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STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL ADVISORY COMMISSION
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P U B L I C H E A R I N G

December 16, 2002
University of Michigan
911 North University Drive
Ann Arbor, Michigan

Panel - ARTHUR PORTER, M.D., Chairman
Detroit Medical Center
JAMES K. HAVEMAN, JR., Member Ex-Officio
Department of Community Health
ROD NELSON, Member
Mackinac Straits Hospital
LARRY WARREN, Executive Director
University of Michigan Hospital

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Jeanne Trudeau, CER-6845

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(Hearing scheduled to start at 4:00 p.m.; actual start time was 4:08 p.m.)

MR. WARREN: I would ask if you have any other items you'd like to discuss, to do it before this session begins. Dr. Porter?

DR. PORTER: Thank you very much, Larry. And let me

introduce Rod Nelson, the CEO of Mackinac Straits Hospital who's one of our commissioners, and Director Jim Haveman, Director of the Department of Community Health. What we've been tackling over the last six months as a hospital advisory commission is to look at several issues that are important as we try to look at strategies to help government with health care and some of the health care issues.

The Hospital Advisory Commission was created in the summer by Executive Order 2002-15, and part of the process was to, within the year, develop a report that outlines some of the issues that are important to you, to health care providers, et cetera, on a range of issues. The issues were those of funding, how we could look at garnishing most out of State, Federal, and other funding; looking at medical safety and security issues; and evaluating the future of health care, how we would interact with the life sciences corridor, how research would be important, and how we could, in fact, develop mechanisms

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to, say, partner with the State to reduce pharmaceutical expenses.

The way the Commission has been set up is that representatives were geographically chosen from some of the larger health care systems as well as some of the smaller health care systems that really had a diversity in terms of location within the state, type of institution, type of geography, and type of mission. Our commission met and held it's first hearing on November 20th in Lansing. This is its second meeting; and will over the next few months, meet in Grand Rapids, Detroit, Pontiac, Kalamazoo, Gaylord, and St. Ignace.

On the commission and who are not here for the meeting today is Rick Breon, representing Spectrum Health; Joe Damore, representing Sparrow Health Care System; Phil Incarnati, representing the McLaren Health Care Corporation; Ken Matzick, from William Beaumont Health Care System; and Don Gilmer, who's a member ex-officio as the State Budget Director.

Today we have a line-up of panelists who've asked to testify before the commission and without further adieu, let us start off with Gary Freed, who is director of the Child Evaluation and Research of the Share Unit, Director of the Division of General Pediatrics at the University of Michigan, and who will talk about pediatric research at the

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University of Michigan. Dr. Freed, welcome. Have a seat, and the floor is yours. And we are grateful that you decided to be the "opening act" today.

DR. FREED: It's a privilege to be the opening act, to set the tone.

TESTIMONY BY DR. GARY FREED:

DR. FREED: Thank you very much for allowing us to come and make a presentation before the commission today. We greatly appreciate the opportunity to share with you some of our activities on behalf of the State of Michigan and how we believe that activities of this type can make a significant difference in the health care of children in

this state.
We represent a research unit that works here at the University of Michigan, that's based out of the division of general pediatrics. This research unit has begun a relationship with the State, now dating back three years, where we initially went to the State with the novel concept of we are a state institution, and as -- the fact that we are a state institution, we believe that we have a responsibility to the children of this state, and wanted to bring the ability of our research unit to be able to help provide data and information to the State of Michigan to be able to better evaluate and to better consider the types of

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programs and policies that are now shaping the health care system for the children of this state, and to be able to provide data and information to the State Department of Community Health to be able to make better decisions.
Through this process we have now gone through, on an annual basis, meetings with the heads of the divisions of the Department of Community Health. Each year those heads of those divisions come up with the issues that they believe are of significant importance to the state with regard to children's health. We then go through a prioritization process with them, helping to understand where data will help to make a difference, where people can begin to make decisions based on information rather than just rhetoric, where people can begin to understand the impact of the decisions they make in fairly real time.
Each year those division heads have gone through this process with us. And we've done usually three and sometimes four projects a year on behalf of the State. I'm proud to say that the information that we've provided is fed back directly to individuals within the Department of Community Health, and have a direct impact on policy. And significant changes have been made with regard to policy in the state based on the information that we've provided.
One of the things that we pride ourselves on is that we are purveyors of information, not purveyors of advocacy.

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We believe strongly that somebody out there needs to be able to provide information that can be trusted, no matter who is in authority, whether it be in the legislature or in the governor's mansion. We want people to be able to trust information at any particular time and any particular place. And that's been our goal. And I believe that our relationship with the Department and their continuation of this relationship over time has proven that to be the case. Sometimes the information we provide, they love to hear. Sometimes the information we provide, that wasn't what they were expecting. But, regardless, they know it's the straight information whenever we provide it.
In the remainder of the time that we have, I'd like to give you a couple of examples of the type of projects that we've done for the State, and also our continued willingness to be able to provide information and data for the State, not only to help make future decisions, but also to help understand the impact of the decisions that will be made, the very difficult decisions that will be made over the coming years.

So I'd first like to turn the program over to Dr. Alex Kemper, who is an assistant professor of pediatrics, who will share one of the most recent projects that we've done. He'll be followed by Sarah Clark, who's the associate director for research of our unit, who will share results

of a project she did recently on the use of the emergency department for non-emergent conditions in the state. And then also she'll share with you the upcoming projects we'll be tackling in the next year.

TESTIMONY BY DR. ALEX KEMPER:

DR. KEMPER: Thank you. I'm very pleased to be able to talk about a project that we just recently completed, looking at the State's hearing and vision screening programs. The State, through local public health departments, offers vision and hearing screening for all children, beginning in kindergarten and going through high school. These screening programs are coordinated with the local schools. Screening technicians from the local public health department go into the schools to offer screening. These programs have been in place for more than 30 years, and were placed into the Public Health Code in 1978. Despite the fact that these screening programs have gone on for a long time, they've never been formally evaluated before. It should be recognized that both vision problems and hearing problems are common in school age children, and early detection is thought to confer benefit in terms of better educational outcome and those sorts of issues.

To develop the project, we worked with officials both at the state level and Department of Community Health and

with those people responsible within local public health departments across the state. We chose 10 health department regions representative of the State of Michigan as a whole to complete the evaluation. We met with officials around the state to understand how they thought their program was running. We abstracted data on thousands of children from their files. And from that information we've contacted families to find out from them about the impact of the screening programs. We also discussed these screening programs with selected primary care physicians that had taken care of some of those children.

What we learned was that most of the children who had an abnormal screen did receive follow-up with either a hearing or vision specialist, which was quite a surprise because looking at the Health Department records, it looked like maybe only 20 percent of people had follow-up. The problem is that the system relies a lot upon primary care, the follow-up physicians returning information about the individual child and that there was probably a lesion in that system. A significant amount of energy was spent on the current tracking systems, and clearly we've recommended that the tracking system be modified.

We also found out that for vision screening, the majority of those children who were referred and who had follow-up did end up receiving glasses. So that program

certainly appeared to be very effective. We found out that for hearing screening, that as the child became older, the likelihood of them needing to receive treatment for a hearing impairment fell markedly. And so from that we've recommended that the screening programs be modified to target those children who are at highest risk of hearing or visual impairment.

We are now working with, again, officials at the state and the local health departments to feed this information back. They've been very happy about the information that we've been able to return to them about the effectiveness of the program and I'm excited to see that some change is already occurring in these programs.

TESTIMONY BY MS. SARAH CLARK:

MS. CLARK: Michigan's not alone in having experienced a pretty dramatic increase in use of the emergency department by kids. And one of the issues that the division directors in the Department of Community Health brought to us was looking at the use of the emergency department for non-urgent conditions. And a couple of years ago when the State of Michigan moved to encouraging kids to be in Medicaid-managed care, one of the thoughts was, "We will get these kids in a situation where they have a primary care provider, they have a medical home. We

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should be able to use that setting for regular sick visits, and we should see a move away from the emergency department."

So we were asked to look into that and did so in a "two-parter," as we call it, using two different methods. The first was using Medicaid data, working with the staffers in the department. Those folks do a great job of processing administrative data but don't really have the manpower and sometimes not the analytic expertise to be able to do a large analysis of their data. So we looked at the 1997, which was the last year that most kids were in a fee-for-service arrangement, and the year 2000, which at the time was the most recent year for which we had good data. And it turned out that the longer a child had been enrolled in a Medicaid-managed care plan, the less likely that kid was to use the emergency department for a non-urgent condition. It was good news. It was exactly what we had been hoping for, if you were in a policy position thinking managed care would work. So that was a good finding. Still, though, more than half of those ED visits could potentially have been dealt with in the primary care setting.

So that brings us to the second part of our study, where we actually sent folks out to 13 hospital emergency departments all across the state. And we sat there, and

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when parents brought children in and the condition was coded as "non-urgent," at that lowest triage level, right then and there we talked with the parents about what was wrong, how long had it gone on, who did you attempt to call and what was the response that you got? And I think that's where some of the reasons behind emergency use really started to emerge.

We talked with parents both of privately insured children and of Medicaid children, and there were some pretty clear differences. The parents of the Medicaid enrolled children were much more likely to view the emergency department as a place to go for sick care. In addition, when they did try to call the doctor's office, they often were unsuccessful at getting any advice over the phone -- no one would talk to them or they didn't get a call back -- or they got what the parent interpreted as advice to go to the emergency room. That could have been, "If you think your child is very sick, go to the ED," one of those kind of medicolegal statements, which the parent heard as, "You probably want to take this child in."

So it really articulated an opportunity to intervene on this pattern of use, thinking very clearly we need to better understand how people are seeking advice when their child is sick. We need to understand that parents need help then when they identify -- not necessarily two or

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three days later when an appointment might be available, but at the time that that parent is seeking care. And we need to think of what is the best way to allow those parents to get some medical advice, get some reassurance that the child is okay, and perhaps not have it be in such an expensive setting as the emergency department.

The other thing that we looked at was the difference from plan to plan, among the different Medicaid-managed care plans. And there were quite large differences there. And we were able to attend meetings of the clinical advisory committee for those plans, and give each plan information back on what did their rates look like compared to all the other plans within the State of Michigan. And that was very well received by those folks so they could understand, sort of in the continuum of use, where did they fall so they might know how much emphasis to put on that particular problem.

