basket updates influence your decision to participate?
- Does your health system publicly report hospital-specific measures of patient volume, use, and outcomes? Do you believe these comparisons make a difference when consumers choose facilities?
- How have quality measurements changed? Have generally recognized standards emerged or is still there still duplication or contradiction? What are the barriers and critical success factors for implementation? To whom are reported results valuable?
- Has your system been affected by the increase in physician-owned specialty hospitals and ambulatory surgery centers? Do these facilities have a negative financial impact on general hospitals? Do they increase or decrease access to care?

2:30 pm Bus departure to Group Health Associates (GHA)

3:00 pm FROM CAPITATION TO FEE-FOR-SERVICE:
PHYSICIANS GO FULL CIRCLE

Michael Barber, MD, *Chief Executive Officer, GHA*

David M. Morad Jr., MD, *President and Chairman of the Board*

Christopher E. Hayner, MD, *Board member and Pulmonary/Critical Care Specialist*

Dennis Curran, *Vice President, Organizational Resources*

Stephen Beck, MD, *Staff Physician, Internal Medicine*

Sheldon M. Polonsky, MD, *Staff Physician, Pediatrics*

- How have GHA's relationships with health plans changed recently? How has the shift from capitation to fee-for-service payment affected health care delivery in your practice?
- How many multispecialty physician organizations exist in Cincinnati? What factors weigh in a specialist's decision to practice in a multispecialty rather than a single-specialty or solo practice?
- What incentives are offered by health plans or purchasers to measure and improve clinical performance? What incentives are offered by GHA internally? Do nonfinancial incentives have an impact?

AGENDA

Monday, May 24, 2004 *(continued)*

- How does your practice incorporate evidence-based practice guidelines? How much of medical practice still lacks unambiguous scientific evidence?
- Has today's patient become an actively involved consumer, and is this good or bad for the practice? Are patients able to communicate electronically with their physicians?
- Does having an electronic health record (EHR) system result in cost savings to the practice? Does it influence your malpractice insurance rates?

5:00 pm Departure for headquarters hotel

6:00 pm Reception [*Fountain Room, Westin Hotel*]

7:15 pm Bus departure for dinner

7:30 pm Dinner [*Rookwood Pottery Bistro*]

Tuesday, May 25

7:00 am Continental breakfast available [*McKinley Room, Westin Hotel*]

7:30 am Bus departure for Cincinnati Children's Hospital Medical Center (CCHMC)

8:00 am PURSUING PERFECTION IN CARE
DELIVERY: THE RE-ENGINEERING OF CCHMC

Lee A. Carter, *Chair*, Board of Trustees

Scott J. Hamlin, *Senior Vice President, Finance and Chief Financial Officer*

Uma Kotagal, MBBS, MSc, *Vice President, Quality and Transformation*

Honor Page, *Parent*

- How has the original project to improve quality in cystic fibrosis care been modified and expanded?
- How have families been incorporated into the care team?
- What are the training issues in workflow redesign?
- What steps have been taken to increase hospital caseload capacity?
- Has management philosophy changed since this project began? How well does a body with fiduciary responsibility, such as a board of trustees, incorporate quality as well as financial measures into its deliberations?

AGENDA**Tuesday, May 25, 2004** *(continued)*

- How resource-intensive are these efforts? Could they feasibly be replicated by hospitals that face more competition in the local marketplace?

9:30 am CLINICAL ROTATIONS
(Each rotation will have three participants.)

Transplant Team **John Bucuvalas, MD**
Operating Room Team **Cindi Bedinghaus, RN**
Acute Care Team **Steve Muething, MD**
Cystic Fibrosis Clinic Team **Jeanne Weiland, RN**
Diabetes Clinic **David Repaske, MD**
Primary Care Clinic **Melissa Klein, MD**
Neonatal Intensive Care Unit **Pattie Bondurant, RN**
Specialty Care **Ron Levin, MD**
Juvenile Rheumatoid Arthritis Clinic **Brent Graham, MD**
Drug Safety **Brian Jacobs, MD, and
Jack Horn**

11:00 am RECRUITING AND RETAINING TRI-STATE PHYSICIANS
[Sabin Center board room]

Thomas F. Boat, MD, *Director*, The Children's Hospital Research Foundation and *Chairman*, Department of Pediatrics

L. Thomas Wilburn Jr., *Director*, Bethesda Services, and *Chair*, Health Improvement Collaborative of Greater Cincinnati

James Wendel, MD, *Managing Partner*, Mt. Auburn Obstetrics and Gynecological Associates, Inc.

