



Health Care in the Motor City: Thriving or Surviving?

SITE VISIT
REPORT

DETROIT, MICHIGAN

FEBRUARY 19–21, 2014

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BACKGROUND

Southeast Michigan, home to over half of Michigan's population, is an area characterized by sharp contrasts. Surrounded by relatively affluent, well-managed suburbs which continue to grow and attract new business, Detroit is bankrupt and in distress. The city has lost over half its population since the 1950s and struggles to provide basic services to those residing within its 123 square miles. The area has been characterized as one of the most racially segregated in the country. Detroit is a majority minority city with nearly 90 percent of its population African American or Hispanic. The median household income in 2012 was about \$27,000 compared with over \$48,000 for the state as a whole. Over 38 percent of Detroit's residents live below the federal poverty level; nearly 20 percent are uninsured. Wayne County, home to Detroit, ranks last among Michigan's counties rated for health outcomes, and Detroit has one of the highest infant mortality rates in the nation.

Although these statistics paint a bleak picture of Detroit, there are nascent signs of economic recovery linked to the resurgence of the auto industry and to large investments in the mid-town core by several entrepreneurs committed to Detroit's revitalization. Charitable foundations have also poured millions of dollars into helping Detroit find a new future, one that relies in part on growing the health care and education sectors.

Despite the city's economic woes, health care providers as a whole are perceived to be doing relatively well in Detroit. Henry Ford Health System (HFHS) and Detroit Medical Center are among the city's largest employers, and both systems reported positive operating margins in 2013. There is concern, however, that inpatient utilization will continue to decline, putting additional pressure on systems to reduce costs and expand their patient bases through mergers and acquisitions outside the city. While HFHS remains not-for-profit, Detroit Medical Center was purchased by for-profit Vanguard in 2011, raising questions about whether the system would continue to serve as the city's de facto safety net hospital. Vanguard has since been absorbed by Tenet Health Systems. The outlook for the remainder of Detroit's limited array of safety net providers is also uncertain. There are no clear signals yet on how the expansion of Medicaid which began April 1, 2014, under a section 1115 waiver, will play out.

On the insurer side, Blue Cross Blue Shield of Michigan controls over 75 percent of the commercial market and 56 percent of the individual market statewide. The insurer's dominance has allowed it to experiment with a variety of payment innovations designed to reduce costs and improve quality. Medicaid benefits are provided through managed care plans in Michigan, with Molina and United HealthCare capturing just under 48 percent of the market.

PROGRAM

The site visit began the morning of February 20, 2014, with an overview of the major characteristics that define the city of Detroit and its health care marketplace. A discussion with executives from two organizations representing large employers followed, focusing on a range of issues related to cost containment. The morning ended with an insurer/provider panel discussion of payment reform initiatives in Michigan that included Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (PGIP), patient-centered medical home (PCMH), and organized system of care (OSC) initiatives, and the Pioneer ACO program. After lunch, the group travel to Henry Ford Health System (HFHS), where executives discussed a wide-ranging set of topics related to HFHS's role in the Southeast Michigan marketplace and the effect of health reform on health care services in Detroit. From HFHS, the group traveled to Detroit Medical Center (DMC) where the discussion focused on DMC's role in the marketplace, education, and training, and its Michigan Pioneer ACO.

Day two began with a candid conversation with a prominent health care executive about Detroit's political, economic, and racial history and the city's prospects for the future. Next, the director of the Detroit Department of Health and Wellness Promotion described the public health challenges facing the city and discussed recent changes in how public health services are provided in Detroit and possible changes for the future. The group then traveled to the CHASS Center for a tour of this state-of-the-art federally qualified health center. After the tour and lunch, the day concluded with a panel of federally qualified health center directors and a free clinic director, who discussed the challenges facing Detroit's safety net providers.

IMPRESSIONS

The National Health Policy Forum asked site visit participants to reflect on what they saw and heard during the site visit. What follows is a compilation of their impressions.

- » **The overwhelming influence of social determinants of health makes it difficult to improve health population-wide in Detroit.**

Detroit is a city beset with health care problems and underlying economic, social, and physical conditions that make improving the population's health extremely difficult. The city has one of the nation's highest infant mortality rates and significant disease burden in such areas as heart disease, diabetes, asthma, and lung cancer. Mortality rates for unintentional injury are also much higher than the national average. Substance abuse and mental health conditions are prevalent. This disease burden translates into higher levels of hospitalization for Detroit residents compared with residents of the outlying suburbs. Detroit had 49 hospitalizations per 10,000 residents for asthma compared with 14.9 per 10,000 residents in nearby Oakland County.

Many factors contribute to the poor health of Detroit's residents. Air quality is five times worse in Detroit than in neighboring Oakland County, for example. With very few large supermarkets in the city, residents have trouble accessing healthy foods and are more likely than their suburban counterparts to get their food from corner stores and fast food restaurants. Liquor stores are highly concentrated in Detroit compared with surrounding communities.

The city's infrastructure poses barriers to accessing care. Very slow response times from emergency services providers are blamed for unnecessary deaths and poor outcomes. The lack of a reliable transportation system is frequently cited as a reason people do not make and/or keep appointments with health care providers. Safety concerns also play a role in deterring care-seeking behavior and physical activity. Street lights are not working in many parts of the city, and some residents live in blocks with burned-out houses or vacant lots where properties have been torn down. With the exception of the mid-town area redevelopment, blight is rampant throughout the city.

The absence of employment opportunities—especially for those with limited skills and education—and a failing school system further add to the sense that residents are more likely to be focused on meeting daily needs for food and shelter than engaging in behaviors to improve their health such as exercise and healthy eating. Add to these concerns a history of many residents using emergency departments as a primary source of care, and it is not surprising that many think that tackling these social determinants of health is a prerequisite to improving population health in Detroit.

The ability of the city to address these problems is limited. The city is in bankruptcy and has limited resources to invest in improving infrastructure, promoting economic development, or providing basic health care services. Many of the city's public health functions were contractually spun off in 2012 to the non-profit Institute for Population Health (IPH). Although this arrangement allowed the city to reduce its workforce and pension obligations—a high priority for the previous administration—it sharply diminished the Department of Health and Wellness Promotion's role, reducing its capacity to interact with and influence other city agencies whose activities affect the health and well-being of Detroit's residents. The city's new mayor is currently reconsidering the department's role and the contracting arrangement with IPH.

» **Detroit has evolved from a market with many independent hospitals to one with major systems that compete with each other. There is still interest in further consolidation. Despite Detroit's high rate of uninsurance, the city's major health care systems are relatively robust.**

As the city of Detroit has undergone transformation over the past 50 years, so too has the health care delivery infrastructure. Once populated with many independent hospitals, the city has experienced some closures and is now home to two dominant health care systems: Henry Ford Health System (HFHS) and Detroit Medical Center (DMC). Founded by Henry Ford in 1915, HFHS's over 800-bed tertiary care hospital sits in the heart of Detroit. HFHS uses an employed physician model to staff its downtown hospital, which is the second largest non-university teaching hospital in the United States. In an effort to diversify its payer mix, the system opened a new state-of-the-art hospital in suburban West Bloomfield in 2008. The HFHS

also includes a staff-model health maintenance organization, Health Alliance Plan, which is offering insurance on the health insurance marketplace in Michigan. In addition to hospitals and a health plan, the HFHS encompasses 30 ambulatory care clinics; more than 2,000 employed and affiliated physicians; two nursing homes; and a host of ancillary services including home health, physical therapy, and pharmacy services. A new electronic medical record (EMR) is being implemented system-wide. A proposed merger with Beaumont Health System in Royal Oak fell through after six months of discussions, purportedly over cultural differences between HFHS's employed physicians and Beaumont's affiliated independent practice physicians.

Detroit Medical Center, the largest provider of hospital services to Medicaid beneficiaries and the uninsured in Michigan, was formed in 1985 by consolidating several of the city's oldest hospitals including the city's main safety net hospital, Detroit Receiving, for a total of 2,000 licensed beds and more than 3,000 affiliated physicians. It moved from non-profit to for-profit status in 2011 upon its acquisition by Vanguard, which has since been acquired by Tenet Health Systems. When acquiring DMC, Vanguard promised that it would continue the same charity care policies and would not close any hospitals in Detroit for ten years. It also agreed to invest \$850 million in capital improvements over five years. Among DMC's holdings is Michigan Children's Hospital (MCH) and its newly constructed outpatient facility, which sits across the street from the hospital. Under an agreement with HFHS, all pediatric patients requiring hospitalization or specialty care are referred to MCH. The proposed HFHS/Beaumont merger threatened this arrangement because Beaumont also provides inpatient services to children and has expressed interest in expanding this service line. Beaumont is now negotiating with Botsford Health Care and Oakwood Healthcare to combine finances and operations under a single leadership structure. Competition for pediatric inpatients raises concerns about excess supply and an insufficient population to support more than one inpatient provider in the metropolitan area.

While most observers agree that Detroit's economic woes and the recession generally have affected every sector of the city's economy including health care, both HFHS and DMC reported positive total profit margins in 2012. With a profit margin of 1.2 percent, HFHS executives express concern about the system's future financial viability.

Concerns center on a heavy charity care burden, which has doubled in the past ten years; a significant drop in hospital admissions; a 3 percent drop in hospital readmissions; low Medicaid payment rates; and cuts to hospitals imposed by the federal Patient Protection and Affordable Care Act of 2010 (ACA) legislation. HFHS expects to continue to “lose money” on Medicaid patients, and executives believe bad debt will grow if some newly insured individuals are unable to meet their cost-sharing obligations. Whether HFHS’s modest margin reflects a truly precarious situation, or that the system is spending the resources it has on infrastructure improvements such as the new EMR, remodeling, equipment, or other needs, is unclear to outside observers.

Detroit Medical Center posted a profit margin of 73 percent in 2012. DMC shed jobs in 2013 and it seems likely that the for-profit ethos of Vanguard (and now Tenet) compelled DMC to look for efficiencies throughout its operations. DMC achieved \$4 million in shared savings with the Medicare program in its Pioneer ACO (accountable care organization), but it is unclear whether the system’s investments in care coordination and the savings distributed to participating physicians exceeded the shared savings received from Medicare. Although direct evidence is lacking, other providers express concern that DMC may be cutting back on charity care.

While there is certainly room for concern, Detroit’s major health care systems appear to be relatively robust. Future strategic partnerships or mergers that allow the systems to capture more of the suburban market and a better payer mix seem likely. Continued improvements in efficiency at DMC are also likely, at least in the short term. Pressure on HFHS’s bottom line may also prompt it to look for opportunities to economize.

» **Purchasers believe that both insurers and Medicare are not aggressive enough in pursuing policies that promote price transparency, quality, and greater efficiency.**

Two organizations, the Greater Detroit Area Health Council, Inc. (GDAHCC) and the Economic Alliance for Michigan (EAM), are attempting to further purchasers’ interests in reducing health care costs and promoting population health. GDAHCC focuses on solving health care problems that “can be addressed only through multi-

sector collaboration”; its members include employers, providers, and insurers. EAM’s membership is comprised solely of employers and labor unions in the for-profit sector, who see rising health care costs as a drag on job growth.