With regard to the 2002-2003 year, four projects have been decided on already, and we've begun work. The first involves looking at the use of stimulant medication by children enrolled in Medicaid. Stimulant medications like Ritalin are often prescribed to children for Attention Deficit Hyperactivity Disorder. There seemed to be some pretty interesting geographic trends in terms of stimulant use that we have just began to identify. And we'll be

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exploring some of these high prescription and low prescription areas, talking with primary care doctors, talking with school officials, talking with parents, and talking with mental health providers to try to figure out what drives this. At this point we can't say any area is too high or too low. We have to do the background work to really understand what's the basis for these decisions to put kids on these stimulant medications.

We'll also be looking at trends in asthma-related health services utilization. A lot of institutions and health care plans have some sort of asthma management program that's offered at a plan level or an institutional level. We want to dig down and see how do those type of programs affect provider behavior and decision making and

ultimately affect patient outcomes. That's the second one.
We'll be looking at the administration of vaccines by Medicaid providers. Medicaid providers are charged with either administering vaccines directly to children or ensuring that they are provided. And there are a number of children who are enrolled in Medicaid and are not being vaccinated appropriately, somewhere between 25 and 40 percent. We want to look at those children who aren't being vaccinated appropriately and figure out what are the characteristics of the kids, what are the characteristics of the providers, what may need to be done to make sure

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that we do a little better job vaccinating those kids.
And the last one looks at the provision of well care to adolescents, a notoriously difficult population to provide care for, a population that when you generate rates of well care, they always look very horrible. And what we'd like to do is look down at some sub-population of adolescents that may need to have more care than others, and also compare the current Michigan guidelines for well care to other state and national guidelines to see if what we're recommending is really in line with what's going on nationally.
Thanks very much for your time. We'd be happy to answer any questions that you have.
DR. PORTER: Thank you very much. And I think there will be several questions. May I just ask one question firstly, because I think it's a fabulous program that you have. How do you select your projects? I mean, you've got four for this coming year. You've had some excellent ones. Where do you get the projects from?
DR. FREED: Those project come from State themselves, from the heads of those -- directors of the divisions within the Department of Community Health, to make sure that the issues that we address are the ones that are, right now, most relevant to those who are making decisions or put into policy questions.

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DR. PORTER: And then you prioritize them, you determine that?
DR. FREED: We work with those individuals to prioritize -- usually it's a pretty long list every year. We get that narrowed down to 10 projects. We bring those back, put together research briefs where we look at what the policy question is and what are the methods that we might use to answer them. Sometimes we can't put together a method that would be able for us to be able to provide information in the time in which it's needed. We're honest. We say that. And we'll let people know what the limitations of any of the different methods we use are.
DR. PORTER: And my final question is you have had the opportunity now, doing this for a number of years, to sort of see some of your ideas go back. And what has been the response from the other side, in terms of taking your idea and completing that loop --
DR. FREED: I think --
DR. PORTER: -- of changing or modifying policy?
DR. FREED: Extraordinary; it's a very gratifying thing to be a part of. Because rarely does one get the

opportunity to see their work actually have an impact on policy in very real time. And these are very -- for the most part, they're very fast turnaround projects, which is different than many academic centers usually provide. But

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it's our goal to -- it's very -- it's corny, but we want to make a difference. And one of the ways of making a difference is getting information at the time in which it needs to be there to be relevant. If there's a hearing in the legislature on November 14th, the data have to be there prior to that. We can't do a bunch of extra fancy statistical things and have it ready on December 1st, because the decisions are already made. So working with the State partners, they have utilized the information we have provided and, I think, now depend on us for timely, relevant information to help make those decisions.

The bottom line goal is, as I think both the commission is searching for in terms of process, is that we believe that there's a very limited amount of resources for children right now within the State of Michigan. It's our goal to make sure that every dollar spent on kids is a dollar well spent. And that's our purpose, both for the project -- the programs that are already in existence, to make sure that they're relevant, but also for those that people propose, to make sure that there's evaluation mechanisms in place so that anything new we do isn't just innovative, but it's innovative that actually makes a difference.

DR. PORTER: Thank you.

MR. WARREN: I just have one question. It was

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referenced that -- in these -- in the site visits to the 13 or so hospitals and these parents and children are showing up, what were the individual responses of each of these hospitals? What did they do with these individuals? Were some triaged to urgent care? What did they do?

MS. CLARK: A couple of --

MR. WARREN: What was the intervention?

MS. CLARK: A couple -- at the time, a couple of the hospitals had, like, a "fast track" situation where the kids that were non-urgent could get moved along a little more quickly. Most of the time, they just sat in chairs and waited for an awful long time. Everybody had plenty of time to talk with us. I think it highlighted for both folks in the hospitals themselves and folks at the Department, is there a need to look at a different payment mechanism for something at that intermediary level; maybe not full-blown ED visit, maybe -- maybe the primary care -- 24-hour access to primary care isn't realistic either; do we need to find something in that middle level? So I think that really began a dialogue among different ED directors and among folks at the plan level who heard that information, thinking "this is a significant problem and we need to start looking at different alternatives to addressing it."

DR. FREED: Can we get them a copy of that report?

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MS. CLARK: Yes. If you would like a copy of that

report, I can certainly --
MR. WARREN: Sure. Thank you very much.
MR. HAVEMAN: One of the issues I've thought about and I know we at the Department and others have for some time is how to bridge the fine academic institutions we have in this state to help us make and improve and enhance public policy. And in my career, it's been one of my greatest frustrations in how to do that. And I want the people here today to know what Dr. Freed and his colleagues have done is truly been an extremely helpful thing and improved the care of children in the state. And I want to thank you for that. But maybe what you can do, Gary, is just kind of run what -- I mean, as we take a look at what else we should be doing, because there's a lot of policy with adults and people who have -- I mean, the Department spends 10 billion and touches 2 million people. There's a lot of things to look at. But every time we try to bring someone in, it's like, well we could work on that for a year and a half and, you know, we need a 40 percent indirect, and -- I mean, before you know it, you just give up. Now, what have we learned on this project from the State's standpoint and from your standpoint, the University of Michigan, that has made this work? And what can we learn from this as we look at other projects throughout the state that has other

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academic institutions in the backyard as well?
DR. FREED: I can say what I think. Obviously, --
MR. HAVEMAN: Well, that's --
DR. FREED: I think the reason it's been successful is because -- two reasons. Number one, we have an attitude that we're here to help the children of the state of Michigan, and that that's a priority of our group. Number two, I believe that we maintain a -- I don't want to say a work ethic, but a philosophy that we're going to be on time and on budget. And that's -- for better, for worse, that's not always the academic way of doing things. And our real goal is to be policy relevant. And I think we are very different than most -- not only units on this campus, but other similar units around the country, that we behave very much like an entrepreneurial unit in the private sector where we believe strongly that we have to provide value in return to those who are investing in our services.
And our take home from this isn't a profit, our take home from this is actually having our data go into the mix to make a difference. So it provides the fun for us knowing that we're helping to make a difference. But it also, from the State's side, provides a level of responsibility and accountability that will be there when we're supposed to be. So I think it's a philosophical -- honestly, it's a philosophical perspective on what we think

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our role is and how we want to do it.
MR. HAVEMAN: Is it teachable?
DR. FREED: Certainly, everyone that we have brought into our unit has learned that.
MR. HAVEMAN: Okay. I appreciate that very much.
DR. PORTER: Rod?
MR. NELSON: Just a clarification. Parents of children who are in the Medicaid managed care plans were

more likely to look at the emergency rooms as primary care?
MS. CLARK: Not necessarily in Medicaid managed care, Medicaid, generally. There seem to be a -- sometimes we call it historical patterns of use that is fairly well written about, where it's the ER is on the radar screen for those parents as a routine site of care in a really different way than the parents of privately insured children expressed.
MR. NELSON: So is there a recommendation in the report on how to deal with that issue?
MS. CLARK: The biggest recommendation there is this continuing need to educate parents on what you need to do when your kid is sick, and then make sure that there's a mechanism on the other end to respond. So if what we're going to tell parents is, "If your baby has a fever higher than 102 degrees, you need to call your provider," then when they call the provider, somebody needs to answer the

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phone and talk with them. So we're missing it on two ends with the Medicaid population; first in educating the parents what to do, and then ensuring adequate follow through on those recommendations.
DR. PORTER: Are there any other questions from the commissioners?
MR. WARREN: One. There was a reference to a need for a new tracking system or some sort of a tracking system. Was that an automated one? Do you want to comment? Is that --
DR. KEMPER: The way the tracking system works currently in the majority of health departments is that it's a plain paper-based system where individuals try to ensure that -- individuals within the health department try to ensure the kids have follow up. And when they don't have follow up, they call the family and try to get them to go. And it's very difficult for them to try get ahold of the family, many times.
In some of the health departments that have developed an automated tracking system, the problem is that the automated tracking system doesn't seem to improve the tracking within the health department. But overall it does seem that the majority of kids, regardless of what tracking system you use, do have follow up. So what we've been proposed and are working with various health departments in

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is instead of tracking everybody is to track children who are at particular high risk, for example, based on the degree of their impairment from the screen to ensure that the kids who are at higher risk of having problems do, in fact, get seen.
DR. FREED: I just want to say thank you very much for allowing us the opportunity to be here and to work with the State of Michigan.
DR. PORTER: Dr. Freed, those are very, very interesting comments from you and your colleagues. Thank you very much. And you have a handout that is available for the members here. And I should say while Dr. Freed is passing those out, if there are others who would like to testify before the commission but have not put your name in, Mr. Joe Baumann, at the back of the room, will be more

than happy to add to the list. We will be here from -- until around 7:00 o'clock. And hopefully we'll be able to get everybody an opportunity to testify.

The next individual who has requested to testify is Dr. Thomas Veryser, the assistant dean, Community Outreach, University of Michigan School of Dentistry, who will talk about the University of Michigan dental outreach program.

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TESTIMONY BY DR. THOMAS VERYSER:

DR. VERYSER: Thank you. The program I'm going to describe for you is an educational program at the University of Michigan School of Dentistry that was initiated by public health clinics around the state who were crying for help. They needed providers to provide care for the patients they were seeing.