- What factors influence a medical student's choice of specialty? What actions can be taken at a local or national level to attract more professionals to a particular clinical field? Should federal financing of graduate medical education be more explicitly tied to long-term objectives for the supply, training, and distribution of physicians?
- Do University of Cincinnati Medical School graduates tend to stay in the area? What are the critical considerations in choosing where to practice?
- Is there a shortage of physicians in Cincinnati? If so, is this true overall or in certain specialties?
- How do Cincinnati's reimbursement rates compare with those in similar communities? Have these rates been influenced by the strong presence of large purchasers?

AGENDA

Tuesday, May 25, 2004 *(continued)*

- How significant a role do malpractice insurance rates play in a physician’s decision about where to practice? What is the impact on those already established in practice? Are there strategies in play to improve the situation in Cincinnati? Is there a role for peer regulation?

Noon Bus departure to headquarters hotel

12:30 pm Lunch [*McKinley Room, Westin Hotel*]

1:00 pm BRIDGES TO EXCELLENCE: FINDING THE RIGHT INCENTIVES

Beth Hallgren, *Health Care Manager, General Electric*

Michael Barber, MD, *Chief Executive Officer, GHA*

Donna Leussen, RN, COHN, CCM, *Kentucky District Occupational Health Supervisor, United Parcel Service*

Keith Mandel, MD, *Vice President, Medical Affairs, CCHMC Physician-Hospital Organization*

Charles Stemple, DO, *Senior Medical Director, United HealthCare of Ohio*

Derek van Amerongen, MD, *Vice President and Chief Medical Officer, Humana Health Plan of Ohio*

- Why was diabetes chosen as the program’s focus? Will it expand to include other diagnoses?
- What are the selling points to employers? What incentives are offered to clinicians who participate? To consumers?
- What is the role of the primary care physician in this project? How are other health professionals involved?
- How will you determine whether the project is a success? What factors are critical to achieving success?
- What structural quality measures (e.g., implementation of specified information technologies) are included in performance assessment?

3:00 pm THE OHIO HEART HEALTH CENTER (OHHC):
A SPECIALTY HOSPITAL CASE STUDY

Dean J. Kereiakes, MD, *Chief Executive Officer, OHHC, and Medical Director, The Carl and Edyth Lindner Center for Research and Education*

OHHC Physicians:

Thomas M. Broderick, MD

Tom D. Ivey, MD

Michael R. Smith, MD

Mark B. MacDonald, *Chief Operating Officer, OHHC*

James Tomaszewski, *Executive Director, OHHC*

AGENDA

Tuesday, May 25, 2004 *(continued)*

- How many hospitals in the metropolitan area are doing cardiac surgery? Does the city need another one?
- How might a specialty hospital contribute to or detract from a regional approach to the deployment of health care resources? Is such an approach possible when each sector of the health care market has turf to protect? Can incentives among competing hospitals and between physicians and hospitals be aligned?
- How do you respond to allegations that physician-owners will refer the good-risk and paying patients to their own facility while sending the risky, poor, and uninsured patients to a community hospital?
- If Medicare payment rates were adjusted so that cardiovascular services were not much more profitable than other services, would establishing an independent heart center still make good business sense?
- How are you prepared to document the provision of superior care?

4:15 pm Adjournment

4:30 pm Bus departure to Airport

Federal & Foundation Participants

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Health Care, Medicaid, and Private Health Insurance Programs
U.S. General Accounting Office

Pamela D. Bataillon

RWJF Health Policy Fellow

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Diana Birkett

David A. Winston Health Policy Fellow
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Nancy Delew

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Department of Health and Human Services

Jill Gotts

Health Policy Fellow

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Dawn Gencarelli
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Biographical Sketches — Speakers

Michael Barber, MD, is chief executive officer of Group Health Associates (GHA), where he was hired in 2003 as chief operations officer. He is a board-certified family physician who earlier served as the chief medical officer of ChoiceCare, an independent local HMO since acquired by Humana. In addition, he was the chief executive officer of Momentum Health Solutions, a managed care company that managed long-term health care for a senior population on a risk-bearing basis. Dr. Barber has also served as the chief executive officer of The Haelan Group, a start-up population health management company that developed a tool to predict the future high-cost utilizers in a population of people. He continues to have a very close relationship with Haelan as this product, One Care Street™, is rolled out across the country.

