



Site Visit – Chicago

March 16–18, 2008

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Site Visit Report

Competition and Collaboration, Chicago-Style

THE GEORGE
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2131 K Street NW, Suite 500
Washington DC 20037

202/872-1390
202/862-9837 [fax]
nhpf@gwu.edu [e-mail]
www.nhpf.org [web]

Judith Miller Jones

Director

Sally Coberly, PhD

Deputy Director

Monique Martineau

Publications Director

Site Visit Managers

Laura A. Dummit

Principal Policy Analyst

Lisa Sprague

Principal Policy Analyst

Administrative Coordinator

Marcia Howard

Program Associate

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Competition and Collaboration, Chicago-Style

While cost, quality, and access are concerns in health care markets irrespective of geography, each locality struggles to address them in a different context and with a different set of players. By providing federal policymakers with opportunities to study a variety of markets, the National Health Policy Forum hopes to give them the tools to identify promising approaches and distinguish the factors in health care that respond to local forces from those that may respond to federal intervention. The March 2008 site visit to Chicago was the latest in a Forum series looking at these markets around the United States.

Chicago may best be described as several health care markets. Because of its large population, extensive geography, and immigrant history, most providers tend to serve neighborhoods rather than the entire city. Providers must consider the distinctive ethnic character of their neighborhoods in their service offerings, whether this calls for interpretation services or sensitivities to cultural divides. The characteristics of a neighborhood also can change with gentrification, possibly stranding safety net providers, or with suburban flight, which may leave a provider without a thriving community.

The nature of competition within the city appears to be shaped by a few large players. Blue Cross Blue Shield (BCBS) of Illinois holds a commanding share of the private insurance market. Other insurers struggle to gain a foothold, in part because they cannot negotiate provider discounts that match those of BCBS. Some nationally recognized hospitals maintain their reputations by ensuring they have the most up-to-date technology and are regarded as must-haves in any provider network. Because of their status, they are not obliged to compete with other facilities on the basis of cost. These premier facilities draw patients and possibly physicians from community hospitals, which may drive up spending with indeterminate effect on quality.

Few of the city's hospitals are affiliated, reducing their ability to leverage resources or work together. Less formal alliances among hospitals do occur, but shift depending on the issue. Hospitals in the city stand together in discussions about Medicaid funding for disproportionate share hospitals, to draw resources into Chicago from downstate institutions. However, the safety net hospitals have formed their own alliance to try to capture a greater share of state-imposed provider taxes.

Severe financial and managerial problems at John H. Stroger, Jr. Hospital, the largest of Cook County's three public hospitals, form a backdrop to discussion with other providers. The fear of losing the safety valve this public hospital provides—and having to pick up the burden of uninsured and low-income patients—may force other hospitals to figure out collective strategies to address access in the city.

There are some glimmers of collaboration that might serve to improve access and increase efficiency, such as agreements between an academic medical center and the community hospitals in its vicinity. The city's health department also is trying to pull providers together to try to solve common problems in three regions of the city. However, these are nascent efforts; mutual distrust is not overcome quickly. In addition to hospitals, access proposals must consider the ambulatory care safety net, pieced together with the county hospitals and clinics, the largest federally qualified health clinic (FQHC) network in the country, smaller FQHCs, free clinics, and city clinics.

PROGRAM

The site visit began the morning of March 17, 2008, with an overview of state-level policy concerns and the governor's health reform agenda. Perspectives on the Chicago market were offered by an economist and a safety net hospital administrator. Site visitors walked along the Gold Coast to visit Northwestern Memorial Hospital and hear from its chief financial officer about the institution's business plan and the relationship of financial performance to mission. The market's dominant insurer, BCBS of Illinois, was next on the agenda; presentations focused on the HMO (health maintenance organization) product line and quality improvement initiatives. The day ended with a visit to Mount Sinai Hospital, a facility serving predominantly Medicaid and self-pay patients.

The second morning brought participants into a discussion with executives from Holy Cross Hospital and community leaders from the neighborhood it serves, once eastern European, now predominantly African-American and Latino. Next the group visited a clinic site of Access Community Health Network, hearing from its director as well as the director of a free clinic and an executive vice president from the University of Chicago Medical Center (UCMC) who is spearheading new collaboration with the South Side community. The program concluded with a conversation with an assistant commissioner from the city's Department of Public Health.

IMPRESSIONS

After the site visit, participants were asked to reflect on their experiences and the perspectives offered by speakers. The following are key impressions participants took away from the program, as well as additional insights developed during a follow-up debriefing session.

The Importance of Market Dominance

The Chicago market is defined by the presence of some dominant players, leaving the smaller stakeholders to try to band together or to align with the dominant ones. Observers were struck by the power and resources of the principal insurer, a few hospitals, and the country's largest network of FQHCs. A strong employer voice or physician leadership independent of academic medical centers and teaching hospitals seemed absent.

- BCBS of Illinois has a 60 percent market share, nearly four times that of its closest competitor. Patient volume alone ensures that the Blues can secure favorable rates from hospitals and physicians; for the most part this seems less a matter of negotiation than “take it or leave it.” While proud of its quality improvement programs, BCBS is not driven by employers to develop creative ways to promote efficiency or regional health planning.
- Its size gives BCBS the power to hold down provider payments, which virtually ensures continuation of its market dominance.
- BCBS did not pursue lucrative Medicare Advantage business, possibly to avoid competing with its own Medigap business, an indicator of its conservative business strategy.
- BCBS has maintained its dominance by creating products that its customers want, by appealing to national companies in terms of its own national presence and reputation, and by not rocking the boat.
- Northwestern Memorial Hospital, blessed with a Gold Coast location, has a management team that views “exceptional financial performance” as a core element of the hospital’s mission. Northwestern’s strong earning power and endowment make it the envy of less financially robust facilities. Northwestern Memorial is widely regarded as a “must have” in any provider network.
- The UCMC is the principal player on the city’s South Side. Known for its tertiary-level, high-tech care, it has historically been described as oblivious to the community that surrounds the campus.
- Access Community Health Network has 50 clinic sites in metropolitan Chicago. Its five-year vision is for patients to “consider Access to be their medical home and turn to [it] for a continuum of services provided directly by Access or assured through partnerships with hospitals and service organizations.” Access Community Health Network had a head start in achieving its dominance when it acquired the clinics of Mount Sinai Hospital. Its growth was fueled by the enhanced Medicaid reimbursement accorded FQHCs. Access has continued to flourish through a clear focus on a business plan that relies on growth to spread its fixed costs, size to bring in the specialty lines of business that attract paying clients, and reputation to broker favorable arrangements with teaching institutions.
- Chicago is described as a city of corporate headquarters, each with only a handful of local executives, while the factories or sales forces are located somewhere else. This reportedly translates into little interest in local health care costs or efficiency and a desire to maintain well-known institutions in insurer networks.
- The largest employers are the universities (with associated health systems) and city government. Perhaps because of their mixed incentives, the universities appear to exert little pressure on insurers to increase efficiency among providers.

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- The presence of seven medical schools in the city means that a significant proportion of Chicago physicians have an affiliation with a faculty practice and an academic medical center. Perhaps because of this economic tie, they have not been as entrepreneurial as physicians in other areas in setting up physician-owned facilities, such as imaging and ambulatory surgery centers.

Competition

Competition is hard to spot in Chicago. The market dominance of BCBS of Illinois, Access Community Health Network, and the major academic medical centers does not leave much room for lesser players to challenge their positions. The smaller stakeholders have maintained community ties or struggle to gain a foothold. Rather than lowering costs or improving quality, competition seems to center on trying to get a larger share of scarce resources from the Medicaid program or public coffers.