We started it back in 1997-98 as a pilot program, sending a few dental students to a community health clinic that was specifically a Federally-qualified health care center. The program was very successful. And as we approached other stakeholders, primarily the State of Michigan and the Department of Community Health, the Michigan Primary Care Association and others, we determined that this was not a unique problem to this particular health center, that it was statewide and that there was a manpower -- personpower shortage, if you will, in providing dental care to the Medicaid-served population. Since that time, we have through the gracious grant of the State of Michigan, achieved the funds to allow for many of these clinics to expand, and to allow our school to participate throughout the state.

So we created a program. We made it mandatory. It involves all of the senior dental students who currently are out of our school and into clinics around the state for

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a period of three weeks, at least -- many of them longer. Today I learned just this afternoon that I'm going to have to expand that to five or six weeks, because we have a larger class coming up and we need to make more room at the school. So we're going to automatically be expanding this program.

In addition to the 105 senior dental students we have out this year, we have 25 dental hygiene students, 12 graduate students in the advanced education in general dentistry program, 2 in the general practice residency program, and 6 in the pediatric dentistry program, for a total of about 150 dental care providers that we are adding to the work force, if you will, of the public health sector. These individuals are having their education enhanced. And that's our primary objective, of course, as educators, is to improve and enhance the clinical experience of these students. But in addition to that, we're obviously providing increased access to oral health care for the unserved, or underserved population.

Our third major objective is to provide the experience of a public health center for our students and residents so that they can have the experience of working with members

of the profession who are used to serving the underserved. It's a different breed of cat. And it is a unique experience that is literally changing the lives and the

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attitude of our students. Daily I have students coming to me, telling me how their future plans for practice totally changed now that they've been out to these clinics. I have one student, for example, who is from Seattle. He was planning on going back to Seattle and run a private practice who is now going to be joining the Hackley Community Health Center in Muskegon as a full-time employed dentist for at least the next two to three years, perhaps forever.

We also, in this setting, our dental students and residents get an opportunity to practice with physicians, with nurses, with other members of the medical and nursing professions, PA's, who are working, providing a total health medical home, if you will, for the underserved population in these clinics.

Currently, the clinics that we are involved with are all over the state. We have them in Saginaw, Bay City, Grand Rapids, Muskegon, in Baldwin, Marquette in the U.P., Traverse City through Dental Clinics North; Jackson, Michigan, and in Dexter we have a private practitioner offering an opportunity for our students to work with the developmentally disabled patients.

In addition to the State of Michigan and these clinics, obviously, the Michigan Primary Care Association has been involved, the Delta Dental Fund has been highly --

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intimately involved in providing funds to help support this effort, and the Michigan Dental Association. So we've created what I think is a unique group of individuals from many, many different sectors that have never had the opportunity to work together for this common goal.

The clinical emphasis in the clinics includes oral surgery; a lot of oral surgical procedures, a lot of pediatric dentistry. And in Marquette, that includes operating remember experience at both Marquette General and Bell Memorial Hospitals. They do a lot of general restorative dentistry. We're adding a lot of endodontics, periodontics, and prosthodontics to the mix. And our expectation and planning includes adding more specialists that are being trained in the various disciplines of dentistry; the residents in those specialties being added to the mix of students who rotate.

We look back on our accomplishments and over the past 12 months, we have over 7,000 dental procedures being completed. That's a very conservative estimate because some of our data from some of the clinics hasn't been as ideal as we'd hoped. We're building an online data reporting system so that every patient, every procedure can be adequately documented for us.

The program has evolved from 5 to 10 clinic sites in the last three years. We expect that to continue, our

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evolution in size and in depth. Currently we have 12 graduates of this program in the last three years who are

now employed full-time as dentists in these community health clinics. I just learned yesterday of a young lady who's going to become employed at a public health clinic in Ohio as a result of this experience.

In addition, the majority of the graduates report that they intend to treat Medicaid patients, which is something that the majority of dental practitioners don't do. And the students are learning that there is a lot of reasons to treat these patients. Financially is only a small one. And they're being fed by this experience in ways that they can't quantify. We find that we -- we expected this to occur, and it is occurring. Good citizen dentists that are being formed. Our students lives are being changed, and their world view is, indeed, being expanded.

Where do we go from here? Well, we expect, as I said, to include more specialties. We're developing live, interactive communication between the sites and the dental school and the specialists here at the school so there can be online, real time direct interaction for consulting purposes, for educational purposes. And I think that in the next couple of years we'll become real viable across the entire state, for all clinics whether we're sending our students there or not.

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One of the things we face is some creative solutions to our funding issues. And we're constantly trying to be creative. As I was asked today to increase our capacity by sending students out more, I immediately did the math and said, "Well, how many more could we send out if we added more weeks if we did, you know, whatever we had to do to tweak the program?" And so now we're going to request students to go out on their otherwise vacation time, providing incentives for such behaviors -- selling it, if you will -- and hopefully we will be able to increase our capacity as we see the need to do so.

I wasn't directly involved in this process in the planning. I've been involved with it since it's been initiated as a full-time program. And I consider the whole program from the planner's point of view to really have been an act of courage. It took a lot of courage for these community health clinics to come to the University of Michigan, the 10,000 pound gorilla, and wonder how they were going to be received and how the University of Michigan was going to react. It took a lot of courage for the University of Michigan to send its students out and lose control, if you will, of their educational process. It's taken a lot of courage on the part of the dentists that work in these clinics to face the critical questions that students ask every minute of every day. And it took a

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lot of courage on the part of the State, the Department of Community Health, to stick its neck out and fund this experiment. And I congratulate all the partners; I congratulate all the stakeholders. And I think its success speaks for itself. Any questions?

DR. PORTER: That's fabulous. Let me first ask --

MR. HAVEMAN: Jim, why did it take us so long to figure how to do this?

DR. VERYSER: Do you mean why did --

MR. HAVEMAN: Why didn't we do this 10 years ago? It just makes so much common sense. You know? And if I take a look at your presentation, it's been a win/win academically for the students as well --
DR. VERYSER: Oh, yes; it has.
MR. HAVEMAN: -- in their own clinical --
DR. VERYSER: It has. The students -- in fact, our big dilemma, the students enjoy this so much that they don't want to come back here. You know, when we talk about expanding the weeks that they're going to be in Marquette, Michigan, a lot of people said, "Oh, my god." You know, who would want to do that? This is a classic example of "How you going to keep them down on the farm after they've seen Paree?" You know, we are showing them life as it can be lived, and they can't stand it, coming back to the confines of an academic environment. It's -- you're right.

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It's a win/win situation of the Nth degree. Why it wasn't done sooner, I think it's just the myopia of tradition. Everybody just keeps plodding along the way they always have. And we face something in this state that you all may or may not be aware of, and that is we are up against an impending shortage of dental practitioners that is going to become critical in the next 5 to 10 years in our state. And for the Medicaid-served population, that's extremely foreboding. This particular program, because it does get students into those community clinics and let them see what's available, I think will help solve that problem -- for that Medicaid problem.
MR. HAVEMAN: Do you have a paper or something you could get to us on the pending shortage over the next 10 years --
DR. VERYSER: I can --
MR. HAVEMAN: -- that might helpful for us to have?
DR. VERYSER: I can in concert with the Michigan Dental Association, probably put something together.
MR. HAVEMAN: That would be good to have. Get it to Joe.
DR. PORTER: How would you see this program expanding? I mean, what would you like to see done, given the --
DR. VERYSER: Well, there is a limit. There is a limit to what's practical. Other states have done things

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like and I think it's good to see -- rather than try to reinvent the wheel, see what others have done. Colorado, for example, they backed up the curriculum so that the last term of school, they're totally out in community clinics. And that would be, like, a 15-week, 16-week rotation. Currently, our students are going out 3 to 4 weeks. We're going to pump it to 5 to 6 weeks in the next year. We're a long ways from going to a 12- to 16-week venture. I see that happening in time, I suspect, probably over 5 to 10 years. And that's all good.
When I -- I'm asked on a weekly basis to provide an overview of this program to incoming dental students, students who are looking at the University of Michigan as a possible place to choose to come for their dental education. And overwhelmingly, the reason people are signing up to come to Michigan is this program; it's so

attractive to them. It is unique in that it's fairly comprehensive. It's not unique totally to dental education, though, so other schools are starting to offer some work programs.

MR. NELSON: Just a comment. I really commend you for your program. In Mackinaw County, Medicaid recipients have to travel up to 50 miles to go to a dentist. And the reason I know that, our long-term care residents have to be placed in a van, transported 50 miles because that's the

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closest dentist that will accept Medicaid. So this is a tremendous program.

DR. VERYSER: The Medicaid program for dentistry is highly weighted to children. And that's good, and it's bad. You know, so the tremendous unmet need that you're talking about is in the adult population, especially the elderly adult population, who are more often going to be on Medicaid. And that's where we, the state of -- we've let down. We've let them down.

MR. WARREN: Dr. Veryser, in point of clarification when you say that the program is weighted towards children, do you mean towards the standpoint of eligibility?

DR. VERYSER: Yes; eligibility and benefits, scope of services covered.

DR. PORTER: Are there any other questions? Again, fabulous program.

DR. VERYSER: Thank you.

DR. PORTER: And keep it up. Thank you. The third presentation today will be by Dr. John Billi, the Associate Vice President of Medical Affairs. He is not here yet? Okay. Is Lloyd Jacobs? Yes? Okay. Fabulous. Dr. Jacobs, Chief Operating Officer at University of Michigan Health Science, Associate Dean, Clinical Affairs, at the medical school, to talk about the importance of GME, graduate medical education.

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TESTIMONY OF DR. LLOYD JACOBS:

DR. JACOBS: Dr. Porter, commissioners, I thank you for letting me do this. I appreciate the chance to be here. Unlike the previous speakers, I don't have a cogent, completed or near-completed story to tell you. The fact is graduate medical education is, in my opinion, currently in a state of crisis. And if I am successful today, I will list for you some of the problems, some of the pressures upon it and the importance of our beginning to think together about those issues.

The fact of the matter is that graduate medical education may be the most important segment in the life of a physician. I speak now of that segment of a person's career that begins upon graduation from medical school and ends somewhere between three and eight years later when that person is eligible for Boards in various disciplines and a fully trained surgeon or pediatrician or whatever.

That segment of a person's career is, as I say, perhaps the most important segment. It is the time when a person's identity is most formed around the specialty in front of that person. The depth of the understanding, the identification of myself, say as a surgeon, happens more during that segment of a person's career than during

college, medical school, or subsequent careers. It is during that segment when a person takes on the identity of

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the pediatrician, a psychiatrist or what have you.