Stephen Beck, MD, is a board-certified internist with GHA. He holds a BS degree from the University of Dayton and an MD degree from the University of Cincinnati. He was a resident at Good Samaritan Hospital, where he also served as the residents' computer coordinator.

Paul Beckman is vice president of the Southern Ohio Health Service Area with Anthem Blue Cross and Blue Shield. Before joining Anthem, he was administrator of multispecialty group practice GHA. He is a past president of the Ohio and Cincinnati Medical Group Management Associations (MGMA) and the Managed Care Assembly of the national MGMA. Mr. Beckman is a fellow of the American College of Medical Practice Executives and has taught in the graduate program at Xavier University for 18 years. Paul holds bachelor's and master's degrees from Xavier.

Thomas F. Boat, MD, is director of the Children's Hospital Research Foundation and chairman of the department of pediatrics. He also is physician-in-chief and a member of the board of trustees of Cincinnati Children's Hospital Medical Center (CCHMC). A pediatric pulmonologist by training, Dr. Boat joined CCHMC in 1993 after serving as chairman of the department of pediatrics at the University of North Carolina, Chapel Hill. Previously, he was co-director of the Cystic Fibrosis Center at Rainbow Babies and Children's Hospital in Cleveland. Boat is a member of the Institute of Medicine. He earned his MD degree at the University of Iowa.

Lee A. Carter is chairman of the board of trustees of CCHMC. He founded Local Marketing Corporation, a marketing consulting firm, in 1971 after working for the Drackett Company in sales and marketing. He sold Local Marketing in 1989 to Grey Advertising in New York and continued to run the company until his retirement in 1995.

Gerald J. Domis is manager of corporate health care benefits for Procter & Gamble (P&G). He is responsible for plan design and purchase of health care plans for the more than 18,000 P&G Corporate and Customer Business Development employees in the United States and for improving the quality and efficiency of their health care. His P&G career has included assignments in finance, product supply/manufacturing, human resources, and employee benefits. Mr. Domis received his undergraduate business degree from Ohio State University and his MBA degree from the University of Cincinnati.

Biographical Sketches — Speakers

Beth Hallgren leads GE Transportation's efforts to manage group health care costs while ensuring access to quality care. Hallgren joined the GE Healthcare Team in 1998 as a health care manager for its Aircraft Engines division. Her experience includes work at one of the largest not-for-profit health care and hospital systems in the West. She has also worked for a national managed care company where she gained experience in network management, call center management, and sales and account management, finishing her time there as the regional director of provider networks. Hallgren holds BS and BA degrees from Arizona State University and an MBA degree from the University of Phoenix.

Scott J. Hamlin is senior vice president of finance and chief financial officer of CCHMC and also serves as corporate treasurer. He joined the hospital in 1988 as director of finance and was named assistant vice president of finance in 1990 and to his current positions in 1997. Earlier, he specialized in health care practices at Arthur Anderson & Co. Hamlin holds a BBA degree from the University of Cincinnati.

Ken Hanover joined the Health Alliance in 2001 as president and chief executive officer. He came from the Main Line Health System in Pennsylvania, where he had been chief executive officer since 1996. Mr. Hanover also had experience with the Legacy Health System in Portland, Oregon. He received a bachelor's degree from the University of Massachusetts and a master's degree from Cornell University. He is chair-elect of the Greater Cincinnati Hospital Council.

Christopher E. Hayner, MD, is a GHA board member, board-certified in pulmonary diseases/critical care. He earned a BS degree at Marshall University and an MD degree from that university's school of medicine. His residency at Good Samaritan Hospital was followed by a fellowship at the University of Cincinnati.

Dean J. Kereiakes, MD, is chief executive officer and director of research of the Ohio Heart Health Center and is also medical director of the Carl and Edyth Lindner Center for Research and Education and a professor of clinical medicine at Ohio State University. Dr. Kereiakes is board-certified in internal medicine and cardiology. Earlier positions in research and cardiology practice were centered at Cincinnati's Christ Hospital, and he was a professor at the University of Cincinnati College of Medicine from 1996 to 2001. Dr. Kereiakes is a member of the editorial boards of and a frequent contributor to several medical journals, including *Circulation* and the *American Journal of Cardiology*. He holds both undergraduate and medical degrees from the University of Cincinnati.