Some perceive insufficient effort on the part of self-insured employers, insurers, and the Medicare program to adopt policies that would help hold the line on costs and improve quality. There is skepticism, for example, that savings from payment reform efforts will be passed along to employers in the form of reduced premiums. Lack of communication from insurers to employers about outcomes data is another source of frustration.

Both organizations have attempted to work directly with consumers to promote more cost-conscious behavior. GDAHC is trying to engage consumers directly in their care through such things as public service announcements about the Choosing Wisely campaign to reduce the use of services with little value, a Find My Care initiative that helps hospitals redirect patients to local providers for follow-up care, and a MyCareCompare website that compares area hospitals on various quality measures using Medicare data. EAM has focused on helping consumers facing heart surgery make educated choices about facilities and treatment options.

Specific actions that purchasers would like to see insurers and Medicare pursue include: providing greater price transparency; reducing price variation in “shoppable” services; weeding out low-performing providers; stopping the migration of services to settings with high facility fees; reducing observation stays; paying no more for new technologies that do not deliver more benefits than existing technologies; and supporting states’ ability to use certificate of need (CON) to control the supply of hospital beds.

» **Payment Reform in Michigan has taken multiple forms with mixed results.**

Much of the payment reform activity in Michigan has its origins in the decade-long effort of Blue Cross Blue Shield of Michigan (BCBSM) to transition from paying for individual services (fee for service) to paying for value. Characterizing its efforts as “catalyzing health system transformation in partnership with providers,” BCBSM initiatives include a progression from a Physician Group Incentive

Program (PGIP) to Patient-Centered Medical Homes (PCMH) to Organized Systems of Care (OSCs). Each initiative requires physicians and physician organizations to take steps to modernize systems and care processes, integrate care across providers, manage population health, and optimize cost and quality performance. The insurer froze base physician fees at 2009 levels and made all future increases contingent on participation in the initiatives and performance. A 5 percent PGIP incentive pool is split 50/50 between supporting infrastructure development and rewarding physician organizations and OSCs for population-level cost and quality performance. BCBS reports savings of \$155 million in 2012 associated with its PCMH program. Although PGIP was initially targeted to primary care physicians, increasing numbers of specialties have been brought into the program. BCBSM executives report that key lessons learned from PGIP include the following:

- Collaboration among providers is essential: align incentives for PCPs, specialists and facilities so they create clinically integrated systems which best serve the community, rather than compete for declining resources and further fragmenting care.
- Making a substantial portion of reimbursement dependent on system development and performance can move the needle on cost and quality performance.
- Savings come from moderating procedure, emergency department, and inpatient use; right-sizing capacity is necessary and requires a plan for facilities to adjust to changes in volume.

From the perspective of physicians represented by health management company United Physicians, the PGIP initiative has helped fund important infrastructure developments, including information technology improvements, process redesign, and administrative functions essential to improving performance. Of its 2,128 physician members, 77 percent participate in PGIP, 88 practices are certified as PCMHs, and 769 doctors (47 percent primary care/53 percent specialty) participate in an OSC. While some physicians near retirement have opted out of these initiatives, it appears that most physicians recognize that the only way to grow their incomes in an environment with a dominant insurer is to embrace the BCBSM initiatives.

The ACO experience in Michigan is decidedly mixed. As noted earlier, the DMC Pioneer ACO realized first-year shared savings of \$4 million primarily by targeting those patients where savings were

likely, smoothing care transitions, and improving the coordination of post-acute care. Program executives point to numerous structural barriers that make their job more difficult. These include the lack of timely data feeds from the Centers for Medicare & Medicaid Services (CMS) and the absence of a local health information exchange that would alert them when their patients are being treated outside the ACO's network, something that happens with great frequency. But they also note that the ACO experience is helping them develop the systems and skills necessary to succeed when payment eventually will be based on improvements in population-based health. The DMC ACO expects to achieve savings again in 2013, possibly even more so than in 2012. Keeping physicians engaged in the long run is a challenge, however, as many feel they cannot give up the revenues associated with traditional fee-for-service Medicare in exchange for a smaller amount of shared savings. In addition, data lags make it extremely difficult for the ACO to know how it is performing against the benchmark, something that may not be tolerated in the long run in a profit-driven environment.

DMC's experience contrasts sharply with that of another Michigan ACO located about 60 miles northwest of Detroit. Genesys Health System (GHS) is a regionally integrated health care delivery system that includes a continuum of primary care services anchored by Genesys Regional Medical Center, a 410-bed hospital in Grand Blanc. The Genesys Physician Hospital Organization (PHO), a collaborative effort between GHS and Genesys Physicians Group Practice, is the organizational base of the Genesys Pioneer ACO. The PHO selected 100 primary care physicians and 200 specialists to participate. Although the ACO successfully bent the cost curve, it did not perform better than the benchmark against which savings are measured and ended up owing Medicare \$2.5 million in 2012; losses are expected in 2013 as well. Genesys has left the Pioneer program but plans to participate in the Medicare Shared Savings Program (MSSP) beginning in 2015. Executives believe that the Pioneer benchmark methodology is flawed.

Although it participates in the BCBSM initiatives, HFHS, in contrast to DMC and Genesys, eschewed the Pioneer ACO demonstration. Executives expressed concerns about the ACO patient attribution rules, the benchmarking methodology, and the fact that the benefits of reducing utilization accrue to Medicare, but not necessarily the health system for whom fewer services means less revenue. They

told participants that HFHS is trying to advance population-based health, and they believe the ACO fee-for-service payment approach is incompatible with its vision of the future.

The level of payment innovation in Michigan is significant and includes other initiatives not explored during the site visit, such as the Multi-payer Advanced Primary Care Practice Initiative. Site visit participants, however, found it difficult to assess the long-term impact of these initiatives on the cost and quality of services in Southeastern Michigan. The lack of a functioning health information exchange is seen as a significant inhibitor to future cost-containment efforts. Health care providers and systems can only go so far in reducing costs if they are unable to track their patients as they travel throughout the region seeking care. Some believe self-insured employers could be doing more to push the envelope. And while BCBSM's payment reform initiatives are viewed in a positive light, there is also a sense that additional competition in the insurer market might be beneficial to both purchasers and consumers.

» **All segments of the health care community are anxious for Medicaid expansion to begin but are concerned about the challenges of enrolling a population with low levels of health literacy and ingrained behaviors of using emergency departments as a substitute for primary care.**

Medicaid expansion cannot come quickly enough for most of the health care providers in Detroit. As much as 80 percent of the uninsured are likely to qualify for Medicaid. Michigan's Medicaid expansion, which is taking place under a section 1115 demonstration waiver negotiated between the Michigan Department of Community Health (DCH) and CMS, began April 1. Healthy Michigan, as the program is called, will enroll newly eligible beneficiaries in managed care plans, require premiums and cost sharing that can be waived or reduced by engaging in healthy behaviors, provide financial incentives to providers to improve quality, and require the state to carefully monitor changes in the level of uncompensated care. After two years, the expansion population can choose to move to marketplace plans with regular ACA subsidies or remain in Medicaid managed care plans but with higher premiums and cost-sharing requirements.

Although supportive of the expansion, providers express a number of concerns about the implementation of Healthy Michigan. Health and insurance literacy among the expansion eligible population is generally low, causing fear that beneficiaries may not understand how the program works or how it is different from the marketplace plans for which those under 100 percent of poverty have been told they are ineligible. Family structures among this population are complex, another impediment to sorting out eligibility, and the April 1 start date is problematic because of the nationwide emphasis on signing up for health insurance by March 31. Whether plans will be able to reverse long-ingrained behaviors, such as using emergency departments for primary care, is another area of concern. Among community health centers, there is concern that some of their currently uninsured clients will unwittingly enroll in, or be auto-assigned to, managed care plans that do not contract with the center, disrupting long-standing relationships. A final concern is whether there are sufficient numbers of providers to meet the increased demand for primary care services that is likely to come with expansion. Providers have attested in surveys to their willingness to take on new Medicaid beneficiaries, but there is some skepticism, at least in Detroit where primary care providers are scarce, that supply will be sufficient to meet demand.

Healthy Michigan is a work in progress with many details still to be worked out among DCH, providers, and CMS. It is simply too early to tell what effect Medicaid expansion will have on reducing the number of uninsured or encouraging more appropriate use of health care services.

- » **Detroit's community health centers and free clinics have a history of financial support from the city's major hospital systems and from foundations. With the expansion of Medicaid and a potential foundation emphasis on getting Detroit back on its feet financially, the future of these relationships is unclear and potentially worrisome.**

The number of community health centers (CHCs) and free clinics in Detroit is considered by most observers to be small in relation to the need for primary care services. These providers are generally excited about the prospect of more of Detroit's residents becoming insured, either by enrolling in plans sold on the marketplace or

via the Medicaid expansion. The CHCs hope to continue to serve their newly insured clients through relationships with managed care plans, and both the CHCs and free clinics expect to continue to serve those who either don't enroll or are not eligible to enroll because of immigration status. While providers of all types appreciated the state's concerns about "getting the website right," they acknowledged considerable confusion and uncertainty about how the expansion would actually unfold. Many were concerned that residents would be confused by the April 1 start date after all the nationwide hype about the March 31 deadline for signing up for health insurance. There was also unease among safety net providers due to the uncertain future of the City of Detroit and fear that possible mergers and acquisitions among health care systems could affect existing relationships.

Detroit's major hospital systems have a history of providing significant charity care and working directly with community health centers and free clinics to provide ancillary services and access to specialty care. HFHS physicians, for example, staff the two locations of the CHASS Center, a federally qualified health center (FQHC). HFHS also provides vouchers to CHASS and the Cabrini Free Clinic to enable their patients to access inpatient and specialty care from HFHS's physicians and hospitals. The Oakwood health system processes all the laboratory work for Cabrini, and HFHS rotates internal medicine and psychiatry medical residents through Cabrini. DMC-affiliated physicians see patients at Detroit Community Health Connection, another FQHC. If the number of uninsured is significantly reduced, there is concern that these systems may pull back on their commitments, especially to FQHCs who have more capacity to contract with managed care plans than free clinics.

FQHCs and free clinics are also the beneficiaries of individual donor, corporate, and foundation grants and gifts. The CHASS Center's beautiful new building on South Forte Street is testament to its ability to raise funds from these sources. With several large foundations now providing substantial financial support to the City of Detroit as part of a plan to reduce bankruptcy-imposed cuts to retiree pensions and to protect the assets of the Detroit Institute of Arts, there is concern that fewer resources will be available to the FQHCs and free clinics from these sources in the future.

CONCLUSION

Detroit is clearly a city in transition. Residents hope that the new mayor can successfully navigate bankruptcy so that Detroit emerges with enough support and resources to proactively address its major problems. Regardless of what happens in terms of economic development, the city's major health care institutions will continue to play a significant role in shaping Detroit's future. These institutions are among the city's largest employers and they, along with community health centers, are expected to contribute to the Motor city's revival by improving the health of its residents. Whether some institutions and providers thrive and others merely survive remains to be seen.