There's a huge amount of information that's exchanged and received by the trainee during that period of time. But perhaps as important as that is this intensity of identity with the mores, with the way that people behave as a physician. So this is a really important segment of a person's career.

In addition to that, it's important because this group of people spending, as I say, somewhere between three and eight years in an institutional setting have come to constitute a huge amount of our work force. A tremendous piece of the work that occurs in hospitals is done by these people in this setting. In high end institutions, they are the surgical assistants, the first and second surgical assistant. They do much of the writing of orders for admission and discharge and medications. And in an institution like ours, if you analyze 100 charts for the actual writing in the order sheet, well over 90 percent of the entries on the order sheet are entered there by physicians in this category. That is not to say, I hope, that in most of our institutions they aren't appropriately guided and supervised by old folk like me. But the people who put pen to paper are almost always in the hospitals in this category. So the pressures that have been brought to bear on these folks have been tremendous over the last 10

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years.

First of all, there's been a relentless increase in workload. Everybody understands that hospitals are once again full, busy. The more there are technological things to be looked after in hospitals or for that matter in outpatient areas where these folks work, the greater the number of entries to be made in those charts; the greater the amount of information, knowledge, that's required to take -- carry out this. And it's important, I think, to notice that as length of stay in hospitals has decreased, there's a -- the whole stay has been compacted nowadays. The time between admission to a hospital and discharge from a hospital is virtually continuous.

And so the piece of work that constitutes the admission to a hospital, the writing of documents, the creation of care plans, the writing of orders is virtually continuous with patient education that happens on the other end. And it's probably worth noting that in a number of major hospitals, including ours, the -- for the first time ever, in history, the length of stay has dipped below five days. And that means that the patient is never outside of this sort of state of flux in which the work load is tremendously intensive.

So work load is increased. There's been major issues raised nationally and locally concerning the ability to

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teach in a milieu like that with such discontinuity. Formerly, patients might have been in the hospital 10 or 15 days, with plenty of time for students and residents to

interact, to get to know the patient, to understand something about the patient's life and life before the hospitalization, life after the hospitalization; all that's gone now. If you're lucky, you might see the patient before the operation, most of them being admitted to surgical services being admitted on the day of the operation. No longer do these students, these trainees have the luxury of visiting the patient the night before to get to know them, and then studying the case the next day.

The great majority of cases are admitted, as I say, the day of surgery, even high end -- valve replacements in heart patients and so forth are admitted the day of surgery; very little time for that interaction to occur.

Finally, there's been a tremendous amount of pressure from new regulatory climate on the teaching here. And most of you know, and I won't review the history of an audit undertaken five or six years ago by HCVA, then HCVA, concerning the supervision of residents and the requirement, very strict requirements, for documentation of resident supervision. More recent, and therefore more relevant, is the imposition now of work limits, long overdue. Absolutely required, in my opinion, for a number

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of reasons: humanistic, safety and other reasons, but still dramatically changing what it is a resident can do; dramatically reducing our availability to this work force in hospitals like ours.

So we have in front of us a tremendously important function from a care delivery perspective and, in my opinion, even more important for the future of medicine, even more important for the high quality delivery of care to future generations, the training of these people. A lot of pressure on it, fiscal pressures, regulatory pressures, and so on. And, frankly, no quick solutions to that. But still a set of problems that I believe that we need to joint together to try to deal with.

The problem that is perhaps most of all in front of us at this point is this issue of an 80-hour work week and specific requirement for rest time between. Now, as I say, I want to dilate on that just a moment, if I may. First of all, that's good. It is entirely appropriate that this resident work force looks less like indentured servitude than it did 10 or 15 or 20 years ago. Frankly, that's what it did look like, and it wasn't appropriate that we built so much of our care-giving apparatus on the backs of these people.

On the other hand, taking some of that away and requiring time off, requiring shift changes requires that

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we learn some things we really never learned about before. How to create continuity in the face of required handoffs, for example, is not one of our best skills. It is a new set of problems that we need to undertake. It clearly is going to cost more if a person is limited to a certain number of hours. It is not at all clear how many hours these folks actually work. It turns out it's widely variable, some being in the range of 50 hours a week, others approaching, in fact, 100 hours a week.

You will recall, of course, that these requirements

grew out of the events in New York state, where safety was identified as an issue. And as I say, I strongly support this in terms of these people now being in these programs for sometimes five, sometimes seven years. They have children, they have lives, they have families, they have other responsibilities. So I believe this is the right thing to do. But it is going to have a major impact. And it has already begun to do that. And we are wrestling with that.

So I believe that this commission has in front of it this issue which constitutes, perhaps, the single most important public health issue; the single most important work force issue that you're likely to face in your tenure as a commissioner. Each of our large institutions depend heavily on these people, on this particular work force, for

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continuity, for quality. It is no exaggeration, in my opinion, to say that the presence of these people 24/7 on a Thanksgiving and Christmas day in the hospital constitute the single most important underpinning of quality in large medical centers. They are the thing that distinguishes places like DMC or University of Michigan and allows us to take care of these incredibly complex, difficult patients. I'd like to think it was my being at the University of Michigan, but frankly, it is not. It is these folks being there 24/7 that distinguishes us.

So we're going to have to figure out ways to substitute that work force, to unload that work force from some of the work they've traditionally done, like starting I.V.'s and drawing bloods and being patient couriers and substituting as x-ray technicians and so forth. And if all of that weren't enough, gentlemen, we are looking down the road at a huge influx of baby boomers into the system; all of whom are going to be requiring, expecting, the kind of care that institutions like ours can and must deliver to them.

So this probably constitutes the most important problem we have at the University of Michigan, about 900 of these. Recently a overall cap based on 1965 census for these folks was imposed, which is in the range of 700. We have many of those; 200, that disparity, rotated other

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places, other hospitals. That figure, the 900 figure, includes 100-odd salaries and positions at the Ann Arbor VA. But we are 20 or 25 people over that cap. And I implore you, frankly, to -- I urge you to consider the continuation of the funding that's implicit in the Medicaid in the future because of the importance of this particular work force; and to engage in this very complex set of interlocking problems that to my mind, as I say, constitute the single most important work force issue in front of the State of Michigan at the current time.

So I didn't give -- I will be happy to take questions, because I hope raised questions. I certainly don't have answers.

DR. PORTER: Well, thank you very much. And this is, indeed, an extremely important point. With the change in working hours as well as HCVA and CMS's change in scope of activities, do you feel that the residents are gaining the

learning experience that residents in bygone years learned in the time they have available? Or do you feel it's going to mean longer residency periods to be able to develop the same skills that, after all, there's a very large component of apprenticeship within --

DR. JACOBS: I think this is, in fact, an apprenticeship, Dr. Porter. I think that correctly characterizes the methodology, the pedagogical methodology

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that we have all evolved to. I believe that they are getting excellent training. It is so much more intense that it's more packed in. There is less down time. And I do not believe that residencies, training programs, should be lengthened. They are already inordinantly long for some of these high end people. I will have operating with me on this Thursday a young person who is 34, who's been in training over eight years. And to extend that by any -- to any degree is unreasonable in terms of the impact on one's life.

Furthermore, as a public health issue, Jim, to limit these folks at both ends, that heavy duty kind of work where you have to sort of stop about 65 and you don't get started until you're 35, compresses your career to such a degree that there's economic issues involved. So, no, sir, I do not believe they will be lengthened. I believe they're being wonderfully trained in most of our centers at this time.

DR. PORTER: Larry?

MR. WARREN: Dr. Jacobs, is there -- is there something in particular that can connects GME to the Medicaid population? Is there something about this particular population that requires more attention than others, if you will?

DR. JACOBS: Yes; thank you. I think that the thing

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that these folks contribute to most of all are very complex, very difficult and indigent poor people. And so I believe there is something that -- there is a common denominator here. Medicaid people frequently, for reasons that you heard from Gary Freed and others, come to an institution disadvantaged, either from a health perspective or socioeconomic perspective. They need the underpinnings that -- and the supports that that work force offers more than almost anyone.

And for better or for worse, we have chosen, traditionally, to support various indigent groups, be they veterans or others, by use of this particular work force. I personally don't feel that's a good idea. I'm -- I think it's right and proper that we evolve from that. But there is still some of that.

MR. HAVEMAN: Dr. Jacobs, I always find it interesting about the evolution and the history of graduate medical education and how it happened. In Michigan, you know, we put almost -- I think about 180 million of Medicaid money into GME. Some states do, some states don't. We don't have to.

DR. JACOBS: Right.

MR. HAVEMAN: Medicare puts some of it into graduate medical education as do private insurance. If you add it

up, you get almost $1 billion that comes into Michigan

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through graduate medical education. Does that make you nervous, a formula like that? And is this the type of formula that is going to carry graduate medical education for the next 20 years? Or is there a better model to use than the current one that's in place for graduate medical education?
DR. JACOBS: That model makes me nervous. I do not have a better one.
MR. HAVEMAN: Okay.
DR. JACOBS: I believe that graduate medical education is extremely expensive. Replacing these people -- for the reasons that I mentioned make it necessary to replace them -- is extremely expensive. There will be a huge cost borne by various elements of our industry, our state, as this thing evolves. But I also believe, Jim, I believe it firmly, that it's worth it. If the University of Michigan has a single value proposition, if the academic medicine has a single value proposition, it is this: That the very best quality and cost efficient medical care is delivered in a setting where research and education is an integral part of the daily life. I believe that to my core. That's why I'm here. That's the fundamental value proposition of what we're doing. And I am convinced that -- we need to count it up carefully. I'm not saying -- suggesting that money should be thrown at this problem. But I believe it

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will ultimately turn out to be worth it.
MR. HAVEMAN: Thank you.
DR. PORTER: I think this is a very important area and I think it would -- hopefully we'll hear a lot more about it because this is the future of our medical work force. Thank you so much, Dr. Jacobs. I promised the commissioners that after the third presentation we'd be able to take a five-minute break for the -- just to make sure everybody's fine and that we can come back. So if we can reconvene at 20 past 5:00, that will be fabulous.
(Off the record)
DR. PORTER: Well, maybe we can reassemble. I'd like to suggest that we can get together. Just as a point, if there's still folks who would like to put in testimony, then please let Mr. Baumann know and he'll bring it up.
The next presenter is Janet Olszewski, Vice President, Government Programs -- Dr. Billi just arrived. Well, let's get back on track, then. Yes, because Dr. Billi was earlier. Dr. John Billi is the Associate Vice President, Medical Affairs and the Associate Dean of Clinical Affairs, University of Michigan, and will talk about outcomes-based medicine here at the university. Dr. Billi?