Uma Kotogal, MBBS, MSc, is vice president of quality and transformation at CCHMC. She is a practicing neonatologist and was director of neonatal intensive care units at University Hospital and CCHMC for several years. More recently, she has received additional training in clinical epidemiology and clinical effectiveness, culminating in a master's degree from the Harvard School of Public Health. She received her undergraduate and medical degrees from the University of Bombay.

Donna Luessen, RN, COHN, CCM, joined the United Parcel Service (UPS) in June 2000 as the Kentucky district occupational health supervisor. Her responsibilities include

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vendor management across the entire health continuum, Department of Transportation medical compliance oversight, respiratory surveillance management, and regulatory controlled substance training. She acts as a community liaison to local health agencies and assists in the development of new health and wellness programs. Prior to working with UPS, Ms. Luessen worked as a supplier to GE Aircraft Engines as an on-site case manager for 10 years. She is a graduate of Good Samaritan School of Nursing.

Keith Mandel, MD, joined CCHMC in January 2000 as vice president of medical affairs for the physician-hospital organization (PHO). The PHO represents Cincinnati Children's, over 500 pediatric medical and surgical specialists, and an independent practice association of nearly 170 primary care physicians across 40 practices, with regard to managed care contracting and quality improvement initiatives. Dr. Mandel led the effort to recruit the participation of Cincinnati Children's in the Bridges to Excellence program from both the employer and provider perspectives. He is also co-leading CCHMC's participation in Pursuing Perfection, the national initiative launched by The Robert Wood Johnson Foundation and the Institute for Healthcare Improvement. Before joining CCHMC, Dr. Mandel was a Robert Wood Johnson Clinical Scholar in Health Policy and Management at Johns Hopkins University School of Medicine, as well as a management consultant to academic medical centers and children's hospitals. He earned an undergraduate degree at Duke University and a medical degree from the University of Pittsburgh School of Medicine.

Cookie McDonough is director of compensation and benefits at Frisch's Restaurants, Inc. She joined the company in 1975. She is a trustee and past president of the Employer Health Care Alliance and serves on the Community Health Outcomes Steering Committee of the Health Improvement Collaborative of Greater Cincinnati. Ms. McDonough holds an undergraduate degree from the University of Cincinnati.

David M. Morad Jr., MD, is president and chairman of the board of directors of GHA. He is board-certified in otolaryngology and a specialist in facial reconstructive surgery. He graduated from John Carroll University and earned his MD degree from the University of Cincinnati, after which he was a resident at the Jewish Hospital of St. Louis and the Barnes Hospital of the Washington University School of Medicine and held a fellowship with the American Academy of Facial Plastic Reconstructive Surgery.

Lynn Olman has been president of the Greater Cincinnati Health Council and secretary of the Hamilton County Hospital Commission since 1983. She also serves as executive director of the Health Improvement Collaborative of Greater Cincinnati. Prior to 1983, Ms. Olman was assistant director at the University of Cincinnati Medical Center. She served in several senior staff capacities for the American Hospital Association in Chicago from 1976 to 1978. From 1973 to 1976, Ms. Olman was a legislative assistant to former Sen. Howard H. Baker, Jr. Olman serves on numerous local, state, and national committees and boards, including the Greater Cincinnati Chamber of Commerce, the Ohio Public Health Leadership Institute, and the Association for Community Health Improvement. She holds a BA degree from American University and an MA degree from The George Washington University.

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Honor Page is a pharmacist and the mother of a child with a chronic illness. In her role as parent team leader at CCHMC, she advises the clinical staff about services that would best help patients and fosters mutual support among parents.

Sheldon M. Polonsky, MD, is a board-certified pediatrician with GHA. He earned a BA degree from Boston University, an MD degree from the University of Wisconsin School of Medicine, and an MS degree in epidemiology from the University of Cincinnati. He was both a resident and a fellow at CCHMC.

John S. Prout is president and chief executive officer of TriHealth, Inc., an integrated hospital system sponsored by Catholic Health Initiatives and Bethesda, Inc. He also holds the position of president and chief executive officer of its two anchor hospitals, Good Samaritan Hospital and Bethesda North Hospital. Earlier, Mr. Prout was president and chief executive officer of St. Joseph Medical Center in Towson, MD. He currently serves on the boards of the Ohio Hospital Association and the American Heart Association. Prout holds a master's degree in health care administration from Washington University in St. Louis.