- There are many free-standing hospitals in the city, with few systems and little consolidation, which limits their ability to leverage resources to compete with larger institutions. This is exacerbated by the insular neighborhoods and racial divides throughout the city.
- There seems to be competition between some of the safety net hospitals and Access over specialty services. Some safety net hospitals report concern that Access's expansion of in-house specialty care will reduce demand for some of the relatively well-reimbursed services and procedures the hospitals now provide. Other FQHCs feel that, due to its size, Access is better positioned to keep insured clients, leaving a higher proportion of the uninsured to be treated in clinics outside Access.
- Physicians do not seem to be competing with hospitals to provide ancillary services, as has been observed in some other markets (see "Competition and Collaboration: The Spirit of St. Louis (April 3–5, 2007)," Site Visit Report, July 16, 2007; available at www.nhpf.org/pdfs_sv/SV_StLouis07.pdf). This may be due to the large share of physicians in faculty practice plans in the city, which may limit their entrepreneurial leanings. It may also owe something to the high real estate and operating costs associated with developing ancillary services in the city neighborhoods with a high concentration of paying patients, as opposed to reaching similar populations in suburban areas.
- Because of the dominance of so many well-known teaching institutions, it is alleged that community hospitals have difficulty competing for the patients who could appropriately and cost-effectively be treated in their institutions. When generally held notions of the standard of care include marble foyers, high-tech equipment, and big-name clinicians, other hospitals are pushed to compete to provide amenities that may not be necessary for high-quality care.

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The Precarious State of the “Have Not” Provider

The large academic health centers in the city proper and several well-heeled hospitals in the city and surrounding affluent suburbs attract the vast bulk of privately insured patients. Although the large county health system, dominated by Stroger Hospital, takes all comers, many of the community hospitals struggle to make ends meet because they also provide care to a large share of Medicaid or uninsured patients. Many feel that the county hospital system is “imploding,” raising concerns that its patients will look to many of the already strapped “have nots” for care.

- Through some combination of location, mission, management, and politics, certain providers are hard-pressed to keep their heads above water. This is particularly difficult for institutions that are dependent on Medicaid, because the state has kept the basic Medicaid payments low. Some facilities continue to survive by covering operating expenses with funds intended for infrastructure maintenance, drawing on community resources, or lobbying the state for additional disproportionate share (DSH) funding.
- Illinois’s provider tax redistributes resources among hospitals on the basis of care provided to the poor, but the calculation of payments and their various add-ons as well as the timeliness of their remittance are vulnerable to political maneuvering. A safety net hospital executive observed that state funding via the provider tax and Medicaid seemed designed to allow hospitals like his to survive but never thrive.
- Many of the safety net hospitals are faced with aging physical plants, little if any access to capital, a payer mix heavy on Medicaid and self-pay patients, and shifting demographics requiring increased attention to cultural competence. In some cases, safety net hospitals are also trying to provide a full range of social services to fill what is otherwise a void in their surrounding communities. Mount Sinai, for example, has moved aggressively to provide needed community services, even while struggling to stay afloat. It may have devised a successful strategy of being perceived as indispensable, enabling it to avert crises through governmental financial interventions.
- Many hospitals in the less desirable neighborhoods have to pay physicians for on-call services, further weakening their financial positions.
- Chicago—admittedly like most other cities—has no history of regional planning for the distribution of health care resources. While the city’s commissioner of public health is encouraging providers to come together to address common challenges in various parts of the city, an absence of available funding means that any progress will be driven either by good will or by fear that the continuing fiscal crisis at Stroger will cause larger numbers of the uninsured and underinsured to seek care elsewhere.
- Access to capital—or the lack thereof—in part perpetuates the existence of the “haves” and “have nots.” A hospital such as Northwestern Memorial

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is able to draw on philanthropy as well as commercially available capital to build its endowment and invest in additional property. Access to philanthropy tends to contribute to the ability to obtain commercial capital, also perpetuating the division between the haves and the have nots.

■ Less fortunately situated institutions have difficulty maintaining their physical plants, let alone investing in the new technology and medical advances necessary to attract and keep good physicians and well-insured patients. Even if loans could be obtained, a paucity of insured patients probably prevents some hospitals from servicing them. Combined with the escalating standard, in terms of medical services as well as physical amenities, set by the wealthier institutions, inability to invest in technology and physical plants continues to widen the gap and reinforce the sense that some facilities are inferior.

Mission

A mission to provide health care to a community may be the only force keeping some institutions intact despite financially precarious situations. Missions may be particularly strong for facilities that have close cultural ties with or a long history of serving a particular neighborhood. Academic medical centers typically have a more complex mission comprising teaching, research, and patient care.

- Some of Chicago's safety net hospitals have suffered as the immigrant population responsible for establishing and supporting the institutions started to leave the city for the suburbs. In some cases, the hospital's mission encompasses a commitment to the neighborhood; in others, the facility is more closely aligned with the group responsible for its founding.
- Community outreach activities of some institutions demonstrate their commitment to their community. Such activities also strengthen the community's ties to the institution, helping to ensure its survival.
- As major teaching hospitals juggle the competing demands of their multiple missions, commitment to their local communities may take a back seat.
- The UCMC is trying to establish stronger ties with its community and local health care resources. In part, this is to allow UCMC to better fulfill its teaching and patient care missions. For example, to augment teaching opportunities, UCMC is making arrangements with community health care providers to place its residents in their offices and clinics.
- Given the disparate financial situations of Chicago providers, it is tempting to side with the little guy who serves the downtrodden. However, a strong business plan and the ability to execute it do not necessarily confer a black hat any more than financial jeopardy necessarily confers a white one.

Defining Community Benefit

Defining community benefit and an appropriate level to compensate for tax-exempt status is a hot topic in Illinois and Chicago. Illinois' Attorney General Lisa Madigan brought a successful suit against a tax-exempt hospital for failing to provide adequate community benefit to justify its status. In early 2006, she proposed that community benefit be defined as direct charity care and that all nonprofit hospitals be required to provide charity care equal to a certain share of revenues. The hospital community came together to fight the proposal, but not necessarily the concept of a specified level of community benefit. Claims that some hospitals are not fulfilling their obligations are thinly disguised in some instances and quite pointed in others. Supporters of Stroger Hospital commissioned a study of the value of the real estate tax exemption for Chicago hospitals, targeting especially Northwestern Memorial Hospital.

- Northwestern Memorial, in particular, has been zealous in documenting its benefit to the community, though some might question some of its claims. For example, the hospital classifies payments to the medical school for research as community benefit. Northwestern claims to be one of the largest providers of care to Medicaid recipients in the state. Given its large size and high costs, this is true as an absolute, but not necessarily relative to its ability.
- A coalition of safety net hospitals was formed to try to extract more support from the premier hospitals (primarily Northwestern) for efforts to take care of the poor. The community benefit issue has divided the Chicago hospitals, which historically have united to lobby for Medicaid funding.

Collaboration

Many of the collaborative efforts in Chicago appear to reflect political alliances or defensive positions. Initiatives at the UCMC, Stroger Hospital, and CommunityHealth met with mixed success.

- UCMC has begun a major initiative to collaborate with neighboring community health care providers. Its intent is to “trade” resources to mutual advantage. UCMC has an emergency department (ED) filled to capacity; many of the patients who are admitted through this portal do not need the resources of a major teaching facility. The UCMC’s partnering with neighboring hospitals is intended to encourage the less-intensive patients to go to a community hospital, which needs the patients, freeing UCMC space for more intensive cases. It is also partnering with FQHCs and other clinics to try to create a medical home for some of its patients that enter the hospital through the ED. This frees more ED space at UCMC and provides patients for clinics, which can financially benefit. UCMC also places medical residents with these other providers, bolstering their medical staffs and providing UCMC residents with primary care

IMPRESSIONS

experience. UCMC represents these efforts as “win-win” propositions; some other observers remain skeptical.