AGENDA

WEDNESDAY, FEBRUARY 19

Afternoon	Arrival at Headquarters Hotel — DoubleTree Suites [525 West Lafayette Boulevard; 313/963-5600]
6:30 pm	Optional Dinner — Slows Bar BQ [2138 Michigan Avenue; 313/962-9828] Gather in Hotel Lobby to travel to Slows by cab

THURSDAY, FEBRUARY 20

7:30 am	Breakfast Available [Ft. Drummond Room, Mezzanine Level]
8:00 am	Welcome and Introductions
8:15 am	Setting the Context: The Southeast Michigan Health Care Marketplace and the Effects of Health Reform

Over half of Michigan’s population lives in Southeast Michigan, which is home to a majority of the state’s businesses and industries including major health care providers such as Detroit Medical Center and Henry Ford Health System, located in downtown Detroit. The region has long been buffeted by major economic shifts. The auto industry, once the heart of the American economy, endured decline and bankruptcy and is now experiencing somewhat of a resurgence. With a population of just over 700,000, Detroit has lost over half of its residents since 1950 and is now in bankruptcy. The city’s population is majority minority (83 percent African American), and 36 percent of its residents live below the poverty level. Wayne County, home to Detroit, ranks last among Michigan’s counties rated for health outcomes. In the health care sector, adaptation has been essential, but also key to more than mere survival. Mergers, acquisitions, closures, and suburban expansions have been numerous over the past several years as health care providers look for ways to remain viable and potentially vibrant. Blue Cross Blue Shield of Michigan is the dominant insurer in the state and has undertaken payment innovations to promote efficiency and quality improvement among physician groups and systems of care.

Marianne Udow-Phillips, MSHA, Director, Center for Healthcare Research and Transformation

- What are the defining characteristics of greater Detroit and its health care marketplace?

THURSDAY, FEBRUARY 20

8:15 am

Setting the Context (continued)

- Who are the major providers, payers, employers, and government entities shaping the marketplace?
- How do health systems distinguish themselves in the metro Detroit market? On what basis, and to what extent, do they compete directly?
- What is the effect of having a single, dominant insurer for private insurance?
- How has Detroit's decline over the past 20+ years affected the organization and delivery of health care?
- What is the role of Medicaid in providing coverage in Detroit?
- What are the most important health care challenges facing the city of Detroit and the providers who deliver care there?
- What will Michigan's decision about Medicaid expansion mean for Southeast Michigan?

9:15 am

Health Care Cost Containment: The Purchaser's Perspective

The Economic Alliance for Michigan, whose members include businesses and labor unions, brings a purchaser's perspective to health care cost containment. The Alliance has been active on issues related to scope of practice, hospital expansions and consolidations, insurance design, and consumer information/transparency.

The Greater Detroit Area Health Council, Inc. (GDAHC), whose membership includes employers, unions, and providers, is focused on issues that require multi-sector collaboration. To promote its vision of "healthy people, healthy economy," GDAHC has focused on reducing the inappropriate use of services, encouraging self-care, reducing avoidable hospital readmissions, and promoting consumer engagement.

Bret Jackson, *President*, The Economic Alliance for Michigan

Kate A. Kohn-Parrott, MBA, *President and Chief Executive Officer*, Greater Detroit Area Health Council, Inc.

- What factors have caused purchasers to become more focused on health care costs?
- What are purchasers' priorities in seeking cost control while maintaining access?

THURSDAY, FEBRUARY 20

9:15 am

Health Care Cost Containment (continued)

- How has Michigan's Certificate of Need program affected the provider landscape in Southeast Michigan?
- What successes/stumbling blocks have purchasers encountered?
- What is the appetite for collaboration in Detroit? How successful have initiatives been? Are they making a difference in terms of controlling costs?

10:15 am

Payment Innovation in Southeast Michigan: PGIP and ACOs

Blue Cross Blue Shield of Michigan is the dominant insurer in the state with about 70 percent market share. Over the past eight years, the insurer has used its Physician Group Incentive Programs (PGIP) to reward physicians who come together to improve performance on cost and quality measures and who adopt the infrastructure and care processes associated with a patient-centered medical home (PCMH).

Formed with the merger of two Beaumont physician groups (Royal Oak and Troy) United Physicians is a health management company representing 2,200 independent physicians with staff privileges at hospitals throughout Southeast Michigan. Half of its physicians participate in PGIP, and 88 practices are PCMH-certified.

Genesys Health System (GHS), part of Ascension Health, is located about 60 miles northwest of Detroit. GHS is a regionally integrated health care delivery system that includes a continuum of primary care services anchored by Genesys Regional Medical Center, a 410-bed hospital in Grand Blanc. The Genesys Physician Hospital Organization (PHO), a collaboration between GHS and Genesys Physicians Group Practice, is a Pioneer accountable care organization (ACO).

Jean Malouin, MD, MPH, Medical Director, Value Partnerships, Blue Cross Blue Shield of Michigan and Co-chair, Michigan Multi-Payer Advanced Primary Care Practice Demonstration

Kimberlee Coleman, MD, Medical Director, United Physicians, Inc.

Betsy Aderholdt, President and Chief Executive Officer, Genesys Health System

- How does the PGIP incent the formation of PCMHs and organized systems of care (OSCs)? How are efficiency and quality among participating physician practices measured?

THURSDAY, FEBRUARY 20

10:15 am

Payment Innovation in Southeast Michigan (continued)

- To what extent are physicians participating and achieving positive results?
- From the physician's perspective, what are the advantages and challenges of participating in PGIP? In PCMH? In OSCs?
- What is next on the payment innovation horizon?
- How has Genesys Health System's structure and care delivery approach changed in recent years? What role did a declining economy and more parsimonious health benefits play in causing this shift? How did these experiences influence GHS' decision to become a pioneer ACO?
- What have been the challenges related to ACO patient attribution, data monitoring, and performance metrics?
- What did GHS learn from its first year participation in the Genesys PHO Pioneer ACO?

11:45 am

Lunch

12:30 pm

Bus Departure — Henry Ford Hospital, Clara Ford Pavilion
[2799 W. Grand Boulevard, Valade Boardroom]

1:00 pm

Henry Ford Health System

Henry Ford Health System (HFHS) is an integrated system comprised of four acute care hospitals; a 1,200 member multi-specialty group practice; a large HMO (health maintenance organization); over 30 ambulatory care clinics; more than 2,000 private practice physicians; two nursing homes; and a host of ancillary services, including home health, physical therapy, and pharmacy services. HFHS provided over \$211 million in uncompensated care in 2011 and reported a profit of \$48 million for a total margin of 1.1 percent of its \$4.4 billion in revenue.

Nancy Schlichting, MBA, Chief Executive Officer, Henry Ford Health System (HFHS)

Robert Riney, President and Chief Operating Officer, HFHS

William A. Conway, MD, Executive Vice President and Chief Quality Officer, HFHS; Chief Executive Officer, Henry Ford Medical Group (HFMG)

THURSDAY, FEBRUARY 20

1:00 pm

Henry Ford Health System (continued)

John Popovich, Jr., MD, *President and Chief Executive Officer*, Henry Ford Hospital (HFH)

Charles E. Kelly, DO, *President and Chief Executive Officer*, Henry Ford Physician Network

James M. Connelly, MBA, *Executive Vice President, Finance & Administration, and Chief Financial Officer and Treasurer*, HFHS

Naim Munir, MD, *Senior Vice President and Chief Medical Officer*, Health Alliance Plan (HAP)

Mary Ann Tournoux, *Senior Vice President and Chief Marketing Officer*, HAP

Eric Scher, MD, *Chair*, Department of Internal Medicine, HFH and HFMG, and *Vice President of Medical Education*, HFHS

Mary Whitbread, *Vice President, Reimbursement and Managed Care Contracting*

Mary Alice Annecharico, RN, MS, *Senior Vice President and Chief Information Officer*, HFHS

Thomas Nantais, MBA, *Chief Operating Officer*, HFMG

Kimberlydawn Wisdom, MD, MS, *Senior Vice President, Community Health & Equity, and Chief Wellness Officer*

David R. Nerenz, PhD, *Director*, Center for Health Policy and Health Services Research, HFHS

Darlene Burgess, *Vice President*, Corporate Government Affairs, HFHS

Sharifa Alcendor, *Director*, Patient Care Management and Assistance

- How has HFHS fared as Detroit has declined? What is the system's current patient and payer mix? How has it changed over the past 10 years? What is HFHS' strategy for remaining viable into the future?

THURSDAY, FEBRUARY 20

1:00 pm

Henry Ford Health System (continued)

- How have changes in the provider landscape (mergers, ownership changes, closures, etc.) affected HFHS?
- How important is the presence of an employed physician group and a health plan to HFHS' success?
- Where does HFHS stand in terms of fully integrating its physicians and hospitals?
- Cultural differences have been cited as the reason Beaumont Health System backed out of a proposed merger with HFHS. What barriers might hinder exporting the HFHS vision of health care to other provider systems?
- What is HFHS' relationship with safety net providers, such as community health centers and free clinics?
- How do/will health systems approach the notion of managing population health in a community like Detroit with high levels of poverty and unemployment and less-than-desirable housing conditions?
- How does HFHS' HMO, Health Alliance Plan (HAP), balance its allegiance to HFHS against its members' desire for a broader network?
- What influenced HAP's decision to participate in the Michigan marketplace/exchange under the federal Patient Protection and Affordable Care Act (ACA)?
- What role does HFHS play in physician education in Southeast Michigan? How has that role changed over time?

2:45 pm

Break

3:00 pm

Bus Departure — Children's Hospital of Michigan Specialty Center at Detroit Medical Center [3950 Beaubien Street; 313/745-KIDS]

THURSDAY, FEBRUARY 20

3:30 pm

Detroit Medical Center

Detroit Medical Center (DMC) is the largest health care provider in Southeast Michigan with over 2,000 beds and 3,000 affiliated physicians. DMC operates 11 facilities, most in downtown Detroit. In a deal that included capital improvements, new facilities, and a commitment to sustain DMC's level of charity care, DMC was purchased by for-profit Vanguard Health Systems effective January 1, 2011. A new Children's Hospital of Michigan Specialty Center opened in June 2012, and a new heart hospital is under construction. Called the Michigan Pioneer Accountable Care Organization, DMC's Pioneer ACO reported first-year savings of 4.5 percent of baseline. Purchase of Vanguard Health Systems by Tenet Healthcare Corporation was announced in June with conclusion of the sale expected in January 2014.

Jay B. Rising, JD, Executive Vice President & Chief Strategy Officer

Suzanne R. White, MD, MBA, Executive Vice President & Chief Medical Officer

Herman B. Gray, MD, MBA, Executive Vice President, Pediatric Health Services, Children's Hospital

[Possible tour of Children's Hospital Specialty Center]

- How has DMC fared as Detroit has declined? What is the system's current case and payer mix? How have these changed over the past 10 years? What is DMC's strategy for remaining viable into the future?
- How is DMC preparing and positioned for 2014 when coverage expands? What effect will Michigan's decision regarding Medicaid expansion have on DMC?
- How have changes in the provider landscape (mergers, ownership changes, closures, etc.) affected DMC?
- What factors influenced DMC's decision to become a Pioneer ACO?
- What have been the challenges related to ACO patient attribution, data monitoring, and performance metrics?
- What did DMC learn from its first year as an ACO?

THURSDAY, FEBRUARY 20

3:30 pm

Detroit Medical Center (continued)

- How do/will health systems approach the notion of managing population health in a community like Detroit with high levels of poverty and unemployment and less-than-desirable housing conditions?
- What is the landscape for children’s services in Detroit and the surrounding suburbs? How is the marketplace for children’s services changing?
- What role does DMC play in physician education in Southeast Michigan? How has that role changed over time?