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TESTIMONY BY DR. JOHN BILLI:
DR. BILLI: Thank you very much, Dr. Porter and members of the commission. It's really a pleasure to be able to address you today regarding a few comments from the

University of Michigan and from my perspective on what we can learn from the movement of evidence-based medicine and best practice that can help and form the future of Medicaid in the State of Michigan. I've provided the commission with a couple page handout entitled "Comments for the State of Michigan Hospital Advisory Committee." I've also provided several examples of a number of other pieces of paper that I'll refer to. I know that you won't be able to go over these during the meeting today, but I thought they might be helpful for the members and for their staff for the future to try and put some of my comments into context.

I have a very simple presentation, actually, for you all today, even though there's a lot of paper passing around. The few points that I want to make, essentially summarized on the sheet that has my name at the top, and then says in bold print, "Evidence-Based Medicine," essentially the points that I want to make are as follows: That substantial variation in the use of health care services occurs in the State of Michigan. This variation consists primarily of underuse and overuse of services for health care; that within each area of health care in which

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there's over- or underuse, the optimal care can be defined through a process of evidence-based practice guidelines; that either overuse or underuse can harm beneficiaries and worsen costs so that both of these problems I consider equally important; that evidence-based guidelines alone are not adequate to improve to care. And then I have a couple of recommendations that I think would be helpful for the commission to look through. So I'd like to go through these in a couple -- in a little more detail and try and set the stage for some of my colleagues who will be speaking afterwards.

First of all, I brought one copy for the commission of the book produced through Blue Cross/Blue Shield, with the help of the folk from Dartmouth on variation in the State of Michigan. This book documents, for the commercial Blue Cross population, a huge amount of variation in the provision of health services by geographic region in the state. There are ample examples in there of both underuse of services of proven benefit, such as vaccines -- vaccines for children, vaccines for the elderly for the prevention of influenza or pneumococcal pneumonia.

In addition, underuse of services for specific populations, such as the hemoglobin A1C test for the measurement of adequacy of diabetes control. There's also underuse of cholesterol lowering therapy for those with

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coronary disease, diabetes or high lipids, and inadequate use of ACE-inhibitors and beta blockers for those with heart failure. So those are a few of the examples of the underuse of services. That's highly variable across the state, but there are pockets where those services are less used than they should be.

In addition, there's a second category of services in which there's overutilization including examples like plain sinus x-rays to diagnosis sinus infections or spine surgery when a person hasn't gone through a conservative management trial or antibiotics for respiratory infections. There's a

couple of examples of overuse of services.
Within each example, the optimal use can be identified through a process of evidence-based guideline development and deployment. At the University of Michigan, we have a comprehensive process for the development of evidence-based guidelines. Those guidelines, we carefully think through which questions we'll approach, ones that are high risk, high cost, high frequency were the evidence is known, where a gap exists. And we then set a team in place to develop the guidelines through a very comprehensive process that reviews all of the literature systematically and then puts the guidelines together with an expert panel, feedback from our clinicians. We then deploy them through a education process.

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Now, either the overuse of services or the underuse of services not only can harm the beneficiaries, but it can also cost us money. The overuse of services, it's pretty obvious how that money can be wasted there. If folks are getting sinus x-rays for the diagnosis of sinus infection instead of the more appropriate techniques, that wastes resources that are better spent where there's actual value in documented evidence. But it's clear also that underuse of services can also waste money, because similar to a company like Ford Motor Company, the Medicaid program has some of its beneficiaries for life. So even if you're not saving money in the 4th quarter of 2002, you have the aged, blind and disabled, essentially, for the rest of their lives. So for that population, if we're able to do services, perform services more appropriately even if it might raise costs in one year by performing more services on diabetics, people with heart disease, we hope that we'll be able to save money in subsequent years by preventing folks with diabetes from going on to end-stage renal disease or folks with diabetes from developing more serious heart problems and then ending up in a cycle of admission after admission for heart failure. So in a way, these people are similar to other employers who keep their populations for life. And any investment that we can make that will decrease their future use of services can be

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considered a prudent investment from a cost perspective, in my opinion.
Now, there's plenty of evidence in the literature that the excellent kinds of practice guidelines, some examples of which I've circulated to you, and many of the institutions that you represent have programs, I'm sure, that have endorsed evidence-based guidelines. But there's good evidence that just having guidelines alone never improves the care of the patients. Often when these are mailed to doctors, they'll find they're conflicting; they'll toss them in the trash bin. They may glance at them quickly, but they don't take them seriously and really change practice. The guidelines, to be effective, have to be in -- nested in a medical and disease management program designed to try and help the patients -- help the doctors manage the patients. The guidelines have to be distributed in a way where there is educational programs so the doctors know how to use them. They have to have the help of nurses

and others who are figuring out whose not getting the needed services in their practice and can develop programs to identify those people and reach out to them to receive them.

Now, programs like medical and disease management programs that we found effective in dealing with indemnity populations, commercially insured populations like Ford and

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General Motors, those kind of medical and disease management programs can't be sustained on the basis of fee for service reimbursement. The amount of money a physician gets for the individual service they provide is never going to be adequate to cover having a nurse that phones about -- phones a patient with congestive heart failure or diabetes to ask them. So we believe that the current reimbursement model under Medicaid really doesn't encourage the kind of coordination of complex care, the coordination of these aged, blind and disabled people so that they'll be able to receive the best care. If the only thing you're reimbursing a doctor or a hospital for is when they have a visit or a procedure or they're hospitalized, then where will the reimbursement come from to pay for all the other services needed to glue care together and make the care function seamlessly, to try to get ahead of the patient who hasn't shown up for a visit for three or four times but who has diabetes or asthma, to reach out to them. So I think we need to think about new reimbursement models for the Medicaid system besides just chasing individual fee for service reimbursement.

Now, the State's experience with capitated health care through Medicaid-qualified health plans was an experiment to see if we can try and rearrange the financing and try and cover some of those care management services. But

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unfortunately, capitated managed care has had a difficult time covering those kinds of care management programs. For one thing, doctors and patients when they receive help with care management from a managed care plan don't always receive it as favorably as they do when its coming from their own colleagues. They sometimes are suspicious because it's coming from a health plan, they may perceive that the main goal is to try and reduce costs rather than improve quality. And so even under capitated care, if I was the doctor in my community who had the best reputation for managing Medicaid beneficiaries with asthma or diabetes or heart failure and I was able to attract those sickest patients who wanted to reward me by -- reward my excellence in these areas by having more and more patients who have -- especially recalcitrant diabetes or resistant heart failure, there's no way that the reimbursement models under the managed care plans that at least have been tried to date, would actually reward me for the infrastructure my office we need to be able to do a superb job managing those folks.

So I ask the commission to think about alternative models we can use besides the experiment in fee for service that's gone on for decades, and the more recent experience with capitated managed care. I don't think either of those models really encourages the development of systematic

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programs to try and identify the highest cost beneficiaries and move them into a setting; help them, help their doctor to really get the care they need.

So I have a few suggestions for you that I finish my comments with that are listed at the bottom of my handout. One is that we have an initiative in southeast Michigan called the Michigan Quality Improvement Consortium. It includes six health plans plus Blue Cross, the University of Michigan health system, Michigan State Medical Society and Michigan Osteopathic Association. And I'm pleased that MDCH has had Giovannino Perri at many of these meetings as well to try and integrate M-Quic's consortium of quality improvement with the State's actions. So I certainly encourage that the State continue to support and sponsor that kind of initiative. The Michigan Quality Improvement Consortium, or M-Quic, their goal is to develop common guidelines across multiple conditions so doctors don't have one guideline for the diabetic patient from HAP, one guideline for the diabetic patient from MCARE, and a third one for the diabetic patient who happens to be in Medicaid.

In addition, that group works on common measurements for these, so that I won't, in my office, have a team come in from HAP, and then a team come in from MCARE, and then a team come in from Blue Cross, and a team come in from Medicaid, each using different criteria to evaluate my

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care; each giving me an incomplete profile of my care. So that's recommendation number one, support the Michigan Quality Improvement Consortium. The University of Michigan's invested its time and effort heavily to try and get that moving forward. And we certainly hope the State will support it as well.

The second, on B, support the Southeast Michigan Quality Forum. Although to date this has focused on the auto's, UAW and the large health systems in southeast Michigan, I think the State of Michigan deserves a seat at the table. This is the only consortium of payers/providers that is systematically trying to improve quality of care in southeast Michigan, a place where most of the Medicaid beneficiaries are located in this state. That group tries to coordinate quality improvement programs. And as I said, the U. of M. has spent a lot of time trying to get -- keep this program on track. And we'd appreciate the State helping us out with that.

The third recommendation that I have has to do with investigating innovative health plan structures, like the ones that the U. of M. has worked on for Ford and General Motors, Partnership Health and ActiveCare. These programs still allow fee for service reimbursement, so there's no disadvantage to a doctor or a health system from attracting the sickest patients in the population, yet they reward

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them with care management support. So if I have a sick diabetic, I can call a health navigator in Partnership Health and say, "Can you help me with this person? Can you get him into this clinic and help me manage him? Can you call him on Thursday? Call him on the Monday after

Thanksgiving and make sure they haven't had too much turkey and need to have their insulin adjusted?" That kind of help at least two of our large private purchasers of health care in the state have made investment trying to understand different models of health care. And you'll hear about a few more of those kinds of innovative models from the next speakers. But I would encourage the State to think outside the box because I think that the old treadmill of low reimbursement to physician per unit service, a physician is providing service and the only way they're getting reimbursed is by the services they provide, is not going to solve the high percentage of health care costs that's coming from the small percentage of aged, blind and disabled, a population with a lot of very special needs.

So I know I've gone through a lot of material fast, but I understand that you and your staff will be able to go over some of the samples that I've given in some of the materials. I've provided examples of the guidelines we use, an article on the guideline development process we use. I've provided a pharmacy card that's been developed

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to try and sort through the Tower of Babel of which ACE inhibitor is preferred by which health plan in this state. And you'll notice that we have a column on the side for the Medicaid program, because our doctors now need to know if a patient's in this plan or that plan or has Medicaid, there's actually a different preferred drug. And I've provided one copy of our complete guideline book that you're welcome to peruse. That's the looseleaf binder that's at the end of the table; and one copy of the Dartmouth Atlas that Blue Cross produced about the variation.