- Many of UCMC’s physicians have concerns about turning their patients over to providers whom they view as less qualified (and certainly less prestigious). Lack of trust and respect, evident on both sides, could take a long time to overcome.
- Because federal grant dollars from the National Institutes of Health support UCMC’s community outreach activity, much as Access benefits from enhanced Medicaid FQHC rates, it would appear that some of the more creative initiatives in Chicago have their roots in incentives from Washington rather than springing from local sources.
- The city, through the health department, is beginning efforts on the South Side of Chicago to get providers to work together to address population health problems. The city is not providing money to further these efforts, just the bully pulpit of its well-respected leader. However, the precarious situation of the Cook County health system, primarily Stroger Hospital, may make these efforts more compelling as providers try to shore up the safety net to prevent being inundated by uninsured patients if they cannot receive care at Stroger.
- Stroger Hospital had developed some useful programs in collaboration with FQHCs, but their continuation is threatened. One program, in which FQHCs could schedule specialty appointments for their patients at Stroger through the Internet, was discontinued with no notice.
- Through a donation program, CommunityHealth (a free clinic that relies on volunteer medical professionals) has established a pharmacy available to any uninsured, poor person in the area. It has enhanced access to this pharmacy for clients of some FQHCs through regular courier services.
- Palpable tensions with respect to wealth, class, ethnicity, and race remain an obstacle to widespread collaboration.

Transparency

Politics and personal relationships seem to color all interactions in the health care market in Chicago. The state’s method of funding safety net providers through add-ons calculated with complex, arcane formulas in effect establishes a reserve fund that the state can dole out as needed. Recently, the state has delayed payments to hospitals to help fund a coverage expansion for children. The lack of an explicit, transparent method for funding safety net providers with Medicaid dollars seems to strengthen political bonds and side deals. Some providers are better positioned to play this political game than others.

IMPRESSIONS

Sunday, March 16, 2008

Afternoon Arrive in Chicago and check-in at headquarters hotel –
The Drake Hotel [140 East Walton Place, 312/787-2200]

7:15 pm Cab to Dinner
(optional) – Gioco Restaurant
[1312 S. Wabash, 312/226-8388]

Monday, March 17, 2008

7:30 am Breakfast available [Venetian Room]

8:00 am STATE HEALTH REFORM, ILLINOIS-STYLE

David Carvalho, JD, Deputy Director, Illinois Department of
Public Health

In January 2007, the Adequate Healthcare Task Force, required by the Health Care Justice Act, recommended expanding health insurance coverage through a public-private model that includes an individual mandate, subsidized options for residents under 400 percent of the federal poverty level (FPL), and employer play or pay requirements. The proposal is consistent with Gov. Blagojevich's goal of state health reform to insure all state residents. To date, however, the only expansion has been the All Kids program, which covers children up to 200 percent of FPL. The Illinois Health Care for All Act, which incorporated many of the recommendations of the task force, was not passed by the General Assembly in 2007.

- What is Gov. Blagojevich's vision for health reform in the state? What financing mechanisms has he proposed? What dynamics will affect whether his entire proposal gets adopted?
- How was coverage expanded to include all children?
- Why has the Illinois Medicaid program kept its base hospital payments low and supplemented them with add-ons? How are the payment add-ons determined?

Agenda / continued ►

AGENDA

Monday, March 17, 2008 / continued

9:00 am

THE COMPETITIVE MARKETPLACE: AN ECONOMIC PERSPECTIVE

David Dranove, PhD, *Walter McNerney Distinguished Professor of Health Industry Management, Kellogg Graduate School of Management, Northwestern University*

The Chicago health care market, like all markets, includes some unique features that have influenced relationships among institutions, have helped determine the winners and losers, and have affected which health care stakeholders collaborate and which compete. The area boasts six medical schools and the city proper has 38 acute care hospitals. Many of these institutions have had to adapt to significant changes in their communities, with urban flight and more recent gentrification. Many of the city's physicians are affiliated with one of the medical schools, practicing in the faculty practice plan. There does not appear to be much in the way of single specialty practices organized to provide ancillary services, although this may be more the pattern in the suburbs. Health insurance is dominated by Blue Cross and Blue Shield of Illinois, which has a 60 percent market share. United Healthcare has recently tried to increase its presence, but commands only about 15 percent of the market.

- How do hospitals distinguish themselves in the Chicago market? On what basis—and to what extent—do they compete directly? What is their bargaining position with the insurers?
- How are physician practices organized in the city? What is their bargaining position vis-à-vis the insurers? The hospitals? How have physicians shaped the Chicago market?
- How have insurers affected the delivery of health care in the Chicago market? How have they responded to the payers? What is the effect of having a single, dominant insurer? To what extent has managed care been a factor?
- How has Illinois's Certificate of Need program affected the provider landscape in the city?

Agenda / continued ►

AGENDA

Monday, March 17, 2008 / continued

AGENDA

10:00 am THE MARKETPLACE: A PERSPECTIVE ON THE GROUND

Kathleen DeVine, *Former Chief Executive Officer, St. Anthony Hospital*

St. Anthony Hospital, with about 150 beds in the central western part of the city, is one of several small hospitals that play a vital role in the safety net while struggling to remain financially viable. In 2003, 57 percent of its patients were on Medicaid, 21 percent on Medicare, with the rest self-pay or charity care. Like many similarly situated hospitals, St. Anthony's is dependent on revenues from the provider tax program and subsidies through Medicaid.

- What does the market look like from a small-hospital vantage point, given the prevalence of academic medical centers, the Cook County public health care system, the mix of payers, and Chicago's many ethnic neighborhoods?
- How is the Cook County public health care system financed? How does the state support private safety net hospitals? What is the relationship between the private safety net hospitals and the Cook County hospitals?
- How are the safety net hospitals trying to ensure their own survival through joint programs with other providers? Which ventures appear successful? Which have failed? What factors enable or prevent their success?

11:00 am Walk to Northwestern Memorial Hospital [251 E. Huron Street]

11:30 am Tour and Lunch

12:15 pm FROM THE GOLD COAST: LOCATION, LOCATION, LOCATION?

Peter McCanna, *Executive Vice President for Administration and Chief Financial Officer, Northwestern Memorial Hospital*

Northwestern Memorial is a renowned academic medical center in downtown Chicago. It has recently rebuilt its women's hospital, its medical-surgical hospital has a 10-year old plant, it has just received approval to relocate its children's facility, and it has plans for the closed VA hospital that it recently acquired. Viewed by many as the deep pockets for supporting the floundering safety net, Northwestern has invested considerably in its community services and reporting on the benefits it provides to the community.

- How does Northwestern Memorial maintain its favorable financial position? What is the hospital's case and payer mix? How did Northwestern Memorial amass its considerable endowment?

Agenda / continued ►

Monday, March 17, 2008 / continued

- 12:15 pm FROM THE GOLD COAST...continued
- How does the hospital define its community? What are its obligations to the community? How does it assess whether it is meeting the community's needs?
 - How does Northwestern Memorial intend to position itself in the next decade?
 - What characterizes the relationship between the hospital and its physicians? How does this affect Northwestern's position in the community? How does the hospital-physician relationship affect its plans for the future?