5:15 pm

Departure — Hotel

5:30 pm

Free Time

6:45 pm

Walk to 24 Grille Restaurant — The Westin Book Cadillac Detroit Hotel [204 Michigan Avenue; 313/964-3821]

FRIDAY, FEBRUARY 21

7:15 am

**Breakfast [Ft. Drummond Room, Mezzanine Level]
Checkout [Ft. Gratiot Room available for luggage storage]**

8:00 am

Betting on a Brighter Future: An Insider’s View of Detroit

The City of Detroit faces considerable—what some may see as insurmountable—problems. The city is broke and the population has dwindled from 1.8 million in the 1950s to about 700,000 today. Scores of properties in the 139-square mile city are burned out, and whole city blocks are abandoned. Services such as street lighting, police, and fire are spotty. Yet against this backdrop, the auto industry is on the rebound, business incubators have emerged, and significant redevelopment is taking place in the mid-town and downtown core, attracting new businesses and young urban professionals back to the city. Detroit Future City, a strategic framework plan released last December, has identified education and health care employment (“Eds and Meds”) as one of the four Pillars of Economic Growth.

Conrad L. Mallett, JD, MPA, MBA, Chief Administration Officer, Detroit Medical Center, and Campaign Chairman, Mike Duggan for Mayor

- Can Detroit make a successful “comeback?” What role will health care likely play in the city’s revitalization?

FRIDAY, FEBRUARY 21

9:00 am

Public Health in Detroit: A Public-Private Partnership

Faced with declining revenues and pressure to reduce costs, the City of Detroit transferred all state-funded public health programs from the Department of Health and Wellness Promotion (DHWP) to a co-located independent, not-for-profit Institute for Population Health (IPH) effective October 2012. DHWP employees were invited to reapply for their jobs; 60 percent of current IPH employees were formerly with DHWP. DHWP operates with a much-reduced staff and retains its legal public health authority. Vital records, HIV programs, Healthy Start, and tuberculosis services remain with DHWP. All other public health and preparedness services, such as WIC (Women, Infants, and Children), family planning, immunizations, and food safety, are under the purview of IPH.

Vernice Davis Anthony, MPH, Director, Detroit Department of Health and Wellness Promotion

- What are the most pressing public health needs/issues in Detroit?
- What led to the creation of the Institute for Population Health?
- How are responsibilities for public health functions determined, assigned, and financed?
- What are the benefits and challenges of having public health responsibilities split between DHWP and IPH?

10:00 am

Break

10:15 am

Bus Departure — CHASS Southwest Center

10:30 am

Tour — CHASS Southwest Center
[5635 West Fort Street; 313/849-3920]

FRIDAY, FEBRUARY 21

11:00 am

State of the Safety Net: Detroit's FQHCs and Free Clinics

CHASS Center, Cabrini Free Clinic, and Detroit Community Health Connection (DCHC) provide safety net services to Detroit's low-income residents. Staffed by physicians from HFHS, CHASS operates at two locations including a new facility serving the primarily Hispanic residents of Southwest Detroit. CHASS began in 1970 and became a federally qualified health center (FQHC) in 1993. Cabrini Free Clinic sits in the Corktown neighborhood of Southwest Detroit. It is supported by Most Holy Trinity Church, grants, and donations, and the Clinic provides services to the uninsured at no charge. Detroit Community Health Connection, also an FQHC, is a community-based primary care organization operating six clinics in Detroit that offer medical, behavioral health, and dental care services. DCHC serves the insured, underinsured, and uninsured.

Ricardo Guzman, LMSW, MPH, Chief Executive Officer, CHASS Center

Sister Mary Ellen Howard, RSM, Executive Director, Cabrini Free Clinic

Wayne W. Bradley, Sr., President and Chief Executive Officer, Detroit Community Health Connection

- How does the patient and payer mix vary among different kinds of safety net providers, such as FQHCs, other community clinics, and free clinics?
- What is the relationship between clinics and the area's major hospital systems?
- How hard or easy is it to obtain specialty care for patients?
- How will Michigan's decision regarding Medicaid expansion affect clinics?
- What role will clinics play in providing care to those obtaining coverage from the federal exchange?
- What has been the effect of Detroit's financial woes on clinics?

12:00 pm

Working Lunch and Discussion

1:15 pm

Bus Departure – Detroit Metro Airport

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BIOGRAPHICAL SKETCHES

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Evelyne Baumrucker, MA, is an analyst in health care financing with the Congressional Research Service (CRS). Over her tenure at CRS, she has provided Congress with policy analysis and legislative support for Medicaid and the Children's Health Insurance Program (CHIP). Her primary areas of expertise include Medicaid eligibility and enrollment facilitation for children and families and other non-disabled adults, interactions between Medicaid and Patient Protection and Affordable Care Act exchanges, and the section 1115 waiver authority. In addition, she covers issues related to CHIP. She received a BA degree from the Pennsylvania State University, and an MA degree in social policy from the George Washington University.

Melissa Cohen, JD, MPA, is currently the project lead for the Pioneer ACO Model in the Seamless Care Models Group at the Center for Medicare & Medicaid Innovation (the Innovation Center), a component of the Centers for Medicare & Medicaid Services (CMS). After completing her law degree at Fordham University School of Law, Ms. Cohen practiced medical malpractice defense law for six years at two litigation firms in Manhattan; lastly as a senior associate at Garson, DeCorato & Cohen, LLP, where she represented physicians as well as major metropolitan health systems in the New York City area. In 2011, she earned a master's degree in public administration with a concentration in health policy from the Harvard Kennedy School of Government. At the CMS Innovation Center, Ms. Cohen has been involved in the design and implementation of the Bundled Payments for Care Improvement Initiative, the Comprehensive ESRD Care Initiative, and the Pioneer Accountable Care Organization Initiative, and she has worked on other health initiatives under consideration or in development. Prior to her role at the CMS Innovation Center, she worked with a number of nonprofits working towards the passage of health reform. Ms. Cohen's undergraduate degree is from the University of Pennsylvania where she was a University Scholar.

Alpa Davis, JD, is a staff attorney in the Federal Trade Commission's Health Care Division. Her practice primarily focuses on antitrust conduct in the pharmaceutical sector and among providers, including investigations and litigation. Prior to joining the Federal Trade Commission, Ms. Davis was an attorney in private practice, focusing on pharmaceutical patent litigation and patent prosecution. Ms. Da-

vis is a graduate of the George Washington University Law School and has a degree in biological sciences from Carnegie Mellon University.

Nancy De Lew, MPS, MPA, is associate deputy assistant secretary for health policy in the Office of Health Policy, Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS). ASPE leads the Department's legislative, strategic, planning, and evaluation activities. She leads a team of staff conducting research and policy analysis on a wide variety of public health, health care access, financing, and quality of care issues.

Prior to this position, she held a number of other positions in HHS including: leading the team setting up the Office of Health Insurance Exchanges at the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS); working in CMS' legislative office with congressional staff as the Patient Protection and Affordable Care Act of 2010 was being developed; and working on other major legislative initiatives including MMA (Medicare Prescription Drug, Improvement, and Modernization Act) in 2003, HIPAA (Health Insurance Portability and Accountability Act) in 1996, BBA (Balanced Budget Amendment) in 1997, and the Health Security Act in 1993.

She joined HHS in 1985 as a presidential management intern after receiving a master's degree in political science and a master's degree in public administration from the University of Illinois at Urbana.

Vijay D'Souza, MBA, is an acting director on the Health Care team of the U.S. Government Accountability Office (GAO), where he manages multiple engagements evaluating federal health care programs. Prior to working in health care, he worked on GAO's Information Technology (IT) team, where he led reviews of a broad range of issues including, most recently, information security. His work has covered many unique areas, including medical device cybersecurity, cloud computing, and human capital issues related to cybersecurity. Prior to GAO, Mr. D'Souza worked on a fellowship for the U.S. Agency for International Development as an advisor to a business consultancy in Amman, Jordan, and before that for several years as a developer of technology training at RWD Technologies. He has an MBA degree from the University of California, Berkeley, and a BS degree in engineering from the University of Maryland College Park.

Philip Ellis, PhD, MPP, returned to the U.S. Congressional Budget Office (CBO) in 2013 after working for two years as a senior vice president in the Center for Health Reform and Modernization at United-Health Group. Prior to that he worked at CBO for over 8 years and served as a leader of CBO's health team during the 2009-2010 debates over health care legislation, focusing primarily on estimating the effects of the provisions affecting insurance coverage. His earlier work at CBO covered a wide range of topics in health care. Prior to joining CBO in 2002, Dr. Ellis was a senior advisor in the Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services and worked in the Office of Economic Policy at the U.S. Treasury Department.

Dr. Ellis holds a PhD degree in economics from the Massachusetts Institute of Technology, a master's degree in public policy from Harvard's Kennedy School of Government, and a BA degree in economics and international relations from Stanford University.

Monica Feit directs the Division of Public Health Services in the Office of Health Policy at the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. Her division works with programs at the Health Resources and Services Administration, the Indian Health Service, and the Agency for Healthcare Research and Quality. Prior to joining the Department of Health and Human Services, Ms. Feit served as a senior program officer at the Institute of Medicine where she led teams on a variety of topics including the integration of public health and primary care, developing a research agenda on LGBT populations, and child abuse and neglect. She worked as an American Public Health Association Government Fellow with the U.S. Senate Committee on Health, Education, Labor and Pensions during the development of the Patient Protection and Affordable Care Act. She has also worked in public health programs in countries as diverse as South Africa, Bosnia, and Niger.

Adam Goldstein is the special assistant to the director of the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS). Prior to joining CMS, Mr. Goldstein served as a speechwriter for Secretary of Health and Human Services Kathleen Sebelius. He also worked for Congresswoman Betty Sutton as health care legislative assistant and for the Glover Park Group as a senior associate in the health care practice. Mr. Goldstein has an undergraduate degree from the University of Maryland and

is in the public management master's degree program at Johns Hopkins University.

CeCe Grant, MA, is a legislative assistant to Rep. Gary Peters (D-MI) covering a portfolio of issues including health care, transportation, labor, higher education, and agriculture. She has a master's degree in legislative affairs from George Washington University and a master's degree in communications from Wayne State University.

Tim Gronniger, MPP, MHSA, is a senior adviser for health care policy at the White House Domestic Policy Council (DPC). His portfolio includes Medicare, health system affordability and quality, and other elements of the Patient Protection and Affordable Care Act of 2010 (ACA). Before joining DPC he served on the professional staff of Ranking Member Henry Waxman (D-CA) at the Committee on Energy and Commerce of the U.S. House of Representatives. There Mr. Gronniger led the staff's drafting and policy development for Medicare and health budgeting issues in the American Recovery and Reinvestment Act and the ACA. Before joining the Committee staff, Mr. Gronniger spent five years at the U.S. Congressional Budget Office, where his portfolio included Medicare Advantage, Medicare budgeting, and private health insurance. Mr. Gronniger holds master's degrees in public policy and health services administration from the University of Michigan (2004) and a BA degree in biochemical sciences from Harvard University (2000), and he has published research in *Demography*, *American Journal of Public Health*, and *Health Services Research*.