I'd be glad to answer any questions or elaborate on anything if that would be helpful.

DR. PORTER: Thank you very much. And thank you for providing this information. We'll be certain to go through it, because I think it is interesting. And these drug cards, I was just looking at it myself. They're absolutely fabulous. Now, you mentioned the guidelines have to be sort inculcated into the framework --

DR. BILLI: Yes.

DR. PORTER: -- of the health care system. And I presume that it's in two formats. Firstly, there must be a mechanism for physicians and health care providers to simply get that information. It may be easier in the electronic age, physician order entry, et cetera. But are

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you also bringing it down to the sort of medical student, resident level so that the physicians of tomorrow -- because I remember for many of us, the best guidelines were the ones we wrote.

DR. BILLI: Well, you're right on target, Dr. Porter. In fact, a lot of the implementation of the guidelines begins when they're being developed. That is, who you involve in developing it can help you with the implementation later. Each of the guidelines that the U. of M. works on, which I have examples here, have a primary care physician lead and a specialty physician lead, often several, so we don't get into a shouting match where

guidelines produced by one group and then the other says, "Well, it doesn't really reflect my practice." They go through a systematic process of searching the literature, evaluating it, and then distilling it into questions.

Then the drafts of the guidelines are circulated extensively. And it's during that process that we actually begin the implementation. Nominally, it looks like it's actually approving the guideline, but in reality the group is getting standardized to this as they see different versions of it. And the ones who didn't know, for example, that beta blockers are now first line therapy for certain types of heart failure, they may be a little behind the time, they start to see that. They see it in the

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guideline, they look at the reference. So that's part of the process.

And then after the guideline's been through that process and formally endorsed, including by our clinical leadership at the U. of M. health system, it then goes to the clinical departments that are affected by it. And they do one of the teaching conferences where the sole purpose of the conference is the guideline; essentially go through the guideline in detail. And then the group -- it's very interactive so the general internist in the audience says, "Well, I didn't know -- why would you do that? Why would you want to treat twice, once for three weeks and then once for six weeks with sinusitis, before getting a CT? And why would you never get a screening sinus film?" So we work through that.

In addition, then, all these guidelines are available on the web, both on an externally available website for continuing medical education, but on our internal website, on our clinical record. We have an electronic medical record. That electronic medical record that our doctors all use in taking care of patients has a little reference button at the top. And I can get -- I was practicing today, in fact, and I referred to these six or seven times during the day.

Likewise, there are books like the one I have here

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that are on the shelves. These are in teaching clinics where we have medical students and residents and we teach them not just what the guideline says but where the guideline is located so they can go to it, wherever they are in the system and get more information. We then track performance on the guidelines and report back to the physicians what my percent of patients who've gotten an A1C among diabetics and who've gotten -- and for whom that value is an acceptable level. So I get reports back on that, based on the audits that we've done in our population. Because until I receive feedback, I might have it in my head, "Oh, yeah. All my diabetics need eye exams? Yeah, they're all getting them." And until I actually see the population back, get that kind of detailed feedback, then the guideline doesn't really sink in.

DR. PORTER: Oftentimes guidelines that are developed by academic institutions have a sort of sense -- of proprietary sense; I mean, "This is the way we do it and this is our guideline." Do you see the collaborations that

would allow joint guideline development or guideline development going outside of the University of Michigan system and being able to be something that would become more Michigan oriented?

DR. BILLI: Another good question. Two initiatives have made a big improvement in the very important problem.

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We wanted to avoid the concept that our evidence-based guidelines would be "ivory tower" guidelines and not applicable to clinical practice. And so we include in the guideline teams, physicians who spend most of their time in practice but who are still U. of M. faculty. After that, we worked collaboratively with MCARE and Bill Herman, an associate medical director of MCARE, facilitates this process, where they use the clinicians who are physicians in MCARE and leaders of groups but not located at the U. of M., to work through the guidelines. Once again to get inside it and stretch it out and say, "Why is it that you have so many cc's of amniotic fluid is defined as this level of problem?" And that process is important to make sure the guideline will play in Peoria. But it's also important, even more so, to make sure that those folks feel like they have a sense of ownership in the guidelines. Because until you've gotten into the middle of this evidence for it, if you're a skeptic in general, you're going to say, "Oh, that was produced elsewhere for use elsewhere."

The other thing we do to avoid the sense that these are, you know, U. of M. or ivory tower guidelines is that wherever possible, we drive them off nationally created guidelines. But we don't just accept them. You may know from your own field of expertise that the American Cancer

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Society regularly produces guidelines that are not evidence-based: Recommending PSA's for, you know, for all men, and recommending mammography at 40. You know, they have their own agenda. And unfortunately it's not always based on the evidence. And so when we do use national guidelines, we look carefully at who developed them, were they sponsored by a pharmaceutical company or by an agency that has a particular advocacy agenda, which I respect, but we need to understand. And a lot of times we will vary from the nationally developed guidelines. That local adaptation results in a little variation, but it's a small price to pay for having it feel comfortable.

The second issue, regarding dissemination of guidelines is I mentioned with regard to my recommendations, M-Quic, or the Michigan Quality Improvement Consortium, it already covers over 6 million lives in the State of Michigan. It's the medicine directors and health plan executives from the plans -- all the large health plans: MCARE, HAP, BCN, Care Choices, the southeast Michigan plans, Blue Cross/Blue Shield, Blue Care Network. And they've agreed to common guidelines, common measures, and common methodology to go into doctors offices to measure.

And that's where we can start taking some of the redundancy out of the system, so that you don't have to

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send a team in, you don't send a team, and you don't. Instead, we have one team come in through a trusted intermediary like MPRO or one of the health plans being designated for a group of doctors doing the evaluation on retinal exams once and then producing a whole profile for the doctors. There's lots of HPPA and confidentiality challenges in trying to do these cross-health plan evaluations. But that's the way we'll take some of that unhelpful work out of the system and produce useful information for the doctors, one disease at a time.

DR. PORTER: Thank you. Jim?

MR. HAVEMAN: One of the most gratifying things on my career last year has been really being introduced to the wide range of evidence-based centers around the state that CMS and others fund, including the -- is it the Cochran --

DR. BILLI: Cochran collaboration.

MR. HAVEMAN: -- collaboration that's been going on. And it's been, like, a new thing for me. And I wonder where I've been all my life. And I would really hope -- and I know this is my last commission meeting, but I would hope that this commission, as it makes it's report, can really say very clearly that, you know, the legislature should really fund initiatives without it being evidence-based. And that we, in Michigan, look at what we can do to put together a evidence-based center that we can

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utilize. And whether it's connected or -- but we have to really bring that to the foreground of all decisions we make, whether on medical devices, on procedures. I mean, I can take you to 50 community mental health boards, and they're providing treatment to bi-polar persons probably 50 different ways. Now, what's the best way to do this, and then to adapt it? So I think this is just going to take off.

And I think what we all should begin to realize, what you just said, Doctor, is how much of the evidence that we have received has not been based on good evidence-based research. It's been biased, it's been physicians paid by pharmaceutical companies, and the list goes on. And I think we're all realizing -- but there is so much interest money funding research nowadays that we have to rise above that and really fund some fine evidence-based programs that can be objective. And I just commend what Michigan's doing, but also we need to expand it and even to get the general population of treating doctors and hospitals to use evidence-based is tough to do.

DR. BILLI: Well, it is very difficult. As I said before, mailing the guidelines out to doctors is woefully inadequate. That's why we're trying to work on models. And I mentioned in my comments -- and I apologize for dumping a lot of handouts on you. I know that probably was

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distracting for you. But I thought somehow it might work a little more smoothly. But anyway, the fact is that whether it's lobbyists asking for mandated benefits and then the next thing you know all health plans in the state, including pressure on Medicaid, end up covering something. You know, your first question should be, "Where is the

evidence that this is helpful?" Not just that there's some intermediate outcome, but it actually saves lives, --

MR. HAVEMAN: That's very true.

DR. BILLI: -- improves disability, decreases cost. And then we should be very, very -- a lot of folks will criticize evidence-based medicine as a concept because there's so much in medicine that there isn't an evidence base. And doctor's have to use a lot of art and judgment. But that -- while that's true, there's so much where we know the evidence, and we're still not doing it right now. Once we got all that right, then we can talk about the fact that there's areas where there's inadequate evidence right now.

So I think for -- especially for the Medicaid population that we're trying to get the best care for the least amount of money, which is -- you know, everyone who funds health care, whether it's an employer or the State of Michigan or the Federal government is on that same goal of value. But certainly here, right at home, we have the

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opportunity to say we're going to pay for what works, we're going to cover systems of care that encourage doctors to do the right things. And unfortunately, a lot of what we have right now in this fee for service model, or even in the first iteration of the managed care model is just not getting it.

So I think we've got to break some new ground. And that's why I mentioned the examples of Ford and General Motors, who have taken a gamble and said, "We'd like to see what would happen if we funded high-intensity medical and disease management without necessarily making the doctors and hospitals take on risks for the sickest people." Because that's a tough thing to do to try and estimate what the future costs will be for a very ill population. It's a population of outlyers. Whether it's the children special services or the aged, blind and disabled under Medicaid, that's a population that's very easy to actuarialy predict. So as a result, you really have to turn to different models. And that's why I suggested some of those. So I appreciate your comments, Mr. Haveman. And I think they're right on target.

MR. HAVEMAN: I appreciate what you're doing.

DR. PORTER: Larry?

MR. WARREN: Dr. Billi, in your recommendations, you ask that support be given to several initiatives. Are

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there specific proposals that are before the State or in the works?

DR. BILLI: I'm not aware of specific proposals. Certainly there's no specific proposal with any financial attribution right now. I know that for M-Quic the State has kindly assigned Dr. Perry to attend those meetings and try to synchronize the activities that affect 6 million commercially covered lives with the activities of covering a million State-covered lives. And that I applaud. I think perhaps some further support. The State might look to what that group has been able to accomplish, entirely on volunteer efforts from the health plans, U. of M., medical societies and the like so far, with great support from Blue

Cross. I have to give them credit for -- they've been the ones supplying the dinners that -- and funded the only staff person who works on that thing.