1:30 pm Bus Departure – Blue Cross and Blue Shield of Illinois
[300 S. Randolph Street]

2:00 pm THE CHICAGO BLUES

Paul Boulis, *President, Blue Cross and Blue Shield of Illinois*

Kevin O'Neill, *Divisional Senior Vice President, Health Care Management*

Kim Reed, MD, JD, *Senior Medical Director*

Carol Wilhoit, MD, *Quality Improvement Medical Director*

Richard Allegretti, *Vice President, Local Market Sales*

Blue Cross and Blue Shield (BCBS) of Illinois is the dominant insurer in the area, with about 60 percent of the commercial market share. A sizeable share of its enrollees remain in health maintenance organization (HMO) products. The insurer has developed innovative provider reporting requirements, which it is using to improve the quality of care.

- What is BCBS of Illinois able to achieve for its clients by virtue of market share? What do they expect in return? How does the degree of market dominance affect BCBS's relationships with providers and physicians?
- How has BCBS maintained a strong HMO product when managed care is so dramatically in retreat in most markets? How tightly managed is the HMO?
- What has been the strategy with respect to cost containment? What will be the next breakthrough in terms of cost containment?
- What has been the impact of BCBS's quality initiatives on local medical practice? How have providers and physicians responded?
- What has been the strategy with respect to Medicare products?

Agenda / continued ►

AGENDA

Monday, March 17, 2008 / continued

3:30 pm Bus Departure – Mount Sinai Hospital
[15th Street and California Avenue]

4:30 pm MOUNT SINAI HOSPITAL

Alan H. Channing, *President and Chief Executive Officer*, Sinai Health System

Steven Whitman, PhD, *Director*, Sinai Urban Health Institute

Cynthia Williams, *Director*, Department of Family Education, Sinai Health System

Mount Sinai Hospital is widely viewed as an essential safety net provider and a critical source of specialty services, taking referrals from smaller facilities and clinics around the city. It has over 400 beds and a payer mix dominated by public programs and self-pay. It incorporates teaching and research programs and a level 1 trauma center. Mount Sinai has also developed some innovative programs to address the needs of its disadvantaged community. It was an instrumental force in building Chicago’s network of community health centers.

- What is Mount Sinai’s financial situation? What is the hospital’s case and payer mix? What is Mount Sinai’s experience with recruiting and retaining clinical staff?
- What is the hospital’s long-range plan with respect to programs, services, and capital?
- How does Mount Sinai define the community that it serves? How does the hospital assess whether it is meeting its community’s needs? What kinds of community outreach programs have been put in place? What is the story of Mount Sinai’s involvement with Chicago’s federally qualified health centers?
- What is the responsibility of financially secure hospitals to vulnerable populations and to safety net providers? What is the responsibility of neighborhood and community leaders?

5:30 pm Bus Departure – Headquarters hotel

7:20 pm Walk to Dinner – Le Colonial [937 N. Rush Street, 312/255-1221]

Tuesday, March 18, 2008

6:30 am Breakfast available [Venetian Room]

7:30 am Bus Departure – Holy Cross Hospital [2701 W. 68th Street]

Agenda / continued ►

AGENDA

Tuesday, March 18, 2008 / continued

AGENDA

8:00 am

HOLY CROSS HOSPITAL

Wayne M. Lerner, DPH, *Chief Executive Officer*

Dennis Ryan, *Vice President, Community and External Affairs*

Anna Carvalho, *Director, Strategic Planning and Systems Review*

John Kahler, MD, *Chair, Ambulatory Services*

Kathy Kalall, MD, *Medical Director*

With Community Leaders

Holy Cross Hospital serves a disadvantaged community in an area with few other provider options. It handles more emergency department (ED) ambulance runs than the much larger Stroger (Cook County) Hospital and University of Chicago Medical Center, with roughly 50 percent of its admissions coming through the ED. It has few resources available to upgrade its aging physical plant and, with approximately 2 percent of its patient days financed through commercial insurance, building reserves does not seem in the cards. Holy Cross is working with its community and other providers to develop a situation that will foster not only its survival, but enough stability for it to flourish.

- What is Holy Cross’s financial situation? What is the hospital’s case and payer mix? What is Holy Cross’s experience with recruiting and retaining clinical staff?
- How does the hospital define the community that it serves? How does it assess whether it is meeting community needs? What kinds of community outreach programs have been put in place?
- What kinds of quality measurement and improvement strategies are appropriate and viable in a community hospital that is so dependent on public programs?

9:30 am

Bus Departure – Access Community Health Network/
Booker Clinic [654 E. 47th Street]

10:00 am

Tour and Introductions

HEALTH CARE ON THE SOUTH SIDE

Donna J. Thompson, *Chief Executive Officer, Access Community Health Network*

Agenda / continued ►

Tuesday, March 18, 2008 / continued

AGENDA

10:15 am

UNIVERSITY OF CHICAGO MEDICAL CENTER: ENLIGHTENED SELF-INTEREST

Eric E. Whitaker, MD, *Executive Vice President for Strategic Affiliations and Associate Dean for Community-Based Research, University of Chicago Medical Center*

The University of Chicago Medical Center (UCMC) is at the forefront of collaborative “win-win” efforts between providers. UCMC is equipped to handle complex cases—patients who need the tertiary services provided in this world-class institution. Yet, many of its beds are filled with patients from its community who need less sophisticated medical care. To help fulfill its role as a teaching and research institution, UCMC is searching for opportunities to partner with smaller hospitals or clinics to divert less intensive patients to more appropriate settings. These partnerships could financially benefit UCMC and community providers, as well as improve the quality and continuity of care for all of the patients involved.

- What is UCMC’s strategy for partnering with other providers to meet its financial needs and mission? What joint programs has UCMC undertaken with community and safety net hospitals? With community health centers?
- What is UCMC’s obligation to its community? How does it ensure that these collaborative efforts are meeting the needs of its community?
- Are these truly win-win programs?
- How have UCMC’s physicians responded to these collaborative efforts? How are they involved?
- What lessons have been learned about creating more stable financial circumstances for safety net institutions while meeting the needs of a disadvantaged community?

11:00 am

COMMUNITY CLINICS: BUILDING ACCESS

Judith Haasis, *Executive Director, CommunityHealth*

CommunityHealth, a free clinic that serves the uninsured poor, uses providers and donations to staff and finance service delivery. The clinic has recently opened a licensed pharmacy, stocked with donated medications, that provides free medications to its patients and patients at other clinics who are poor and uninsured.

- What patient population is served by CommunityHealth? Why is the clinic considering opening a satellite on the South Side of Chicago? How would the clientele differ between its two sites?

Agenda / continued ►

Tuesday, March 18, 2008 / continued

- 11:00 am COMMUNITY CLINICS...continued
- How does a free clinic orchestrate providers and resources to develop a stable site for delivering care to vulnerable populations?
 - How can the federally qualified health clinic and free clinic models collaborate with other providers to ensure a safety net with no holes?
- Donna J. Thompson**, *Chief Executive Officer, Access Community Health Network*
- Access Community Health Network, one of the largest systems of federally qualified health centers in the country, has developed innovative programs with other providers to ensure a medical home for disadvantaged patients, promote medical education in community settings, and develop referral sources for specialty care. Its large size has been instrumental in furthering these efforts.*
- What patient population is served by Access Community Health Network? How are decisions made about where to locate clinics? How does the clientele differ across sites? How do these differences affect each clinic’s programs and offerings?
 - How has Access Community Health Network become such a large system? What are the advantages of its size? Are there any drawbacks?
 - How does Access Community Health Network attract and retain providers? Are some types of professionals more difficult to recruit and retain than others?
 - How does Access Community Health Network work with other providers in the area? Why did the University of Chicago donate space and services to expand the Grand Boulevard Health Center site? What does UCMC get from this arrangement?