Janet Heinrich, DrPH, MPH, is senior advisor at the Center for Medicare and Medicaid Innovation (CMMI), Centers for Medicare & Medicaid Services (CMS), where she assists with State Innovations Models, health workforce evaluation, and portfolio management.

Prior to joining CMMI, she was the associate administrator of the Bureau of Health Professions in the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA). The Bureau of Health Professions provides national leadership on the planning, development, and implementation of strategies and initiatives to expand and improve health professions education and training.

Dr. Heinrich served as senior policy advisor at Health Policy R&D, a strategic consulting group, where she led projects on a wide variety of health policy issues for diverse clients that included global

corporations and national non-for-profit organizations. Previously, Dr. Heinrich directed the public health team at the U.S. Government Accountability Office, where her work focused on providing support and oversight assistance to the Congress on bioterrorism, health workforce, vaccine supply, and other public health issues. She also led the American Academy of Nursing, an organization of over 2,000 elected nurse leaders focused on expanding programs and the presence of nurse leaders in the national research and health policy arena. Earlier in her career, Dr. Heinrich was the director of extramural programs and deputy director at the National Institutes of Health, National Center for Nursing Research.

Dr. Heinrich holds a doctor of public health degree from the Yale University School of Medicine, a master of public health degree from the Johns Hopkins University Bloomberg School of Public Health, and a bachelor of science in nursing from the University of Michigan, School of Nursing.

Craig Lisk, MS, is a senior analyst with the Medicare Payment Advisory Commission (MedPAC). Mr. Lisk has been with MedPAC since the Commission was established and has worked on a variety of issues, including hospital payment policies and graduate medical education financing. He has also worked extensively on the Commission's analyses examining hospital readmissions, payment bundling, and Medicare's payment policies for post-acute care providers. Prior to MedPAC, Mr. Lisk was an analyst with ProPAC (MedPAC's predecessor), where he led the work on its hospital update recommendations and coordinated the Commission's March report. While there, he also worked on a variety of other issues, including graduate medical education, post-acute care, hospital labor markets, transfer payment, quality, and managed care. Before ProPAC, he worked on Medicare hospital payment policy issues at the U.S. Congressional Budget Office. Mr. Lisk has a MS degree in public policy analysis and a BA degree in political science and statistics from the University of Rochester.

Kimberly Lynch, MPH, is currently the director of the Regional Extension Center (REC) Program, in the Office of the National Coordinator for Health Information Technology (ONC). The REC cooperative grant program is working with organizations across the country to assist primary care providers in priority settings to achieve meaningful use of an electronic health record (EHR) system.

Prior to joining ONC, Ms. Lynch was the operations director for the Michigan Center for Effective IT Adoption (M-CEITA, the REC program for Michigan) at Altarum Institute in Ann Arbor, Michigan. In addition to being responsible for managing the M-CEITA program's start-up strategy, budgets, contracts, and diverse staffing teams to support the EHR adoption process, Ms. Lynch built partnerships with provider networks throughout Michigan as well as of key influencers within those networks, including provider organizations, hospitals, health plans, and professional associations. Ms. Lynch also supported health information technology policy, public health surveillance, strategy, and evaluation projects for states including Vermont, California, and Michigan, and within the U.S. Departments of Defense and Health & Human Services.

Ms. Lynch also served in Michigan Gov. Jennifer M. Granholm's administration as a Health & Human Services policy advisor where she was responsible for developing and implementing medical justice, public health, mental health, long-term care, and women's agenda items. Ms. Lynch also worked in governmental affairs for Blue Cross Blue Shield of Michigan, specializing in policy and legislation related to medical information privacy and security, workers compensation, and long-term care. Ms. Lynch has a master's degree in public health from the University of Michigan and a BA degree from Michigan State University.

Suma Nair, MS, is the director of the Office of Quality and Data in the Health Resources and Services Administration's Bureau of Primary Health Care. The Bureau of Primary Health Care administers the Health Center Program that supports the health care safety net for many underserved people across the country. The Office of Quality and Data (OQD) provides leadership and oversight for quality and performance improvement initiatives across the Health Center program, including the Federal Tort Claims Act (FTCA) medical malpractice liability program, the national quality recognition programs including patient centered medical home, the adoption of health information technology, and the design and implementation of program evaluations.

Ms. Nair earned her bachelor of arts degree in nutrition and a master of science degree in public health nutrition from Case Western Reserve University.

Brent Sandmeyer, MPH, is a social science analyst at the Agency for Healthcare Research and Quality (AHRQ) Center for Delivery, Organization and Markets. Mr. Sandmeyer's current projects include an initiative to increase the efficiency of federally qualified health centers in Maine, developing a quality improvement toolkit for hospitals, and improving the science behind public reports of health care quality. The ultimate goal of this work is to drive improvement of care quality, lower the individual and overall cost of care, and reduce disparities in care. Mr. Sandmeyer received his MPH degree in management and policy from Portland State University, and his BA degree in psychology from New York University.

Jeffrey Stensland, PhD, is a principal policy analyst with the Medicare Payment Advisory Commission (MedPAC), an independent federal body that advises the U.S. Congress on issues affecting the Medicare program. His areas of research include hospital payment, geographic variation, rural health, and physician-hospital integration. Prior to joining MedPAC, Mr. 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 on Medicare policy, the financial performance of hospitals, and rural health issues have been published in several health policy journals. In addition to his research experience, Mr. 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.

Tricia Lee Wilkins, PharmD, PhD, is a pharmacy advisor working in the Chief Medical Office at the Office of the National Coordinator (ONC) for Health Information Technology. Dr. Wilkins received her PharmD degree from the University at Buffalo, the State University of New York, and her master's and PhD degrees from West Virginia University, Department of Pharmaceutical Systems and Policy. She previously worked with the Beacon Community Program supporting community-led efforts to build and strengthen local health information technology infrastructure, improve quality of care, and develop innovative delivery of care models. In this role she also led the ONC-sponsored LDL Challenge, a 16-week rapid cycle quality improvement challenge targeting patients with diabetes across 20

medical practices in five states. Her areas of expertise include pharmacy practice, quality improvement, health outcomes research, and claims data analysis.

Carolyn Yocom, MBA, is a director on the Health Care Team at the U.S. Government Accountability Office (GAO). In over 20 years at GAO, she has worked on a variety of issues related to health care for low-income and vulnerable populations, particularly the Medicaid and state Children's Health Insurance Program. Most recently, she has had responsibility for Medicaid work related to CMS program integrity, Medicaid data systems, and issues related to the federal matching assistance formula for Medicaid. Prior to GAO, Ms. Yocom worked for the government of the District of Columbia (Budget and Health Care Financing Offices), and began her career in the state of Oregon. Ms. Yocom received a bachelor's degree with a major in English from Whitman College in Walla Walla, Washington, and a master of business administration degree with a concentration in the public sector from the Atkinson Graduate School of Management (Willamette University) in Salem, Oregon.

BIOGRAPHICAL SKETCHES

SPEAKERS

Elizabeth “Betsy” Aderholdt was named president and chief executive officer (CEO) of Genesys Health System in April 2011. Ms. Aderholdt had been serving as interim co-CEO of Genesys Health System since February 2011 and as president of Genesys Regional Medical Center (GRMC) since 2007. As president of GRMC, Ms. Aderholdt was responsible for the overall management and strategic direction of the 410-bed hospital in Grand Blanc, which under her leadership became one of “America’s 50 Best Hospitals” as designated by HealthGrades. She was also instrumental in leading the organization in its 2009 creation of co-management companies jointly owned by Genesys and physician investors. The model for these companies is already being recognized as a national leading practice for creating hospital/physician alignment to improve outcomes for quality, efficiency and patient satisfaction.

Prior to joining Genesys, Ms. Aderholdt served as president at St. Mary’s Health Center in Jefferson City, Missouri, for five years. She was responsible for strategic and financial planning, managed care contracting, fund development, and operations of an integrated delivery system for a nine-county service area. Prior to her role as president at St. Mary’s, Ms. Aderholdt was executive vice president and chief operating officer of the health center for two years. In this position, she prepared the facility for a successful Malcolm Baldrige site visit that yielded this highly coveted national award. Ms. Aderholdt’s health care administration career spans nearly 30 years, at sites including Carilion Health System in Virginia, where she directed the integration of ambulatory services and inpatient care; Piedmont Medical Center in Georgia; and Sunhealth in Georgia.

Sharifa Alcendor is director of patient care management and assistance at the Henry Ford Health System.

Mary Alice Annecharico, RN, MS, was appointed in December 2011 as senior vice president and chief information officer for the Henry Ford Health System, responsible for the strategic planning and delivery and support of its integrated delivery systems including Project Helios revenue cycle, electronic health record, physician and patient portals, as well as information technology (IT) improvement services across Henry Ford. With an appreciation for the complexities at the

organizational level, Ms. Annecharico plays a major role in fostering the organizational capability needed to extract greater value from IT investments. She is widely recognized for her ability to transform information technology services into highly effective, cross-disciplinary teams responsible for using technology resources to improve services and realize the strategic goals of the organization.

Ms. Annecharico is a registered nurse with an extensive nursing leadership background and more than 20 years' experience in transforming clinical and business environments through the uses of technology. In her previous roles as chief information officer at the University of Pennsylvania School of Medicine and University Hospitals of Cleveland, she collaborated with academic colleagues, peer institutions and industry leaders on the interpretation of privacy and security and clinical research standards for academic organizations.

Ms. Annecharico has been actively engaged in national efforts to create a sustainable, secure, statewide health information exchange (HIE), offering interoperability between regional and national health information networks to provide access to clinical data and improved, measurable health outcomes.

A fellow in the Health Information Systems Society (HIMSS), she serves as editor for the peer-reviewed *Journal of Health Information Management*, the digital publication of HIMSS. Ms. Annecharico is a nursing graduate from St Vincent's Hospital in New York City, and she holds a BS degree in health care administration from St. Joseph's College and an MS degree in organizational dynamics from the University of Pennsylvania.

Vernice Davis Anthony, MPH, is the director of the Detroit Department of Health and Wellness Promotion (DHWP). Ms. Anthony has more than 40 years of leadership experience in the health care field and is known for her success in health policy development. Prior to joining DHWP, she formed her own health care consulting company, and previously she served as president and chief executive officer of the Great Detroit Area Health Council and as senior vice president with St. John Health System. Ms. Anthony's other prior positions include Michigan Department of Public Health director, assistant county executive of Wayne County, and director of Public Health Nursing for the City of Detroit. She holds a nursing degree from Wayne State and a master's degree in public health from the University of Michigan. Ms. Anthony has also served on numerous

committees and boards, including Wayne County Airport Authority Board, Western Michigan University Board of Trustees, Focus: HOPE Board of Trustees, the new Detroit Board, and Wayne State University Board.

Wayne Bradley, Sr., is presently the president and chief executive officer of Detroit Community Health Connection (DCHC), a non-profit community-based primary health care organization, founded in 1988 to provide comprehensive medical health care to the uninsured and underinsured residents of the City of Detroit regardless of their ability to pay. DCHC is a federally qualified health center (FQHC) supported by federal grants, administrated by the Bureau of Primary Health Care (BPHC) and the U.S. Department of Health and Human Services (DHHS). DCHC has five health centers located in the City of Detroit.