James D. Smith is the Grand Lodge Representative for the International Association of Machinists and Aerospace Workers, where he has worked for the past 15 years. He negotiates health benefits on behalf of workers across 14 states from Maine to Michigan.

Larry D. Savage was named president and chief executive officer of Humana Health Plan of Ohio in 1998, having previously served in several executive leadership roles within the organization over nearly 20 years. Under his direction, the plan has grown to more than 400,000 members, providing health benefit solutions to the region's most prestigious employers. In September 2003, Humana of Ohio was awarded an excellent accreditation status by the National Committee for Quality Assurance for the fourth consecutive three-year period. Savage serves on the boards of the Ohio and Northern Kentucky Chambers of Commerce, the Greater Cincinnati Chapter of the American Heart Association, and the Health Improvement Collaborative of Greater Cincinnati. He holds a BS degree from Eastern Kentucky University.

Charles A. Stemple, DO, is senior medical director for United HealthCare of Ohio, where he oversees quality improvement and local pharmacy initiatives and manages physician concerns with respect to contracting and reimbursement. Earlier, he was medical director of ChoiceCare. After completing his residency in emergency medicine, Dr. Stemple spent 13 years working in emergency services at Good Samaritan Hospital in Dayton. He earned a BS degree at Ohio State University, his DO degree at West Virginia School of Osteopathic Medicine, and an MBA degree at Xavier University.

Alfred J. Tuchfarber, PhD, is professor of political science at the University of Cincinnati McMicken College of Arts and Sciences. He recently retired from his role as the founding director of the University of Cincinnati's Institute for Health Policy and Health Services Research. Dr. Tuchfarber was also director of the University of Cincinnati's Institute for Policy Research for 28 years and has studied the Greater Cincinnati community for over three decades. He has been very active in community affairs.

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Thomas Urban was named senior vice president of Catholic Healthcare Partners (CHP) and president and chief executive officer of Mercy Health Partners (southwest Ohio) in June 2002. Prior to this, he served as the region's senior vice president of health delivery and as president of Mercy Hospital Fairfield. Earlier, he had served as regional vice president, chief integration officer, and president of the region's Mercy Hospital Hamilton/Fairfield. Prior to joining CHP, Mr. Urban was executive vice president/ chief operating officer of Beverly Hospital in Beverly, Massachusetts. He also served in hospital management positions in Fort Myers, Florida, and Dayton, Ohio. Urban earned a BA degree from Colgate University and a master's degree in health administration from Xavier University.

Derek van Amerongen, MD, serves as vice president and chief medical officer for Humana Health Plan of Ohio in Cincinnati. Before joining Humana, he was national medical director for Anthem Blue Cross and Blue Shield, responsible for working with Anthem's national accounts as well as creating and directing the company's women's health initiative. His experience also includes over six years as chief of obstetrics and gynecology for the Johns Hopkins Medical Services Corporation in Baltimore and as a faculty member in the Department of Gynecology and Obstetrics of the Johns Hopkins School of Medicine. He chairs the Women's Health Task Force of the American Association of Health Plans and serves on the board of directors for URAC and the executive committee for the National Practitioner Data Bank. Dr. van Amerongen received his undergraduate degree from Princeton University, his MD degree from Rush Medical College in Chicago, and his MS degree from the University of Wisconsin.

James S. Wendel, MD, is managing partner of Mt. Auburn Obstetrics and Gynecological Associates and president of the Christ Hospital medical staff, and he also serves on the hospital's board of trustees. Wendel holds an undergraduate degree from the University of Notre Dame and an MD degree from the University of Cincinnati.

L. Thomas Wilburn Jr. is director of Bethesda Services, which oversees contracted operations at Bethesda Hospital. Before his retirement in 1998, Mr. Wilburn was president and chief executive officer of TriHealth, Inc. He was with Bethesda Hospital, Inc., for more than 20 years before it joined Good Samaritan Hospital in a partnership that became TriHealth in 1995. He is also chair of the Health Improvement Collaborative of Greater Cincinnati.