But that's -- you know, I certainly would encourage that kind of community collaborative quality improvement model. You can get the most leverage. And the state can piggyback on the efforts of the commercial entities as opposed to having the MDCH approach to quality and then here comes Ford and GM, and then we have Leapfrog and the RFI from GDAC and this disease of the month problem where, you know, the docs say, well, you know, last week it was this, this week it's that; different standards, different

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report, different format, different profile -- they toss it.

So there isn't any connection right now with the Southeast Michigan Quality Forum. And I encourage MDCH to offer a representative to that. I'd certainly be willing to take that recommendation back to Jan Whitehouse, my co-chair on the quality forum. And then the third of those, I believe, will require more work. But if this commission were receptive to that suggestion, I'd be glad to discuss the implications further of developing a different health care financing and structure model than the one we have -- we have two models right now, the fee for service and the at-risk managed care. And I'm not sure either of those is going to get us where we need to be, which is why I suggested a hybrid in the middle.

U. of M. had substantial experience with this, from everything from our children's special services program, KidsCare, which the State knows a lot about, to Partnership Health and ActiveCare in the Washtenaw County Health organization you're going to hear about in a minute. And we'd be glad to work with the State to see what this practically means; to try and develop a different, perhaps a hybrid model to build on the features that I've mentioned.

DR. PORTER: Thank you. Thank you very much,

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Dr. Billi. That was very nice and thank you again for the handouts.

DR. BILLI: Thank you very much for the opportunity to discuss this.

MR. HAVEMAN: Thank you.

DR. PORTER: We're now going to move to, I believe it's David Neal and Kathy Reynolds who are going to do the mental health managed care view. And Dr. Tom -- didn't make my list. New addition.

TESTIMONY BY DR. THOMAS CARLI:

DR. CARLI: Dr. Porter, commissioners, thank you for this opportunity to share some ideas and share some examples. My name is Thomas Carli, I'm a physician at the University of Michigan heath system. We'd like to discuss with you tonight some -- what we feel are some solutions to some of the Medicaid problems that we have. I don't need to review for all of you the importance of Medicaid; how many citizens it covers, one in five children, 35 percent of the births in this country, half of the nursing home

costs. But what I would propose to you is that Medicaid -- we're here because Medicaid is in serious, deep trouble, both nationally and at the state level. And what I would propose to you is that we view Medicaid as the "canary in the coal mine." All of health care is in serious trouble.

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Depending on one's sense of optimism, we're either in a major transition or we're in meltdown and collapse with no observable new model.

It's not surprising that the health system that involves our most vulnerable population, that's struggled with inadequate funding would be the first to show the collapse and strain. And what we're seeing now is probably previews of what we will see in the commercial sector and Medicare. It behooves us, then to come up with solutions now, because these will be applicable not just to Medicaid, but they will be applicable to all of health care.

Medicaid is hitting a triple -- you know, a kind of "perfect storm," with falling tax revenues, rising unemployment, provider push-back about rates; this constellation of forces is precipitating this commission and the need for Michigan to once again take a creative lead like it has in previous years. While there are many, many things we need to do, often in the short run right now, from looking at benefits to looking at whether we limit enrollment to much more aggressive pharmacy management to even exploring issues of co-pays, I would submit to you that one of the fundamental things we need to do is to use this opportunity to redesign Medicaid.

And one of the ways to think about how that redesign will occur springs from the graph on the back of the first

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page. This is a graph -- by the way, the Kaiser Commission's report on Medicaid and Medicare is an excellent thing, from this summer, if you haven't had a chance to look at it. What Kaiser has showed us here is that while children comprise half of Medicaid, they comprise almost less than 15 percent of the costs of Medicaid. And while adults, mainly low income women, comprise 21 percent of Medicaid, they're less than 10 percent of the costs.

It's in the area of the aged, blind and disabled, those people with chronic disabilities, chronic illnesses and low income, that we see while they comprise 30 percent of the membership of Medicaid, they comprise 70 percent of our costs. No solution to the Medicaid crisis has a viable chance of working unless we develop approaches to chronic illness. When you look at the growth of Medicaid expenses, at least at the Federal level, 51 percent of the growth that's occurred over '01-'02 has been in the ABAD group. So not only do they consume the largest chunk of dollars, they also are the fastest growing cost. And within that, of course, is pharmacy.

How do we approach chronic illnesses in a different way? Well, that's where you, not just as a commission but as leaders of health systems, must come in. Because I think that when you've moved from hospitals to health

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systems, you have not fully realized your potential yet. We're not going to be able to deal with chronic illnesses in a new way unless we fundamentally redesign the way we provide services. Our models of acute episodic care do not fit for chronic illnesses. And in the Medicaid population, we get into even more complexity because of the composition of these chronic illnesses.

When you look at who makes up the ABAD, 28 percent of severe mental illness, another 27 percent have developmental disability and mental retardation. Over half of the ABAD are community mental clients, or could be community mental health clients. So when we talk about the largest group of Medicaid that consume the largest resources, and within that group the largest category, we're looking at the folks that are served in our community mental health and our public mental health systems of care; people with severe mental illness, developmental disabilities.

After these two, then we get into smaller categories; chronic lung, traumatic brain injuries, spinal cord, congenital anomalies, diabetes, congestive heart failure. Those represent small but important populations where we can target our efforts. Because the public mental health system depends on Medicaid -- over half of the funding for the public mental health system comes from Federal and

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State dollars -- any crisis to Medicaid is a crisis to public mental health as well.

Fortunately, there are new and evolving models for how to redesign health care, to do a better job of taking care of chronic illnesses. Dr. Billi reviewed some of them. We've had the wonderful experience at the University of being able to use our Ford and General Motors experiences as prototypes for developing these chronic illness management techniques. And we've been able to extend them into the Medicaid population. And following me will be some speakers that will tell you about how that works. But these chronic illness strategies have people who bridge the handoffs in our health care system. They have people who make sure that folks don't fall through the cracks. Any chronic illness program must view patients as theirs, whether they show up in the clinic or not.

Those, as Dr. Billi mentioned, those resources, take dollars and we have to find funding mechanisms to implement this. I believe it's in the interest of health systems to actually find ways to fund this and to create ways, with the State, to fund these; ways to coordinate and integrate. But with Medicaid, and especially because of the prevalence of severe mental illness, it's not going to be just health systems that have to be involved in this chronic illness coordination. It must involve community public systems of

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care, and community and social service agencies. Any solution to Medicaid is going to have to involve moving into the community and establishing coordinated linkages and new ways of health systems relating to social service agencies and the public mental health system and the public health system. Those kinds of care coordination models that cross systems are things that we'd like to present to

you today.
With a great deal of support from Jim and from Larry, Michigan was able to create an integrated health system for our Medicaid population in Washtenaw County that created a new governmental entity, that is a combination of the County and the University. Kathy Reynolds is the executive director, and she will present some background in that.
Following Kathy, we will hear from Ellen Rabinowitz, who is from the county's public health department. The county, some years ago, independently had to struggle with what to do with its charity care and its uninsured, and has created an insurance plan. As we started looking at this insurance plan for the uninsured, called the Washtenaw Health Plan, and we started looking at the needs for care management and chronic illness management and that population, and the fact that so many of those folks move back and forth between Medicaid and uninsured, we needed to develop ways to coordinate care, regardless of which bucket

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of dollars was paying for the care this month or this year. And Ellen will tell us more about that program. And then we'll finish up. Thank you.

TESTIMONY BY MS. KATHY REYNOLDS:
MS. REYNOLDS: As Tom indicated, I'm Kathy Reynolds. I'm with the -- executive director of the Washtenaw Community Health Organization, and I'm pleased to be able to share with you some of what we've done in providing an integrated mental health, substance abuse, and primary care benefit for people who are in the public mental health system here in Washtenaw County. And as Tom said, we had great support from the Department to do this. We had to change the law to do this, and so it's taken us awhile. But we've been very successful, I think, in reintegrating the Medicaid benefit here in Washtenaw County. We're the mental health board, we're the substance abuse coordinating agency, and we work with the University of Michigan to provide services for those folks who are in the MCARE, Medicaid, HMO. Those dollars flow through us and are monitored by our board in terms of all of the services that are provided to those consumers in the county.
I wanted to share with you just some of the things that we've been able to do in our three years of existence as a coordinate program. Before I do that I do want to say

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that I think this was a strong initiative by our county, because our mental health board voted to dissolve itself. And it's not often that you'll have organizations do that. So we voted to dissolve ourselves and to merge with the University of Michigan health system in the community health organization. And at present time, that board is appointed half by the university and half by the county so that we have a sharing in the policy development and management which is think is key to its success.
What we've been able to do is we do now have an electronic case record -- patient record that was developed at the University of Michigan that we worked through HPPA and privacy and rights issues to be able to integrate the mental health information into CareWeb, the University's

electronic case record, so that a primary care physician who's seeing a public -- a mental health consumer can go online and look up a portion of that public mental health record. They can find out what the diagnosis is, who the treating psychiatrist is, what medications they're on, what their primary problems are and what we're working on in the mental health system.

Also, the psychiatrists at the community mental health center are on and have privileges on the CareWeb system. And they can go in, when they're working with community mental health patient, and sign in from the mental health

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office and access the primary care record. They can look up the lab tests that have been done, if they're going to prescribe new medications. They can see when the last EKG was done. All of those health records are available to the psychiatrist in the community mental health center. And that's gone a long way towards integrating and providing coordination of care for this population.

You've heard about medical management. We work with Tom Schap at the medical management center with our high utilizers. And we're on a new initiative now to try to bring together what we call on the mental health side, "case managers," what on the medical side are called "care managers." We're bringing those folks together so that we can take an integrated approach to the care and to the management of high utilizers within the system.

We've been able to develop a health risk appraisal so that all the folks in the public mental health system are getting an assessment of their health risks. And we're computerizing that right now into a database, but we're able to assess and determine if they need to go to their primary care physician, if they even have a primary care physician, and getting them linked. So we're able to address the primary care needs in the mental health system.

We're very proud of our data warehouse. We've been able to integrate substance abuse, mental health and

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primary care databases into a single data warehouse so that we can tell you how much all the schizophrenics in Washtenaw County have received in primary health care from the University of Michigan in the last year. We can drill down to the patient level and give you the cost of the public patient in Washtenaw County. So we've been able to bring together all of these Medicaid databases into a data warehouse that's refreshed nightly from each system so that we can see who's been in the ER the day before, do we send the mental health case manager out to get them, do we need to send the care manager out to help them get health care or whatever. But we have, I think, a very positive -- that data warehouse was also funded by the Department in terms of helping us get that in place. But it is functioning now, and we can run the cross-tabs on the data out of that data warehouse.