12:15 pm Bus Departure – Headquarters hotel

12:45 pm Check-out and Lunch [Venetian Room]

Agenda / continued ►

AGENDA

Tuesday, March 18, 2008 / continued

1:30 pm WRAP-UP: WHAT BENEFITS THE COMMUNITY?

Joy Getzenberg, *Assistant Commissioner for Policy and Planning*,
Chicago Department of Public Health

The Chicago Department of Public Health provides health care services to the patients in the city who no one else serves—primarily those without any form of coverage and the mentally ill. The Department is developing a new initiative to pull together providers that serve the same community to understand their common concerns and needs with the objective of shoring up the safety net.

- What efforts is the city making to bring providers in different parts of the city into more effective working relationships in order to serve their communities better?
 - What responsibility do providers have to meet the needs of the community?
 - What health care decisions can and should be determined at a local level, and what concerns are more appropriately addressed by state and federal policymakers?
-

2:25 Adjournment

2:40 pm Bus Departure – O’Hare Airport

AGENDA

Federal Participants

Jody Blatt

Senior Research Analyst
Medicare Demonstration
Programs Group
Office of Research, Development
and Information
Centers for Medicare & Medicaid
Services
U.S. Department of Health and
Human Services

Charles L. Brown, Jr.

Legislative Assistant
Office of Rep. Danny K. Davis (D-IL)
U.S. House of Representatives

Robert Canterman

Attorney
Health Care Services and
Products Division
Bureau of Competition
Federal Trade Commission

Carol Carter, PhD

Staff Consultant
Medicare Payment Advisory
Commission

Nancy DeLew

Senior Advisor
Office of Research, Development
and Information
Centers for Medicare & Medicaid
Services
U.S. Department of Health and
Human Services

John Dicken

Director, Health Care
Medicaid and Private Health Insurance
Programs
U.S. Government Accountability Office

Jack Dusik

Senior Legislative Assistant
Office of Rep. Jerry Weller (R-IL)
U.S. House of Representatives

James Hahn, PhD

Health Economist
Domestic Social Policy Division
Congressional Research Service

Chris Peterson

Specialist in Social Legislation
Domestic Social Policy Division
Congressional Research Service

William J. Scanlon, PhD

Commissioner
Medicare Payment Advisory
Commission

Adelle Simmons

Senior Program Analyst
Office of Health Policy
Office of the Assistant Secretary for
Planning and Evaluation
U.S. Department of Health and
Human Services

A. Bruce Steinwald

Director, Health Care
U.S. Government Accountability Office

Jeffrey Stensland, PhD

Senior Analyst
Medicare Payment Advisory
Commission

Joan Stieber

Medicare Policy Analyst
Office of Legislation
Centers for Medicare & Medicaid
Services
U.S. Department of Health and
Human Services

Lisa Yen

Legislative Analyst
Office of Legislation
Centers for Medicare & Medicaid
Services
U.S. Department of Health and
Human Services

Biographical Sketches

Federal Participants

Jody Blatt is a senior research analyst and project officer in the Division of Payment Policy Demonstrations within the Medicare Demonstration Programs Group/Office of Research, Development and Information at the Centers for Medicare & Medicaid Services (CMS). She is responsible for implementing the Medicare Care Management Performance Demonstration as well as the Medicare Replacement Drug Demonstration, both of which were mandated under the Medicare Modernization Act of 2003. Before joining CMS, she served in various capacities with managed health care plans and health insurers. Ms. Blatt has an undergraduate degree from Brown University and a master's degree in health policy and management from the Harvard University School of Public Health.

Charles L. Brown, Jr., is a legislative assistant for the Office of Rep. Danny K. Davis (D-IL) handling health care, foreign affairs, labor, science and technology, Social Security, taxes, and telecommunications issue areas. While pursuing a master of social work degree at Howard University, he came to Rep. Davis's office on a fellowship. Earlier, he worked for ten years for General Motors in roles ranging from assembly manufacturing to management.

Robert Canterman is an attorney in the Health Care Services and Products Division of the Federal Trade Commission's Bureau of Competition. He leads investigations and conducts litigation involving alleged antitrust violations in the health care field, including matters involving physicians and other health care professionals, and pharmaceutical companies and other health care entities. Before starting at the Commission in 2001, he was a counsel in the law firm of Crowell & Moring, where his practice focused on antitrust counseling and litigation, health care fraud and abuse, and health care regulatory matters. Both at the Commission and in private practice, he also has worked on issues relating to the confidentiality of health care information. He received a JD degree, cum laude, from American University, and a BA degree, magna cum laude, from Dickinson College.

Carol Carter, PhD, has been with the Medicare Payment Advisory Commission for almost four years. Previously, she worked at the U.S. Government Accountability Office on Medicare payment issues regarding physician and post-acute services. Before that, she worked at the University of Chicago Hospitals for five years as the director of clinical resource analysis at hospitals, where she also managed the hospital's cost accounting system. Ms. Carter has held a variety of other positions at the University of California-San Francisco Medical Center, Health Economics Research, the Prospective Payment Assessment Commission, the Massachusetts Rate Setting Commission, and Blue Cross of Massachusetts. She has a PhD degree from the Department of Urban Studies and Planning at the Massachusetts Institute of Technology.

Nancy DeLew is a senior advisor to the director of the Office of Research, Development and Information in the Centers for Medicare & Medicaid Services (CMS). She assists the director in carrying out special projects, currently implementation activities surrounding the Medicare Modernization Act of 2003. Formerly, Ms. DeLew was the deputy director of CMS's Office of Legislation. In this position, she worked with the Congress to develop the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997. Earlier, Ms. DeLew held several other positions in the Department of Health and Human Services. She joined the department in 1985 after receiving master's degrees in political science and public administration from the University of Illinois at Urbana.

John Dicken is a director for health care issues at the U.S. Government Accountability Office (GAO) where he directs GAO's evaluations of private health insurance, long-term care quality and financing, and prescription drug pricing issues. He previously held analyst and assistant director positions with GAO's health care team. Prior to working at GAO, Mr. Dicken was a senior analyst for the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry and a legislative fellow with the majority health staff of the Senate Committee on Labor and Human Resources. He is a graduate of Carleton College and he has an MPA degree from Columbia University.

Jack Dusik serves in the Office of Rep. Jerry Weller (R-IL) as senior legislative assistant. He successfully managed Rep. Weller's 2006 re-election campaign. Mr. Dusik has been recognized for his outstanding work with community health centers, receiving the National Association of Community Health Centers Distinguished Congressional Staff Award in 2005 and 2006. Prior to his service with Rep. Weller, Mr. Dusik served on the professional staff of the Committee on Ways and Means of the U.S. House of Representatives under the chairmanship of Rep. Bill Thomas (R-CA). He is a graduate of DePaul University in Chicago, where he received a degree in political science.

James Hahn, PhD, is 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 the General Accounting Office (now known as the U.S. Government Accountability Office) 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.

Chris Peterson is a specialist in health care financing at the Congressional Research Service (CRS). He is CRS's expert to Congress on federal State Children's Health Insurance Program (SCHIP) financing and on estimates of the uninsured. He has authored numerous congressional reports on a range of health policy topics and works closely with congressional staff to provide analytical, quantitative

BIOGRAPHICAL SKETCHES

Participants

input on legislative proposals. Prior to CRS, Mr. Peterson held various positions at the Agency for Healthcare Research and Quality (AHRQ), from health services research to handling planning and evaluation for the director. Earlier, he worked for the National Bipartisan Commission on the Future of Medicare. Mr. Peterson has a master's degree in public policy from Georgetown and a bachelor's degree in mathematics from Missouri Western State University.