Biographical Sketches — Federal & Foundation Participants

Kathryn Allen is director for Medicaid and private health insurance issues in the U.S. General Accounting Office (GAO). She directs the agency's work on Medicaid, long-term care, and private health insurance. Her 23-year career with GAO also includes leadership positions in the Seattle and European field offices and, in the late 1980s, direct staff support to the National Commission to Prevent Infant Mortality. She graduated *magna cum laude* from the University of Richmond in business administration and attended Harvard University's John F. Kennedy School of Government Executive Leadership Program.

Pamela D. Bataillon, MSN, RN, is a Robert Wood Johnson Health Policy Fellow in Sen. Blanche Lincoln's office. She has most recently been the Chief Operating Officer for the Visiting Nurse Association (VNA) of the Midlands, in Omaha, Nebraska, and administrator of the VNA of Pottawattamie County (Iowa), which also serves as the county's official public health entity. Ms. Bataillon was a candidate for Lieutenant Governor in 1998, chaired former Sen. Bob Kerrey's Task Force for Health Care Reform, and was appointed by the governor to plan a merger of five state health and human service agencies. She earned a BS degree in nursing from Creighton University and a master's degree in community health from the University of Nebraska Medical Center. She is currently enrolled in an MBA degree program at the University of Dallas.

Diana Birkett is a David Winston Health Policy Fellow, currently working with the Senate Committee on Finance, Minority Staff. She works predominantly on quality of care and health information technology, as well as Medicaid and Medicare payment issues. Before moving to Washington, DC, last summer, Ms. Birkett was in graduate school for public health and public policy at the University of Washington in Seattle and worked for the Washington State Women, Infants, and Children (WIC) Program.

Nancy Delew is senior advisor in the Office of Research and Development at the Centers for Medicare and Medicaid Services (CMS).

Jill Gotts is a presidential management intern (PMI), currently working for the Senate Committee on Finance. Other rotations in this internship have been with the Division of Health Financing and Policy under the assistant secretary for Planning and Evaluation and with CMS in the Department of Health and Human Services. Before becoming a PMI, Ms. Gotts was a health policy analyst with the National Governors Association. She holds an undergraduate degree from the University of Michigan and an MPH degree from Columbia University.

Edward Grossman has been senior counsel with the Office of the Legislative Counsel of the House of Representatives for almost 30 years, concentrating in the fields of health care and immigration. He has been a principal drafter for most major national health insurance bills, including the Health Security Act during the Clinton administration, as well as Medicare and medical legislation, including the recent Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. He received his JD degree from Yale Law School.

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James Hahn, PhD, is an analyst in the Domestic Social Policy Division at the Congressional Research Service (CRS). As a health economist, he works on issues related to prescription drug pricing, hospital and physician payment, and geographic variations in health care expenditures. Before joining CRS, Dr. Hahn worked at GAO and with Lewin and Associates, Inc. He has published articles in the *New England Journal of Medicine* on the effect of for-profit ownership and system affiliation on the economic performance of hospitals and on the comparison of physician payment and expenditures between the United States and Canada. Dr. Hahn has served on the faculties of the School of Public Health at the University of North Carolina at Chapel Hill and at Trinity University in San Antonio, Texas. He is a graduate of Stanford University.

Dora Hughes, MD, is deputy director for health on the Senate Committee on Health, Education, Labor & Pensions. Prior to this, she served as senior program officer at The Commonwealth Fund, where she shared grant-making responsibilities for the Quality of Care for Underserved Populations Program and held principal responsibility for the Fund's Fellowship in Minority Health Policy at Harvard University. Hughes completed medical school at Vanderbilt University and is board-certified in internal medicine. In addition, she holds a master's degree from Harvard University, through participation in the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy.

Jennifer Jenson is a specialist in health economics at CRS, where she focuses on a range of issues related to health care costs, including economic issues in providing health care for an aging population, private health insurance, and strategies for influencing spending on health care. Previously, she has worked on Medicare, Medicaid, and public health issues at several federal bodies: the Office of Management and Budget, the Medicare Payment Advisory Commission (MedPAC), and the Congressional Budget Office (CBO). Ms. Jenson holds master's degrees in public health and public policy from the University of Michigan.

Amy Knight, PhD, is a health policy analyst in the Medicare Demonstrations Program Group at CMS. She is responsible for managing demonstration projects designed to test alternative payment and delivery systems in Medicare. She is involved in the development of payment for quality projects that align financial incentives to promote high-quality healthcare, including the Medicare Care Management Performance Demonstration (Section 649, MMA). Dr. Knight also works on several Medicare Disease Management Demonstrations to improve care for chronically ill beneficiaries. She received her doctorate in clinical psychology from the University of Wisconsin–Milwaukee.