Mr. Bradley spent 27 years with The Wellness Plan, a state licensed HMO (health maintenance organization) predominately serving the public sector; there he held numerous executive positions from his first, administrator of consumer relations, to his last, director of government and community affairs.

Mr. Bradley has also served the citizens of Detroit as a police officer, receiving the City's highest citation and the Medal of Valor when he was severely wounded in an armed robbery attempt in 1970.

Mr. Bradley is the ex-officio Member of Detroit Community Health Connection's Board of Directors; chairman of the Board, Detroit Area Agency on Aging (DAAA); chairman of the Board for Northeast Guidance Center; and chairman of the FQHC Council of SE Michigan. He recently served on the Region V Board of the National Association of Community Health Centers (NACHC) and the Legislative, Finance and Credentials Committees of NACHC; still serves on the Board of Directors of Metropolitan Branch of the YMCA; the Board of Directors for the Greater Detroit Area Health Council, Board of Directors' Secretary for Behavioral Health Professionals, Inc., Board of Directors of Black Family Development, the Board of Directors of Jefferson East Business Association (JEBA), the College of Health Professionals of the University of Detroit Mercy School of Nursing and the Board of Visitors of the Oakland University School of Nursing. He is a member of the Detroit Wayne County Health Authority Patient Care Network; and current chair of COSA (Commission on Senior Adults – City of Southfield). He is also on the advisory boards for the Arab American & Chaldean Council (ACC).

Darlene Burgess is vice president of corporate government affairs for the Henry Ford Health System. As senior legislative policy executive for two of the nation's premier health systems, she has been instrumental in developing a strong presence for integrated health care systems at federal and state levels.

Ms. Burgess serves on legislative committees of the American Medical Group Association, American Hospital Association, American Medical Association, Premier, and the American Association of Medical Colleges. She has initiated coalitions to address key federal and state issues including delivery system reform and cost control. She manages a broad state and federal legislative and regulatory agenda for Henry Ford Health System, including grassroots advocacy and consultants.

Before joining the Henry Ford Health System, she served as director of government affairs for Group Health Cooperative of Puget Sound, one of the nation's earliest hospital-based group-practice health care systems, located in Seattle, Washington. Ms. Burgess was government relations director for the Washington State Department of Revenue and established the first public affairs program for Harborview Medical Center, a large inner-city teaching and research hospital affiliated with the University of Washington in Seattle. She was legislative staff to the revenue and taxation and social service committees of the Washington State Legislature, as well as grant management staff at the California Council on Criminal Justice.

Ms. Burgess completed her BA degree at the University of Washington in Seattle. She has a post-graduate degree in Early Childhood Education. She attended the University of San Jose, Costa Rica (Central America), and completed the Harvard University Executive Program, Harvard Medical School & School of Public Health.

Kimberlee Coleman, MD, is the medical director of United Physicians, Inc., Michigan's largest independent physician organization. In this role, Dr. Coleman works with over 2,100 physicians in the Greater Detroit area to optimize their practices and promote understanding of the changes occurring in health care. Prior to her appointment, Dr. Coleman served as United Physician's associate medical director, co-chair of the Physician Advocacy Cabinet, and physician lead on United Physicians' efforts in Blue Cross Blue Shield of Michigan's Physician Group Incentive Program and Patient-Centered Medical Home (PCMH) initiatives.

In addition to her responsibilities with United Physicians, Dr. Coleman is a practicing pediatrics physician at Birmingham Pediatrics and Wellness Center. Prior to joining Birmingham Pediatrics, Dr. Coleman was founder and co-owner of a highly successful pediatric practice in Bloomfield Hills, Michigan, which achieved Blue Cross Blue Shield of Michigan PCMH designation in 2010. Dr. Coleman has been featured in Blue Care Network's Provider Spotlight.

Dr. Coleman received her undergraduate degree from Albion College in 1984 and her medical degree from University of Michigan in 1988. She completed her residency in pediatrics at St. Louis Children's Hospital in St. Louis, Missouri, in 1991 and she also served as chief resident in 1992. Dr. Coleman is certified by the American Board American Board of Pediatrics.

James M. Connelly, MBA, is executive vice president of finance and administration, chief financial officer, and treasurer for Henry Ford Health System. In this capacity, Mr. Connelly is responsible for managing the fiscal affairs of the System, including capital planning and other related matters that ensure the integrity of the System's fiscal strength. He also is responsible for managing investments, real estate, and insurance, and he has extensive experience with establishing operational guidelines for insurance companies, communicating with domestic regulatory agencies, and developing business strategies.

Mr. Connelly came to Henry Ford Health System from TriHealth, Inc., in Cincinnati, Ohio, where he served as senior vice president and chief financial officer. TriHealth is a joint operating organization sponsored by Bethesda, Inc., and Catholic Health Initiatives that provides a complete range of health care services. Previously, Mr. Connelly was senior vice president and chief financial officer of Bethesda, Inc. While in Cincinnati, he was also senior vice president and chief operating officer of Bethesda North Hospital. He worked 15 years for Arthur Andersen in Detroit, the last three years as an audit partner.

Mr. Connelly holds a bachelor's degree in accounting from Central Michigan University and a master's degree in business administration from the University of Detroit. He is a certified public accountant and a member of the Healthcare Financial Management Association.

William A. Conway, MD, is chief executive officer of Henry Ford Medical Group; executive vice president and chief quality officer of

Henry Ford Health System; and a pulmonologist. Dr. Conway leads the 1,200-physician medical group. In 2013, he was selected one of “50 Most Influential Physician Executives” by Modern Healthcare and one of “50 Experts Leading the Field of Patient Safety” by Becker’s Hospital Review. Dr. Conway played a key role with Henry Ford, receiving the National Business Group on Health Award, the Eisenberg Award for the No Harm Campaign, and the Malcolm Baldrige National Quality Award in 2011. He is a past chair of the American Medical Group Foundation; past president of the American Medical Group Association, where he developed the Acclaim Award for Quality Improvement; and founder of the Group Practice Improvement Network.

Herman B. Gray, MD, MBA, is executive vice president, pediatric health services, at Children’s Hospital of Michigan (part of the Detroit Medical Center). At CHM, Dr. Gray served previously as president, chief operating officer, chief of staff, pediatrics vice chief for education, and director of the pediatric residency program. He also served as associate dean for graduate medical education (GME) and vice president for GME at Wayne State University School of Medicine and the Detroit Medical Center, respectively. In addition, Dr. Gray has held the positions of chief medical consultant for the Michigan Department of Public Health Division of Children’s Special Health Care Services and vice president and medical director of clinical affairs for Blue Care Network. During the 1980s, he was a private practicing pediatrician in Detroit.

Dr. Gray’s service includes many national, state, and local committees including the Medicaid and CHIP Payment and Access Commission (MACPAC), the founding board of directors of the Children’s Hospital Association, the Children’s Hospitals International Executives Forum, the CATCH Board of Trustees, The Skillman Foundation Board, the Green Path Board, the Detroit Symphony Orchestra Board, and the Plymouth Educational Center Board.

In 2012, Dr. Gray was inducted into the Sparky Anderson’s Charity for Children: CATCH Hall of Fame. He is a recipient of the 1st Annual IMHOTEP Award of Excellence by the Unified Detroit Coalition and the 2011 Humanitarian of the Year Award from the Michigan Roundtable for Diversity and Inclusion; in 2010 he was named a Top 25 Minority Executive in Healthcare by Modern Healthcare Magazine, and in 2008 he received the Health Care Leadership Award from the Michigan Health and Hospital Association.

He received his medical degree from the University of Michigan in Ann Arbor and an executive master of business administration degree from the University of Tennessee.

Ricardo Guzman, LMSW, MPH, has more than 41 years' experience working with health and human service programs targeting the southwest Detroit Hispanic community. He has graduate degrees from Wayne State University and The University of Michigan. Since 1983, Mr. Guzman has served as chief executive officer (CEO) for the Community Health and Social Services Center (CHASS), a federally qualified health center (FQHC) organization with two locations in Detroit. The Centers provide a full range of culturally competent primary health care and social services to the residents of Detroit with special emphasis on the underserved African American and Hispanic populations.

During his tenure as CEO, Mr. Guzman has been successful in obtaining federal, state, and local governmental and foundation grant funding to plan and implement several major community-level interventions addressing diabetes, intimate partner violence, and school-based health services in Detroit. He serves as principal investigator for 'LA VIDA' (a multi-component community intervention addressing domestic violence against Latina women). Through his involvement with the Detroit Community-Academic Urban Research Center, based at the University of Michigan, Mr. Guzman serves as a leading advocate for community participation in the planning and implementation of health programs relevant to minority communities.

Mr. Guzman is an active member in several local and national organizations including the National Association of Community Health Centers (currently, chair of the Health Policy Committee and elected member of the Executive Committee), the Detroit Wayne County Health Authority Primary Care Network, and the National Alliance for Hispanic Health. He has received numerous awards including the National Hispanic Health Leadership Award in Washington, DC, the Zenobia Payne-Drake Humanitarian Award from the Detroit Black Family Development agency and the National Association of Social Workers; and Michigan Social Worker of the Year Award for 2010.

Mary Ellen Howard, RSM, is a native Detroiter, a Sister of Mercy, and a nurse. She received her BSN degree from Mercy College of Detroit, her master's degree in health care management from the University

of Wisconsin School of Business at Madison, and was conferred an honorary PhD degree by the University of Detroit Mercy.

Since 1995, she has served as executive director of St. Frances Cabrini Clinic of Most Holy Trinity Church, the oldest free medical clinic in the nation. Founded in 1950, the clinic provides free primary care, prescription assistance, and mental health treatment to uninsured poor families in the Corktown neighborhood of southwest Detroit.

Previously, Sr. Mary Ellen served for 20 years as a health care administrator in Mercy hospitals across Michigan, including as chief executive officer in Grayling and Muskegon. While in Grayling in the mid-1980s, she established Riverside Domestic Violence Shelter. In the mid-90s, she implemented a school-based health center, the Jordan Health Center, at Marcus Garvey Academy in Detroit. She is an affiliate associate professor at University of Detroit Mercy and a visiting scholar at the University of Michigan School of Public Health. Sr. Mary Ellen serves on several local boards, including the Detroit Wayne County Health Authority, and is a vocal advocate for healthcare access for all.

Bret Jackson is president of the Economic Alliance for Michigan (EAM). Established in 1982, the Alliance is a statewide business/labor coalition working on topics of mutual interest. Issues the Alliance is concerned with include transportation, unemployment insurance, workers compensation, and health care. Given the ever-rising costs, EAM has strong focus on health care issues providing both a consumer and purchaser perspective. Mr. Jackson began working at the Alliance in 2007 and became president in January 2011. Prior to joining EAM, he worked in the Michigan Senate as a policy advisor, legislative aide, and deputy chief of staff.

Charles E. Kelly, DO, is president and chief executive officer of the Henry Ford Physician Network (HFPN). In this role, Dr. Kelly leads the development and implementation of a coordinated system of care delivery that aligns almost 1,900 physicians and hospital and ancillary services around new initiatives for clinical integration and quality improvement efforts. This work will result in higher quality and greater efficiency of health care services in southeast Michigan.