William J. Scanlon, PhD, is a health policy consultant and a commissioner of the Medicare Payment Advisory Commission. Until April 2004, he was managing director of health care issues at the U.S. General Accounting Office (GAO, now known as the U.S. Government Accountability Office). 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. Before joining GAO in 1993, he was co-director of the Center for Health Policy Studies and an associate professor in the Department of Family Medicine at Georgetown University. Dr. Scanlon has also been a principal research associate in health policy at The Urban Institute. His research at Georgetown and The Urban Institute focused on the Medicare and Medicaid programs, especially provider payment policies and the provision and financing of long-term care services. He has been engaged in health services research since 1975. 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 at Madison.

Adelle Simmons is a senior program analyst in the Office of Health Policy at the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (HHS/ASPE), where her work focuses on policy and financing issues related to health programs for vulnerable populations; HIV/AIDS prevention, care, and treatment; health care quality and disparities; and international health initiatives. Her previous work at HHS includes ASPE's congressionally mandated evaluation of the State Children's Health Insurance Program (SCHIP), financial management at the National Institutes of Health/Vaccine Research Center, and working as the special assistant to the Deputy Assistant Secretary for Disability, Aging, and Long-Term Care Policy at ASPE. Before coming to HHS in 2000, she was a senior analyst at the New York City Office of Management and Budget. She received her bachelor's degree in psychology from Harvard University and her master's degree in public administration from New York University.

A. Bruce Steinwald is director for economic and payment issues in the Health Care group at the U.S. Government Accountability Office (GAO). He supervises the preparation of health policy analyses, testimony, and reports to Congress on Medicare payment issues and on other issues requiring the application of economic principles. Before joining GAO in June 2002, Mr. Steinwald was an independent consultant specializing in health economics analysis for health care delivery and financing organizations. Previously, he was a senior fellow at the National Health Policy Forum and vice president of Covance Health Economics and Outcome Services, Inc. In the 1980s, Mr. Steinwald worked in the Office of the Secretary in the U.S. Department of Health and Human Services, and he was the deputy director of ProPAC (the Prospective Payment Assessment Commission, now known as the

BIOGRAPHICAL SKETCHES

Participants

Medicare Payment Advisory Commission, or MedPAC). He received his BA degree from Johns Hopkins University and his MBA degree in health administration from the University of Chicago.

Jeffrey Stensland, PhD, is a senior analyst with the Medicare Payment Advisory Commission (MedPAC). His areas of research include hospitals, rural health, and physician-hospital integration. Prior to joining MedPAC, Dr. Stensland was a senior research director with the Project HOPE Center for Health Affairs. He has extensive experience conducting research on the financial performance of hospitals and rural health issues. His findings have been published in *Health Affairs*, *Health Care Financing Review*, *Medical Care*, and *The Journal of Rural Health*. In addition to his research experience, Dr. Stensland worked in the banking industry as a financial analyst and holds the Chartered Financial Analyst certification. He has a PhD degree from the University of Minnesota, Department of Applied Economics with a minor in health services research and policy.

Joan Stieber is a Medicare policy analyst in the Office of Legislation, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, in Washington, DC. She monitors and analyzes legislation and policy initiatives and provides technical assistance to congressional staff on a range of Medicare benefits. From 2004 to 2005, Ms. Stieber spent eight months in Australia on a health policy fellowship sponsored by the Australian Government Department of Health and Ageing and the Commonwealth Fund. Her fellowship research focused on approaches to preventive health care in Australia, efforts to apply evidence-based decision making processes to prevention, and comparisons to U.S. Medicare. Ms. Stieber attended three large state universities and has graduate degrees in law and social work.

Lisa Yen has been working as a health policy analyst in the Office of Legislation, Centers for Medicare & Medicaid Services since 2004. She monitors and analyzes legislation and policy initiatives and provides technical assistance to congressional staff on a range of Medicare benefits. Ms. Yen was selected for the U.S. Department of Health and Human Services' Emerging Leaders Program in 2003. Her previous work experiences include welfare-to-work case managing, work in a community mental health clinic servicing Asians and Pacific Islanders, and the California Census 2000 project. She completed her undergraduate degree in psychology and sociology at the University of California, San Diego, did graduate studies in social work at Simmons College in Boston, and finished her master's degree in social work at the California State University, Long Beach.

BIOGRAPHICAL SKETCHES

Participants

Biographical Sketches

Speakers

Richard Allegretti is corporate vice president for local market sales. He is responsible for the Illinois Local Markets Group and Individual Sales, including specialty markets in Hospitals and National HMO Sales. Mr. Allegretti joined Blue Cross and Blue Shield of Illinois in 1976 as a claims examiner. He held staff and supervisory positions in Claims & Customer Service for eight years. For more than 22 years, he has held several positions in the Sales and Marketing Division, including sales representative and regional manager in Chicago. He became corporate vice president for Sales in January 1996. Mr. Allegretti holds a BA degree in accounting and an MBA degree in marketing/management from DePaul University.

Paul Boulis is president of Blue Cross and Blue Shield of Illinois, which serves more than seven million members. He joined Blue Cross and Blue Shield of Illinois in 1984 following ten years with the Blue Cross and Blue Shield Association in various positions including management of Medicare Part A, director of utilization review, and executive director of marketing services. Prior to being named president of the Illinois plan, he served as a vice president and senior vice president of Blue Cross and Blue Shield of Illinois' National Division for 17 years. Mr. Boulis has served as chairman of the board of the Arts and Business Council of Chicago for the past four years; he is also a member of the boards of directors of Consortium Health Plans, Dental Network of America, and Health Insurance Services Corporation. Mr. Boulis earned a BA degree from the University of Pittsburgh and a master of hospital administration degree from the University of Michigan.

Anna Carvalho is director, strategic planning for Holy Cross Hospital. She served for eight years as executive director of Healing Racism/Chicago Southland following six years in administration at Rush-Presbyterian-St. Luke's Medical Center, where she rose to administrative director, Geriatric Hospital. Ms. Carvalho has served as assistant professor of the graduate program in health systems management at Rush University. She has taken a leadership role on numerous university and community development boards.

David Carvalho, JD, is deputy director of the Illinois Department of Public Health responsible for the Office of Policy, Planning and Statistics. The Office comprises the Divisions of Epidemiological Studies, Health Policy, Health Statistics, Health Systems Development (Certificate of Need), Patient Safety & Quality, and Rural Health. The Office was responsible for supporting the activities under the Illinois Health Care Justice Act of the Adequate Health Care Task Force, which was charged with developing a health care plan to provide access for all Illinois residents to a full range of preventive, acute, and long-term health care services. The Office also supported the development of the state's first State Health Improvement Plan. Mr. Carvalho previously served as the legal and policy advisor to the Cook County Bureau of

Health Services and legal counsel to the Cook County Board President. Mr. Carvalho serves on the boards of directors of the Institute of Medicine of Chicago, where he is president-elect, and the Suburban Primary Health Care Council and is an adjunct professor at Loyola University Chicago School of Law. Mr. Carvalho received his law and bachelor's degrees from Harvard University.

Alan H. Channing is president and chief executive officer of the Sinai Health System in Chicago, Illinois, which is made up of Mount Sinai Hospital, the Schwab Rehabilitation Institute, the Sinai Medical Group, the Sinai Urban Health Institute, and the Sinai Community Institute. He has been the chief executive officer of several large teaching hospitals, including Wishard Memorial in Indianapolis; Elmhurst Hospital Center in Queens, New York; and the renowned Bellevue Hospital Center in Manhattan. He was recruited to lead St. Vincent Charity Hospital and Saint Luke's Medical Center through a merger, a combination of medical staffs, and a dramatic financial turnaround in the urban core of Cleveland. He positioned St. Vincent to be the key health care provider for the revitalized downtown. Mr. Channing attended undergraduate school at the University of Cincinnati and graduate school at The Ohio State University, where he retains an assistant professorship in health care management.