Julie Lee, PhD, joined CBO's Health and Human Resources division in 2003. Currently, she is working on projects analyzing high-cost Medicare beneficiaries, including issues related to disease management. Prior to joining CBO, Dr. Lee was a research analyst in health care policy at the National Bureau of Economic Research, where she analyzed a variety of topics in health economics, ranging from the effects of medical malpractice reforms to the distributional effects of Medicare. She received a PhD degree in economics from Yale University.

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Karen Milgate is a research director with MedPAC, responsible for research and policy analysis on quality and access issues. Earlier, she served as deputy executive vice president for the American Health Quality Association, which represents Medicare's Quality Improvement Organizations. Ms. Milgate spent six years with the American Hospital Association as senior associate director for policy development. Ms. Milgate holds a master's degree from the University of Maryland and undergraduate degrees from the American University.

Scott Noyes is regional director of the local office of Sen. Mike Dewine.

David R. Pender has been the deputy assistant director of the Health Care Services and Products Division of the Bureau of Competition at the Federal Trade Commission (FTC) since 1990. In this position, he supervises the Commission's antitrust enforcement program governing health care. Mr. Pender has held a number of other positions at the FTC's headquarters, including attorney advisor to a commissioner and to a deputy director of the Bureau of Competition, manager of regional office antitrust investigations, and senior attorney for evaluation. Prior to coming to Washington, he was a senior attorney in the FTC's Seattle office, an associate in a Los Angeles law firm, and a special agent with the Federal Bureau of Investigation. Mr. Pender is a graduate of the University of Pennsylvania and earned his JD degree at Stanford University.

Rita F. Redberg, MD, is a Robert Wood Johnson Health Policy Fellow in the office of Sen. Orrin G. Hatch. She is professor of medicine at the University of California, San Francisco (UCSF) Medical Center and director of cardiovascular women's services for the UCSF National Center of Excellence in Women's Health. Dr. Redberg received a NIH grant to study the effects of exercise on heart disease in women and has numerous publications in this field. She started an American Heart Association Committee on Women in Cardiology and chairs the Women's Health Advisory Group for the American Society of Echocardiography, as well as serving on the Scientific Advisory Board of Womenheart. She graduated from the University of Pennsylvania Medical School and has a master's degree in science and health policy and administration from the London School of Economics.

William J. Scanlon, PhD, is a health policy consultant. Until April 2004, he was the Managing Director of Health Care Issues at GAO. He has been engaged in health services research since 1975. Before joining GAO in 1993, he was the co-director of the Center for Health Policy Studies and an associate professor in the department of Family Medicine at Georgetown University and had been a principal research associate in Health Policy at the Urban Institute. At GAO, he oversaw congressionally requested studies of Medicare, Medicaid, the private insurance market and health delivery systems, public health, and the military and veterans' health care systems. Dr. Scanlon has published extensively and has served as frequent consultant to federal agencies, state Medicaid programs, and private foundations. He has a PhD degree in economics from the University of Wisconsin–Madison.

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Madeleine Smith, PhD, is a professional staff member of the Subcommittee on Health, House Ways and Means Committee, where she handles Part B provider issues, Medicare modernization, and health insurance and the uninsured. She began working for the Subcommittee in February 2002. Prior to this position, she spent over 10 years with CRS, the research organization of the Congress. She holds a PhD degree from the University of Rochester.

Ellen-Marie Whelan, RN, NP, PhD, is a Robert Wood Johnson Health Policy Fellow on the staff of the Senate Minority Leader Thomas Daschle (D-SD). She came to this position from Johns Hopkins University, where she is an assistant professor with a joint appointment with the School of Nursing and the Urban Health Institute. Her research examines how academic health centers interact with their surrounding communities. Whelan received her bachelor's degree at Georgetown University. She also received a master's degree in nursing and a doctorate in nursing and health policy at the University of Pennsylvania, where Dr. Whelan established a pediatric primary care clinic in a community center in West Philadelphia. For this effort, former Department of Health and Human Services Secretary Donna Shalala presented her with the Secretary's Award for Innovations in Health Promotion and Disease Prevention in 1995.

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