A graduate of Rutgers University, Dr. Kelly received his medical degree from the Philadelphia College of Osteopathic Medicine and

completed his residency in internal medicine and gastroenterology at Botsford General Hospital.

He initially served as medical director before being appointed chief of staff at Saint Joseph Mercy Livingston Hospital, where he served four terms. During this time, he also served on the Saint Joseph Mercy Health System Joint Chiefs Council, Physician Council, and served ten years as the chair of the Quality Steering Committee, where he was responsible for prioritization and implementation of all clinical quality improvement efforts. In 2006, he was appointed vice president medical affairs and chief medical officer (VPMA/CMO) of St. Joseph's Healthcare and Regional VPMA/CMO of Henry Ford Macomb Hospitals.

Among his other professional activities, in 2007, Dr. Kelly was appointed by Gov. Jennifer Granholm to the State of Michigan Board of Osteopathic Medicine and Surgery, serving a three-year term as vice chairman. He was reappointed by Gov. Rick Snyder and currently serves as the chair of the Licensing Board.

Dr. Kelly served 14 years as flight/fighter surgeon in the Michigan Air National Guard, achieved the rank of Colonel and was awarded the Air Force Commendation Medal and Meritorious Service Medal.

Kate A. Kohn-Parrott, MBA, was appointed president and chief executive officer of the Greater Detroit Area Health Council (GDAHC) in January 2012. A strategic finance and human resources/benefits management expert, Ms. Kohn-Parrott has a proven track record of leading the transformational changes needed to steer organizations through periods of both accelerated growth and economic downturn. She has been instrumental in shaping health care reform at the local and state levels.

Ms. Kohn-Parrott holds a master of business administration degree from the University of Detroit Mercy and a bachelor's degree in business administration (accounting) from Eastern Michigan University. She holds certificates from the Stanford University Executive Program and the Managing Business Program at Insead (France). She is a certified management accountant and a certified internal auditor.

Ms. Kohn-Parrott chairs and serves on a number of public boards. She has won numerous awards for her work in health care benefits management.

Conrad L. Mallet, Jr., JD, MPA, MBA, was reappointed chief administrative officer of Detroit Medical Center in January 2012, after serving as president and chief executive officer of Detroit Medical Center's Sinai-Grace Hospital from August 2003 until December 2011. Prior to that, Justice Mallett served as the chief legal and administrative officer of the Detroit Medical Center beginning in March 2003. Previously, he served as president and general counsel of La-Van Hawkins Food Group, LLC, from April 2002 to March 2003, and chief operating officer for the City of Detroit from January 2002 to April 2002. From August 1999 to April 2002, Justice Mallett was general counsel and chief administrative officer of the Detroit Medical Center. He was also a partner in the law firm of Miller, Canfield, Paddock & Stone from January 1999 to August 1999. Justice Mallett was a justice of the Michigan Supreme Court from December 1990 to January 1999 and served a two-year term as chief justice beginning in 1997. He is a director of Kelly Services, Inc. Justice Mallett has a bachelor's degree from the University of California, Los Angeles; a JD degree from the University of Southern California; a master of public administration degree from the University of Southern California; and a master of business administration degree from Oakland University.

Jean Malouin, MD, MPH, has been a medical director with Blue Cross Blue Shield of Michigan (BCBSM) since 2012. In this role, she works with the Value Partnerships team on the Patient-Centered Medical Home, Organized Systems of Care, and other BCBSM initiatives. She has also served as physician lead for the development of a Care Management Resource Center. This collaborative effort between BCBSM and the University of Michigan has facilitated the development of primary and specialty care management throughout the state of Michigan. Dr. Malouin is currently serving as medical director and co-project lead for the Michigan Primary Care Transformation Project, a state-wide Michigan multi-payer patient-centered medical home (PMCH) demonstration project involving almost 400 PCMH-designated practices. This project is responsible for training and integrating over 350 care managers into participating practices. She has also been a faculty member in the Department of Family Medicine at the University of Michigan since 1994. She currently holds the position of associate medical director for the Faculty Group Practice at the University of Michigan. She maintains her clinical practice at Briarwood Family Medicine in Ann Arbor, where she served as medical director from 1996 to 2008. Dr. Malouin received her medical degree from the University of Michigan in 1991, where she also

completed a master of public health degree in health management and policy in 2000.

Naim Munir, MD, was appointed senior vice president and chief medical officer of the Health Alliance Plan (HAP) in August 2011. Dr. Munir leads the strategic direction of HAP's clinical programs in partnership with the region's premier health care providers. He oversees HAP's Network Development and Provider Relations, Provider Contracting, Health Care Management, Health Management Services, Credentialing, Pharmacy Care Management, Quality Management and Health Performance Management teams.

Dr. Munir is a highly seasoned clinical health plan leader with a proven track record in leading results-oriented, high-performance teams. His passion for measuring and improving the health of populations is evidenced by his ten years of service as a physician reviewer for the National Committee for Quality Assurance (NCQA), and through his two-term appointment to the NCQA's national Review Oversight Committee.

Over the course of his career, Dr. Munir has held key leadership roles at health plans spanning commercial, Medicare, and Medicaid operations. He joins HAP from the Principal Financial Group in Des Moines, Iowa, where he served as chief medical officer at the Health Division of the publicly traded company with health insurance operations in 32 states. Prior to that, he served as executive medical director for quality and care management at Horizon Blue Cross and Blue Shield of New Jersey, as well as chief operating officer at Amerigroup Corporation of New Jersey and vice president for health services at PacifiCare's Southwest region.

Dr. Munir received his medical degree from Rush Medical College in Chicago and completed his family practice residency at Lutheran General Hospital in Park Ridge, Illinois.

Thomas Nantais, MBA, has been with the Henry Ford Health System (HFHS) for 27 years and is presently the chief operating officer (COO) of the Henry Ford Medical Group (HFMG), one of the nation's largest medical groups. His responsibilities include the administrative management of the Medical Group's \$750 million operating budget, covering 26 ambulatory sites and 4,000 full-time staff, including the 1,100 employed physicians who provide service in over 40 medical and surgical specialties. In addition, Mr. Nantais administers the Group's physician compensation programs. He is a member of

several key HFHS leadership committees, including the CEO Forum, Strategy Execution Team and System Quality Forum, and also holds an ex-officio position on the HFMG Board of Governors.

Before being appointed HFMG COO in August 2005, Mr. Nantais was the medical group's chief financial officer for 12 years. His previous HFHS positions include assistant vice-president of corporate finance, where he was responsible for business plan development and merger/acquisition analysis, and numerous other financial management positions.

Mr. Nantais worked in the insurance industry prior to joining Henry Ford Health System. He earned his bachelor and master of business administration degrees from Wayne State University in 1978 and 1982, respectively. He has been an adjunct finance professor at the University of Michigan, Dearborn, for the past 18 years and has conducted numerous workshops at many national meetings and conferences, covering areas such as physician compensation, system integration, and health care financial management.

Currently, Mr. Nantais is a board member of the Michigan Roundtable for Diversity and Inclusion, a not-for-profit company focusing on educating companies on key issues around diversity.

David R. Nerenz, PhD, is director of the Center for Health Policy and Health Services Research at Henry Ford Health System (HFHS). In this role, he is responsible for research on innovation in organization of health care services and for analysis of federal and state health reform initiatives. He is also director of outcomes research for the Neuroscience Institute and vice-chair for research of the Department of Neurosurgery at Henry Ford Hospital. In these roles, he is responsible for fostering clinical research in several specific areas (for example, spine surgery, stroke, traumatic brain injury), supporting translational research of novel approaches to treatment developed by HFHS bench researchers, and leading the development of a statewide quality improvement collaborative for spine surgery. He was appointed in May of 2012 as a commissioner on the Medicare Payment Advisory Commission (MedPAC). He recently served as the chair of the Institute of Medicine (IOM) Committee on Leading Health Indicators for Healthy People 2020 and chair of the IOM Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement. Dr. Nerenz received his PhD

degree in social psychology from the University of Wisconsin, Madison, in 1979.

John Popovich, Jr., MD, is president and chief executive officer of Henry Ford Hospital. Dr. Popovich, the first physician to lead the hospital in more than 40 years, oversees the entire clinical and financial operations of the 805-bed hospital, the medical, educational and research flagship of Henry Ford Health System.

After graduating from the University of Michigan Medical School in 1975, he began his career at Henry Ford with a medical internship followed by residency training—which included serving as chief medical resident—and then a fellowship in the Division of Pulmonary Medicine. He joined the hospital as a senior staff physician in 1980.

Dr. Popovich has been instrumental in the growth of intensive care and critical care at Henry Ford Hospital. While serving as director of the medical intensive care unit, he developed the critical care training program and led the expansion of critical care medicine at Henry Ford Hospital.

He served for ten years as division head of pulmonary and critical care medicine before becoming chair of the Department of Internal Medicine in 1999. He became the health system's senior vice president for clinical affairs in 2008. In this role he was the physician lead in developing the Henry Ford Physician Network. He currently is chief executive officer and chair of the board of this organization.

Dr. Popovich is past chair of the American Board of Internal Medicine Foundation and is a past chair of the American Board of Internal Medicine, the nation's largest physician-certifying board. During his tenure as chair of the American Board of Internal Medicine, he led efforts to expand the recertification program for internal medicine physicians, as well as initiate the development of certification in hospitalist medicine.

In his Foundation role, he led the organization's efforts to advance medical professionalism, working with different health care policy makers and constituents to develop environmental conditions that encourage clinicians to do the right thing in the service of improved quality of care. Dr. Popovich has authored more than 150 journal articles, scientific abstracts, and book chapters. His chief research

interest is the diagnoses of pulmonary thromboembolism and interstitial lung diseases.

Beyond his roles at Henry Ford, Dr. Popovich is a professor at Wayne State University's School of Medicine. He also serves as a member of the American Medical Association, Michigan State Medical Society, Wayne County Medical Society, American Thoracic Society, American College of Chest Physicians, Henry Ford Hospital Alumni Association, and the American College of Physicians. In 2005 he became a Master in the American College of Physicians, the highest honor bestowed by the organization.

Robert Riney was appointed president and chief operating officer of Henry Ford Health System in 2011. In this role, Mr. Riney oversees all hospital and service operations for the six-hospital health system consisting of more than 60 clinical locations; 24,000 employees; and annual revenues of \$4.2 billion. In addition, he is responsible for corporate services, including, information technology, planning and management services, quality and strategic business development, compliance, diversity and the System Chief Nursing Office.

Mr. Riney, a graduate of Wayne State University, joined Henry Ford Health System in 1978 and has had the privilege throughout his career to work in almost every business unit in the System. As a result of this rare career track, he has a deep understanding of health system operations and organizational culture and its impact on operating performance. He has held numerous Henry Ford Health System leadership positions, including: executive vice president and chief operating officer (2003–2011), senior vice president and chief administrative officer (2002–2003), senior vice president and chief human resources officer (2000–2002), and vice president of organizational design and effectiveness (1998–2000).

Mr. Riney's current board and community roles include: board member, Nemours Foundation; vice chair, National Center for Healthcare Leadership (NCHL); board member, Michigan Health & Hospital Association (MHA); board member, ACCESS; and board member, Greater Detroit Area Health Council (GDAH). His past board and community roles include board president/board member, Dominican Healthcare Board; president, American Society for Healthcare Human Resources Administration; and board member, American Hospital Association Commission on Workforce.