Kathleen DeVine's health care career has spanned 30 years in diverse organizations and communities. She most recently served as chief executive officer of Catholic Health Partners/Saint Anthony Hospital, a Catholic inner city hospital serving the southwest side of Chicago. During her 23 years in Chicago, she has held positions at Northwestern Memorial Hospital's Prentice Women's Hospital, Children's Memorial Hospital, and Columbus Hospital. Prior to coming to Chicago, she spent four years at Group Health Cooperative in Seattle. Her health care career began in Detroit with the Sisters of Mercy Health Care Corporation (now Trinity). Ms. DeVine has a master's degree in public health from Yale University and has completed graduate coursework at Aquinas Institute in Saint Louis in leadership formation. She has served on the boards of numerous community organizations and the Illinois Hospital Association. In 2005, she was awarded the Jonas Salk Health Leadership Award by the March of Dimes for her work in health care for women and children.

David Dranove, PhD, is the Walter McNerney Distinguished Professor of Health Industry Management at Northwestern University's Kellogg Graduate School of Management, where he is also professor of management and strategy and director of the Center for Health Industry Market Economics. He has a PhD degree in economics from Stanford University. Professor Dranove's research focuses on problems in industrial organization and business strategy with an emphasis on the health care industry. He has published nearly 75 research articles and book chapters and has written five books. His textbook, *The Economics of Strategy*, is used by leading business schools around the world. His newest book, *Code Red*, will be published by Princeton University Press early in 2008.

Joy Getzenberg has been with the Chicago Department of Public Health (CDPH) for more than 20 years and currently serves as assistant commissioner for policy and planning. Ms. Getzenberg is responsible for developing policy in the areas of chronic disease, health care reimbursement, oral health, mental health, and other

BIOGRAPHICAL SKETCHES

Speakers

areas of interest to CDPH. Planning responsibilities include overseeing the Chicago Health and Health Systems Project, which monitors the health care system at a community and regional level through system-wide data collection and analysis and overall environmental scanning; and special projects, such as mental health service delivery system assessments, and strategic plans for specific programmatic areas within CDPH. Prior to her tenure at CDPH, Ms. Getzenberg worked at a major teaching hospital, and before that, at a federally funded community health center, doing community-based planning and primary care and health promotion program development. She received her master's degree from the University of Chicago School of Social Service Administration.

Judith Haasis is the executive director of CommunityHealth and serves on the board of directors of the National Association of Free Clinics. CommunityHealth is the largest free clinic in Illinois and one of the largest free clinics in the country, with more than 30,000 uninsured, low-income individuals, and families being served since its founding in 1993. Ms. Haasis has more than 15 years of senior management experience in the nonprofit sector, where she has spearheaded the growth of organizations involved in direct services, advocacy, leadership development, and philanthropy at both the community and national levels. She has been the recipient of numerous honors, including leadership awards from Planned Parenthood, the National Organization for Women, and the League of Women Voters.

John Kahler, MD, FAAP, is director of ambulatory services at Holy Cross Hospital. Through 2007, he served as medical director of ambulatory pediatric services with Fantus Clinic's Ambulatory and Community Health Network, part of the Cook County Bureau of Health Services. Dr. Kahler was an attending physician at Cook County Hospital (now John Stroger Hospital) for 34 years, serving as director of the pediatric emergency room and director of the child abuse team. In addition to his work at Cook County Hospital, Dr. Kahler maintained a busy pediatric practice.

Catherine Kallal, MD, FACP, is Holy Cross Hospital's chief medical officer. She came to Holy Cross from a position as medical director of general medicine, Fantus Health Center, Cook County Bureau of Health Services. Earlier, Dr. Kallal was program director, residency in internal medicine from. She has also served as medical director at Woodlawn Health Center and co-director, residency in primary care internal medicine at Cook County Hospital. Dr. Kallal has served in teaching appointments at Rush Medical College, University of Illinois College of Medicine at Chicago and the University of Arizona School of Medicine.

Wayne M. Lerner, DPH, FACHE, is chief executive officer of Holy Cross Hospital. He served as president and chief executive officer of the Rehabilitation Institute of Chicago from 1997-2006. Earlier, he was president of The Jewish Hospital of St. Louis, where he was one of the key executives in the formation of BJC as well as the merger of Jewish Hospital of St. Louis with Barnes Hospital. Dr. Lerner served for 17 years with Rush-Presbyterian-St. Luke's Medical Center in Chicago, where he rose to the position of vice president for administrative affairs and associate professor and chairman of the Department of Health Systems Management. Dr. Lerner chaired the Adequate Health Care Taskforce, a bipartisan healthcare reform commission for the state of Illinois, and is past chairman of the board of the Illinois Hospital Association.

BIOGRAPHICAL SKETCHES

Speakers

Peter McCanna is executive vice president for administration and chief financial officer (CFO) of Northwestern Memorial HealthCare, and its principal subsidiary, Northwestern Memorial Hospital. He joined Northwestern Memorial in August 2002 as senior vice president, CFO, and treasurer. Previously he had been the senior vice president and CFO at Presbyterian Healthcare Services in Albuquerque, New Mexico. Prior to that, he was senior vice president and CFO of the University of Colorado Hospital. Mr. McCanna is a member of the Healthcare Financial Management Association's National Advisory Council, and the Health Management Academy. He received his bachelor of arts degree with honors from The University of Michigan, and he earned his master's degree from the University of Texas at Austin.

Kevin O'Neill is Blue Cross and Blue Shield of Illinois' divisional senior vice president of health care management, charged with overseeing programs designed to enhance the quality of care for Blue Cross members; leading transparency initiatives that provide health care consumers with cost and quality information to help them make informed medical decisions; and building wellness and disease management programs to help Blue Cross members play a greater role in managing their health. In addition, Mr. O'Neill and his staff oversee relationships with Blue Cross and Blue Shield of Illinois' network of physicians, hospitals, and other health care providers throughout the state. Mr. O'Neill has more than 20 years' experience in the health insurance industry, including health care management and sales and marketing. Mr. O'Neill came to Blue Cross and Blue Shield of Illinois from CareFirst Blue Cross and Blue Shield in Maryland, for which he served as vice president of the company's Program Management Office. Previously, he served as president of the Patuxent Medical Group, a division of CareFirst, and vice president of the company's Medical Affairs and Network Management Division. Mr. O'Neill also held management positions at Blue Cross and Blue Shield of Maryland, UnitedHealthcare of the Mid-Atlantic, Chesapeake Health Plan, Healthwise of America, and Kaiser Permanente.

Kim Reed, MD, JD, serves as senior medical director for Blue Cross Blue Shield of Illinois. He joined the company in 1997, having earlier held management positions with LaGrange Memorial Hospital and Mercy Center for Health Care Services in Aurora, Illinois. Dr. Reed received his undergraduate degree in medical science from the University of Wisconsin, Madison. He received his medical degree in 1979 from the Medical College of Wisconsin, where he later served an internship in internal medicine and a residency in emergency medicine. In addition, Dr. Reed holds a law degree from St. Mary's University and a MBA degree from Benedictine University. He is board certified in emergency medicine and is licensed as an attorney in Illinois and Wisconsin.

Dennis Ryan is vice president, community and external affairs with Holy Cross Hospital. He previously served as director of strategic affiliations at ACCESS Community Health Network, following an earlier period as executive director of community and government affairs at Holy Cross. Earlier in his career, Mr. Ryan spent 15 years in management and administration for the MacNeal Health Network, where he rose to division director. He holds leadership positions on several city of Chicago and community advocacy, agency and advisory boards.

Donna J. Thompson joined Access Community Health Network (ACCESS) in 1995 as the chief operating officer and was named chief executive officer in November 2004.

BIOGRAPHICAL SKETCHES

Speakers

Prior to joining ACCESS, she spent 14 years as a staff nurse and manager as well as served as the director of pediatrics at Christ Hospital and Medical Center. Under Ms. Thompson's leadership, ACCESS has grown from 43 to 50 health centers and now has an annual operating budget of \$106 million. In 2002, she organized Stand Against Cancer, which resulted in increased breast and cervical cancer funding. She was selected by the Robert Wood Johnson Foundation as an executive nurse fellow in 2003. Ms. Thompson is also co-chair of the Metropolitan Chicago Breast Cancer Task Force. She serves on the boards of St. Francis Hospital and Medical Center in Blue Island, the Illinois Chamber of Commerce, and the Chicago Foundation of Women. In 2007, she won the Athena Award for professional excellence and was selected as one of Chicago United's Business Leaders of Color.

Steven Whitman, PhD, is director of the Sinai Urban Health Institute.

Eric E. Whitaker, MD, holds the titles of executive vice president, strategic affiliations and associate dean of community-based research at the University of Chicago Medical Center (UCMC). His major objective is to lead the UCMC's Urban Health Initiative, which aims to export to the community the medical center's mission of patient care, teaching, and research for the purpose of improving the health of South Side residents. Until October 2007, he served as director of the Illinois Department of Public Health (IDPH). In this capacity, Dr. Whitaker oversaw an agency with a budget of \$450 million comprised of over 1,200 employees in the Chicago and Springfield headquarters, three laboratories, and seven regional offices and he shared responsibility for improving the health of the 12.4 million residents of Illinois. Prior to his appointment, Dr. Whitaker was an attending physician in internal medicine at Cook County Hospital. He helped found Project Brotherhood: A Black Men's Clinic, a weekly clinic for African American men housed in Woodlawn Adult Health Center, which is affiliated with the Cook County Bureau of Health Services. In 2000, the project received the highest award accorded by the National Association of Public Hospital and Health Systems. Dr. Whitaker received his undergraduate degree in chemistry from Grinnell College, a master's degree in public health from the Harvard School of Public Health, and a medical degree from the University of Chicago Pritzker School of Medicine.

Carol Wilhoit, MD, is the quality improvement medical director for Blue Cross and Blue Shield (BCBS) of Illinois. She has responsibility for clinical quality improvement for BCBS of Illinois members. Her activities include HEDIS (Healthcare Effectiveness Data and Information Set) reporting and NCQA (National Committee for Quality Assurance) accreditation; development and implementation of the plan's health maintenance organization pay-for-performance program for medical groups and IPAs over the past ten years; profiling approximately 200 Illinois hospitals annually; and profiling approximately 4,000 preferred provider organization physicians annually. Prior to joining BCBS of Illinois in 1996, she practiced internal medicine for 15 years. Dr. Wilhoit has degrees from Stanford University, the University of Washington School of Medicine, and the University of Wisconsin. She is board certified in internal medicine.

Cynthia Williams is director of the Department of Family Education of Sinai Health System.

BIOGRAPHICAL SKETCHES

Speakers

Biographical Sketches

Forum Staff

Judith Miller Jones has been director of the National Health Policy Forum at the George Washington University since its inception in 1972. As founder and director, Ms. Jones guides the Forum's educational programming for federal health policymakers, spearheads NHPF's fundraising efforts, and serves as a resource to foundations, researchers, and other members of the health policy community. Ms. Jones was appointed to the National Committee on Vital and Health Statistics in 1988 and served as its chair from 1991 through 1996. She is a professorial lecturer at George Washington University, is a mentor for the Wharton School's Health Care Management Program, and, on occasion, consults with nonprofit groups and corporate entities across the country. Prior to her work in health, Ms. Jones was involved in education and welfare policy. She served as special assistant to the deputy assistant secretary for legislation in the Department of Health, Education, and Welfare and, before that, as legislative assistant to the late Sen. Winston L. Prouty (R-VT). Before entering government, Ms. Jones was involved in education and program management at IBM. While at IBM, Ms. Jones studied at Georgetown Law School and completed her master's degree in educational technology at Catholic University.

Laura A. Dummit, principal policy analyst, is responsible for health care financing and provider payment issues. Her areas of interest include the organization and delivery of health care services; physician payment, including Medicare's sustainable growth rate; health care markets; and post-acute care. Prior to joining the Forum in early 2005, Ms. Dummit was the health care director for Medicare payment issues at the U.S. Government Accountability Office (GAO). During her seven years with the GAO, Ms. Dummit testified before and reported to the Congress on a range of topics including prescription drug costs, skilled nursing facilities, geographic differences in providers' costs, and physician payment. Before joining the GAO, Ms. Dummit was the deputy director of the Prospective Payment Assessment Commission (now MedPAC) where she led analyses of post-acute care and ambulatory care providers. Ms. Dummit has also held positions with the Alpha Center for Health Planning and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services. She has a master's degree in health policy from the University of North Carolina at Chapel Hill.

Lisa Sprague, principal policy analyst, joined the National Health Policy Forum in 1997. She works on a range of health care issues, including quality and accountability, health information technology, private markets, chronic and long-term care, and veterans' health. Previously, she was director of legislative affairs for a national trade association representing preferred provider organizations and other open-model managed care networks. Ms. Sprague came to Washington in 1989 as manager of employee benefits policy for the U.S. Chamber of Commerce. Her

interest in health policy arose in her earlier work as a human resources manager and benefits administrator with Taft Broadcasting (later known as Great American Broadcasting) in Cincinnati, Ohio. She holds a bachelor's degree in English from Wellesley College and a master of business administration degree from the University of Cincinnati.

Mary Ellen Stahlman, principal policy analyst, joined the National Health Policy Forum in 2006. Her work focuses primarily on Medicare and health care financing issues, including the Medicare prescription drug benefit. Ms. Stahlman joined the Forum following an 18-year career at the Centers for Medicare & Medicaid Services (CMS), most recently as the deputy director of the Office of Policy. In that capacity, she was instrumental in CMS's development and analytic work behind the Medicare prescription drug benefit and the discount card program, and she directed a broad range of studies related to Medicare Part D, prescription drug pricing, and other Medicare issues. Ms. Stahlman has also held senior positions in CMS and has worked in a Medicare managed care plan and on Capitol Hill. She has a bachelor of arts degree from Bates College and a master of health services administration degree from the George Washington University.

Jessamy Taylor, principal policy analyst, joined the National Health Policy Forum in 2004. Her research, analysis, and writing focuses on the health care safety net and issues affecting low-income and vulnerable populations. Prior to coming to the Forum, Ms. Taylor worked at the U.S. Department of Health and Human Services managing the legislative portfolio of the Health Resources and Services Administration (HRSA) in the Office of the Assistant Secretary for Legislation and directing a number of rural health systems development grant programs in the federal Office of Rural Health Policy within HRSA. She began her work with HRSA in 1999 when she joined the Office of the Administrator to work on outreach activities for the State Children's Health Insurance Program and a multi-agency oral health initiative. Ms. Taylor began her federal career as a presidential management intern in the Social Security Administration's Office of Disability and Income Security Programs. She holds a bachelor's degree in political and social thought from the University of Virginia and a master of public policy degree from the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin.

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Forum Staff

Site Visit Report

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National Health Policy Forum

Facilitating dialogue.
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2131 K Street NW, Suite 500
Washington DC 20037

202/872-1390
202/862-9837 [fax]
nhpf@gwu.edu [e-mail]
www.nhpf.org [web]