Jay B. Rising, JD, joined the Detroit Medical Center (DMC) as chief financial officer in February 2006 and currently serves as executive vice president & chief strategy officer. Prior to accepting the DMC's invitation, he was Michigan's 42nd state treasurer under Gov. Jennifer Granholm, where he oversaw the collection, investment, and disbursement of state monies and public pension funds. Previously, Mr. Rising was with the law firm Miller, Canfield, Paddock and he was president of Metropolitan Realty Co. His more than 20 years of experience includes providing strategic financial counsel to the city of Detroit, Wayne County, and the state of Michigan. Mr. Rising received his juris doctor degree from the Wayne State University Law School and received his bachelor of arts degree from the University of Michigan.

Eric Scher, MD, is chair, Department of Internal Medicine for Henry Ford Hospital and Henry Ford Medical Group, and vice president of Medical Education for Henry Ford Health System. As chair, he leads the largest clinical, educational, and research enterprise at Henry Ford. As vice president, he oversees all medical education activities for the Health System and leads a successful relationship with Wayne State University School of Medicine in medical student education. He has held committee responsibilities in ACGME (the Accreditation Council for Graduate Medical Education) and AP-DIM (Association of Program Directors in Internal Medicine) and has been active in the American College of Physicians (ACP), organizing and directing meetings, national committee involvement, mentoring resident poster contributions, contributing to continuing medical education projects, serving as a reviewer for the Annals of Internal Medicine, and a long-standing member of the Michigan Chapter Council. He has received numerous internal teaching awards, the ACP Michigan Chapter Laureate Award, the ACP Governors Award, and the ACGME Parker J. Palmer Teacher Award. He continues to practice both ambulatory and inpatient medicine. For decades, Dr. Scher has done extensive community service with the volunteer physicians at St. Francis Cabrini Clinic, for which he received the Good Samaritan Award.

Nancy Schlichting, MBA, is chief executive officer of Henry Ford Health System (HFHS), a nationally recognized \$4.5 billion health care organization with 23,000 employees. She is credited with leading the health system through a dramatic financial turnaround and for award-winning patient safety, customer service, and diversity

initiatives. She joined HFHS in 1998 as its senior vice president and chief administrative officer and was named president and chief executive officer in 2003. Her career in health care administration spans over 30 years of experience in senior-level executive positions.

Ms. Schlichting serves on several national and community boards including The Kresge Foundation, Walgreen Company, Federal Reserve Bank of Chicago – Detroit Branch, Detroit Regional Chamber (Past Chair), Citizen’s Research Council of Michigan, Detroit Economic Club, and Downtown Detroit Partnership.

Some of Ms. Schlichting’s awards include: 2013 Becker’s Hospital Review Annual Healthcare Leadership Award, Michigan Health & Hospital Association “ Meritorious Service Award,” , and Health Care Weekly Review “Health Care Executive of the Year.”

Ms. Schlichting received her AB degree in public policy studies, magna cum laude, from Duke University and her MBA degree from Cornell University. She has also been the recipient of honorary doctoral degrees from Walsh College and Central Michigan University.

Mary Ann Tournoux is the senior vice president and chief marketing officer of Health Alliance Plan (HAP), one of the state’s largest nonprofit health plans with more than 620,000 members. HAP is a subsidiary of the Henry Ford Health System.

As chief marketing officer, Ms. Tournoux leads HAP’s strategic planning, sales and product line expansion for commercial, individual, Medicare, and public sector business. Community outreach, work-site wellness, market research, advertising and communications also fall under her areas of responsibility as she positions the health plan as a health and well-being company and prepares HAP for market opportunities under health care reform.

Ms. Tournoux brings to Detroit and to HAP a national perspective gleaned from more than 25 years of marketing management and health plan leadership experience. She previously served as vice president of sales and marketing at the 300,000-member Health Alliance Medical Plan in Urbana, Illinois. Prior to joining Health Alliance Medical Plan in 2004, she was the vice president, sales and marketing for HomeTown Health Network in Ohio and has held sales management positions in western Pennsylvania and northern West Virginia.

Ms. Tournoux serves on the board of directors of HAVEN, a community nonprofit organization that helps women who are victims of rape, abuse, and domestic violence find hope and regain control over their lives. She also served as a trusted health care advisor on the Crain's Healthcare Leadership Summit strategic planning committee, a role in which she helped to develop an agenda that attracted more Michigan business leaders to the conference. Prior to moving to Michigan, she was on the Board of Directors for the Western Stark Medical Clinic, Catholic Charities for Stark County, and the Domestic Violence Shelter in Canton, Ohio.

Ms. Tournoux holds a bachelor's degree in Business Administration from The Ohio State University.

Marianne Udow-Phillips, MHSA, is director of the Center for Healthcare Research & Transformation (CHRT) at the University of Michigan. CHRT is a non-profit partnership of the University of Michigan (U-M) and Blue Cross Blue Shield of Michigan to promote evidence-based care delivery, improve population health, and expand access to care. From 2004 through 2007, Ms. Udow-Phillips was director of the Michigan Department of Human Services, appointed by Gov. Jennifer M. Granholm. Ms. Udow-Phillips came to state service from Blue Cross Blue Shield of Michigan, where she served in leadership roles for over 20 years, most recently as senior vice president of Health Care Products and Provider Services. She holds a master's degree in health services administration from the U-M School of Public Health; she is a lecturer at the U-M School of Public Health. She serves on numerous boards and commissions including the HighScope Educational Research Foundation, the Early Childhood Investment Corporation, Freedom from Hunger, the U-M School of Public Health Dean's Advisory Committee, the U-M Depression Center's National Advisory Board, Arboretum Ventures Advisory Board, Carepoint Resources board of directors, and the External Advisory Group for the VHA Center for Applied Healthcare Studies.

Mary Whitbread is vice president of reimbursement and managed care contracting at the Henry Ford Health System.

Suzanne R. White, MD, MBA, was named executive vice president, chief medical officer for Detroit Medical Center (DMC) in December 2010. Dr. White has been affiliated with DMC for 22 years, starting out as a resident and later, chief resident of emergency medicine at

DMC Detroit Receiving Hospital. She has extensive training in specialized areas of emergency medicine including medical toxicology, notably toxic agent training and lead poisoning, terrorism incidents, hyperbaric medicine, and other environmental emergency operations. She is a Wayne State University School of Medicine professor and the recipient of numerous awards and honors, including several HOUR Detroit Top Docs recognitions and the 2010 Wayne State University Distinguished Alumna Award. She earned her MD degree with high distinction from Wayne State University School of Medicine and a physician executive master of business administration degree from the University of Tennessee. She completed a fellowship in executive leadership in academic medicine at Drexel University.

Kimberlydawn Wisdom, MD, MS, senior vice president of community health & equity and chief wellness officer at Henry Ford Health System, is a board-certified emergency medicine physician who practiced for 20 years at Henry Ford Health System. She also founded and directed both the Institute of Multicultural Health at Henry Ford Health System (HFHS) and a National Minority Quality Forum award-winning community-based health screening initiative entitled “AIMHI” (African American Initiative for Male Health Improvement), which focused on improving the health of those disproportionately affected by poor health outcomes. Dr. Wisdom is an adjunct assistant professor of medical education at the University of Michigan (UM) Medical Center, and serves as adjunct assistant professor in the Department of Health Behavior and Health Education at UM School of Public Health.

In February 2003, Gov. Jennifer M. Granholm took an important first step toward revitalizing public health in Michigan by appointing Dr. Wisdom as Michigan’s—and the nation’s—first state-level surgeon general to address Michigan’s less-than-desirable health status. Dr. Wisdom focused on physical inactivity, unhealthy eating habits, childhood lead poisoning, tobacco use, chronic disease, infant mortality, unintended pregnancy, and health disparities, among other areas of concern. She is the recipient of numerous awards, has authored several peer-reviewed publications, and has presented to audiences across the country and internationally.

In April 2007, Dr. Wisdom returned to HFHS as vice president of community health education and wellness while retaining her post as surgeon general. She continues to develop and lead efforts that

improve the health of the community. She leads quality initiatives to address health care equity and health disparities and provides clinical leadership to community; directed a \$5 million W.K. Kellogg Foundation-funded project called “Generation with Promise” designed to reverse childhood obesity trends in a generation. Dr. Wisdom provides strong leadership in community health education, focusing on clinical quality and patient safety/equity, and cultural competency. She guides efforts to secure grant funds to conduct research and demonstration projects. She also manages over \$5 million in grant funding to address infant mortality reduction, childhood obesity prevention, and physical inactivity (Instant Recess®). Her responsibilities include LiveWell - the Wellness Center of Excellence, the Institute on Multicultural Health, Community Health Programs & Strategies and Organizational Special Projects.

In March 2011, Dr. Wisdom was promoted to senior vice president of community health & equity and chief wellness officer and also stepped down as state surgeon general when the Governor completed her second term. In February 2012, Dr. Wisdom was appointed by President Barack Obama to serve as a member of the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health.

BIOGRAPHICAL SKETCHES

FORUM STAFF

Judith Miller Jones, MA, 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 informational 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 lecturer in health policy in the School of Public Health and Health Sciences 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 U.S. 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, first as a programmer, a systems analyst, and then as a special marketing representative in instructional systems. While at IBM, Ms. Jones studied at Georgetown Law School and completed her master's degree in educational technology at Catholic University. As a complement to her work in the federal arena, Ms. Jones is involved in a number of community activities in and around Shepherdstown, West Virginia, including chairing Healthier Jefferson County, a committee dedicated to improving public health and medical care in that area of the Eastern Panhandle.

Sally Coberly, PhD, serves as deputy director of the Forum, where her principal responsibilities include managing internal operations, overseeing grant writing and reporting to external funders, and developing programming on private market issues. Prior to joining the Forum in June 2000, she was director of public policy at the Washington Business Group on Health (WBGH), a membership organization of large employers. Before joining WBGH, Dr. Coberly was a senior research associate at the University of Southern California's Andrus Gerontology Center (1979-1990), where she conducted research on a variety of aging and health care issues including

long-term care systems development. She directed the Andrus Center's National Policy Center on Employment and Retirement from 1983 to 1985. Dr. Coberly was elected a fellow of the Gerontological Society of America in 1985. Dr. Coberly received her PhD degree in 1979 from the University of Southern California's Center for Public Affairs. She holds a master's degree in urban and regional planning, also from the University of Southern California, and a bachelor's degree in political science from Kansas State University.

William J. Scanlon, PhD, is a senior consultant to the National Health Policy Forum. He is also currently a member of the National Committee on Vital and Health Statistics and the American Board of Surgery. He has served on the Medicare Payment Advisory Commission, the Visiting Nurse Service of New York Board of Trustees, the National Commission for Quality Long-Term Care, the U.S. Department of Health and Human Service's (HHS's) Negotiated Rule-Making Committee to Define Health Professional Shortage Areas, the 2005 White House Conference on Aging Advisory Committee, and as co-chair of the 2004 HHS Technical Panel for the Medicare Trustees Report. Until April 2004, he was the managing director of health care issues at the U.S. General Accounting Office (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. 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. 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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**SITE VISIT
REPORT**

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