We also, through, I think, our partnership with the University had addressed some of the concerns about evidence-based practice. We use the University to help us find those evidence-based practice and we're implementing them in the mental health organization here in the county.

Right now we have initiatives for fidelity and evidence-based practice and assertive community treatment, supported employment, co-occurring disorders and family support. So we've been able to use the University to bring

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in the experts and to help us develop those types of fidelity instruments and scales that we can use to make sure we're providing the best care for the public dollar.

And then, finally, we're very proud of what we call our health services access system here in Washtenaw County. Medicaid and indigent consumers can call one 1-800 number and get referred to public health, mental health, substance abuse, the Washtenaw Health Plan -- which you're going to hear about in a minute -- and also get help with getting to their primary care physician through that system. So we've been bringing together that triage point and that system of care so that consumers can have a single place to call rather than doing that. It's helped -- you may have heard a lot about the boundary problems between HMO's and the mental health system and primary care. The integrated access system helps us bridge those boundaries and we have very few of those problems here in Washtenaw County, I think as a result of what we've been able to do with health services access.

Most recently we've partnered with what's called the Washtenaw Health Plan. And that was in May we took over their screening and health services access so that, as I said, we can now provide when a public consumer calls, we can get them linked with whichever system of care they need. And if they don't have health care, we can get them

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linked to the Washtenaw Health Plan, which is our indigent health care system. And Ellen Rabinowitz will tell you a little more about that indigent health care system and its link with all of us.

TESTIMONY OF MS. ELLEN RABINOWITZ:

MS. RABINOWITZ: Thanks, Kathy. I'm Ellen Rabinowitz. I'm the executive director of the Washtenaw Health Plan, which is the county's vehicle for providing an expanding access to health care for uninsured residents of the county. As Tom mentioned, Washtenaw County has a long history of serving the indigent and uninsured. For many years the county operated a small indigent care program, first as a hospitalization program under the resident county hospitalization program; later as a small managed care model, and most recently with the Washtenaw Health Plan.

I imagine you know a fair amount of how we're organized, because the Washtenaw Health Plan is Washtenaw County's iteration. These kinds of health plans are operating in other counties in the state: The Ingham Health Plan in Ingham County, Muskegon County has a program like this, Wayne County and many other counties. What we do is we promote, arrange for and organize access to health care for uninsured, low-income county residents. We do it

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very much in partnership with our local health care system.

The Health Plan Corporation works with the county, with U. of M. health system, with St. Joseph Mercy health system, and a variety of other small, local providers who traditionally have served the uninsured.

What we provide are a whole range of health care services; primary and specialty care, hospitalization and pharmacy, operated in a managed care kind of model. You've heard a lot of folks -- you heard Dr. Billi, Dr. Carli -- talk about disease management, chronic illness management protocols. With the help of a large Federal grant, we are operating some disease management programs. Together with the U. of M. medical management program, we're targeting high utilizers. Together with St. Joseph Mercy health system and their quality institute, we're implementing a system of clinical care reminder letters, to remind patients with chronic conditions to get the needed services.

Our client population includes low income residents of the county. Our income guideline is folks who are at or below 185 percent of the Federal poverty level. We also take responsibility for the State medical plan program, the very lowest income members of our community. Currently we have 3200 people enrolled in our program, with projected increases of up to 4500 by the end of next year. As Kathy

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said, we partner with the WCHO. The Washtenaw Community Health Organization provides all of our administration services. Health services access provides that "one-stop" shopping. They do all of our enrollment, member services and provider relations.

Like some of the other health care plans around the state, we're looking to expand in new and different ways. In January we're launching a discount prescription drug program like the ones operated in other counties across the state. In the spring of this year we intend to launch a third-share program, an employer sponsored program in which a health care premium is split in three ways, between an employer, an employee, and then with a public subsidy.

We survive on the commitment of both our county and our local health system providers. As I said, Washtenaw County has had a long-standing commitment to serving this population. Our program also exists with the very substantial donations that our hospital partners provide to us in the form of uncompensated care. Financing for our program comes from the Medicaid special DISH (phonetic) payments that I think you're all familiar with. What that has allowed us to do is to reorganize our local commitment, our local resources, to leverage additional resources, but to create a local solution with some unique local partnerships.

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TESTIMONY OF DR. DAVID NEAL:

DR. NEAL: I am David Neal, and I'm assistant professor of social work in the Department of Psychiatry, and the associate director of the Washtenaw Community Health Organization. I hope that you can appreciate what we're saying in terms of the need of organizations to provide care for these very high utilizers and patients who need care from both systems. And we need the State to be a

partner. Because as Dr. Billi indicated, the risk and the cost for providing this care, we really don't know. And if there isn't -- if the State isn't a partner to share that risk, the system can't take it on.

The other thing I want to raise for you is the traditional Medicaid, because the traditional Medicaid is still on the fee for service model. And the mental health benefit is 10 visits with a psychiatrist. And that's not sufficient. And, in fact, I would submit that a lot of those folks have other kinds of social issues. I mean you can provide the best health care in the world to a consumer, and if they don't have family or other natural supports in the community to help them follow that care, it's not going to work. So we need the traditional Medicaid or a system that will support the health navigator or other kinds of mental health providers to help with that kind of care that these folks need as well. Thank you.

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DR. PORTER: Will you take some questions?

DR. CARLI: Please.

DR. PORTER: Thank you very much. My first question, it sounds sort of like a perfect solution, and you've done everything -- what were the problems that you found getting this public/private partnership? There must have been one.

DR. CARLI: Well, I can think of a few. Somewhat to my surprise, the clinical integration has proceeded rather smoothly. It's the integration at levels above the clinical that has taken a lot of time. Clinicians want to work together. They all are wrestling with the same difficult cases, whether they're on the county side or, you know, the university side.

Getting people to work together in a collaborative way has not been the problem. The problem has been merging data. The data integration piece has only recently been able to be pulled off. That took us two and a half years. Merging funding streams, which was the initial goal, has been -- has proven to be somewhat impossible, because the categorical funding for uninsured mental illness, Medicaid mental illness, substance abuse uninsured, primary care and, you know, HMO, Medicaid fee -- the funding streams are so difficult to merge that we were forced to put the organization together and try to act in cooperation with each other as if the funding streams were merged. So that

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if Kathy, on her side with CMH dollars, can help me on my side with a difficult diabetic who needs to be in one of her group homes, she will stretch the definition somewhat to help us. That's out of her pocket and vice versa. In reality, though, we've not been able to do that because, frankly, the there's so much fear on both sides that the HMO's and the qualified health plans will raid the CMH or that the CMH will somehow consume the physical health care dollars that we've not been to bridge that at a state level. At a local level we have, and we've been able to do it. While it's unique for Washtenaw in many ways, I don't think all of our ingredients are unique. They principally come from a group of folks who've met every week for years, developing this program and developing the trust and the commitment to serve this vulnerable population.

DR. PORTER: Thank you. Jim?
MR. HAVEMAN: Well, for the people in room here and the people who've been watching this, this is probably the finest example of community health in the state right now, and what I think, what we've been trying to do by integrating the department as well. And what happened here is not necessarily being clambered by others to repeat around the state, because they know that what they did here in Washtenaw County, with the hospital and community health board and public health is first said, "What's best for the

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consumers?" and then went back and designed an organization to meet that objective. And most people still want to maintain the silos and the -- and everybody having their own little place and their own little data systems and their own little way of doings things. And what this has done is set a standard, a very high gold standard out there that we can point to, to say it can be done.
And what was unique in Ann Arbor, I think, is the University and a community mental health board that had some experience working with public health through some unification, I mean, they were thinking that way already, and also the University's willingness to partner with that. Now, can this be repeated in other communities? Sure. I mean, there's other universities, there's other medical centers. This could become more of a regional model once some of the details are taken care of here.
So -- and you've got to remember, if you just say Washtenaw, Oakland and Wayne County and Kent and a few others, you've got 80 percent of the Medicaid population. I mean, it's not like you have to do the whole state. So I'm really hoping that the commission endorses and points to models like this as to what can be done. Is it hard work? It certainly is. But it took the commitment of some people who said, "We're going to make this work." And they did. And, sure, it has a way to go, and it did take some

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legislation. And as you know, the system -- the legal rules out there necessarily don't always support change. And so they had to go back and change the law to make this happen. And that took a concerted effort, you know, to make that happen. So this has not been easy, but it's the right thing to do.
DR. PORTER: Thank you.
DR. CARLI: Thank you very much.
DR. PORTER: We have two more presentations tonight. We're going to have Christine Goeschel from the Michigan Health and Hospital Association to comment on health care -- health care and patient safety. And then Janet Olszewski from MCARE to talk about the managed care standpoint. And so if we can welcome Christine.

TESTIMONY OF CHRISTINE GOESCHEL:
MS. GOESCHEL: Thank you, Dr. Porter and members of the commission for receiving my testimony this evening. For those of you that I know personally, my inclination at this point is to throw this paper aside and talk to you about all the stuff they've been talking about. Because I have ideas and excitement and enthusiasm around many of the

issues that we've heard about this evening. But for the sake of brevity and to kind of stick to my agenda, I will read to you from the materials that I've presented.

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I'm Chris Goeschel, and as a registered nurse I have worked full time in health care for over 25 years. My clinical experience includes work with adult and pediatric critical care patients and families, although for most of the past 15 years, I've served in administrative positions in hospitals ranging from nurse executive to quality executive to chief compliance officer and most recently, for the last three years, I've served as senior director for health care quality at the Michigan Health & Hospital Association.

My work at the MHA brings me into regular contact with hospital quality and safety leaders throughout the state. And in my liaison work I'm also in contact with leaders from other key stakeholders groups that are as invested in continuously improving the quality and safety of health care that is provided to Michigan citizens as our hospitals are. The level of dedication and resolve attached to health care quality and patient safety in our state is unsurpassed.

Michigan is recognized as a leader in collaborative quality and safety efforts. We are being watched nationally for the unique ability we have to gather forces around issues in a spirit of voluntarily "doing what is right," and then delivering results. I thus urge the commission examine closely the initiatives that are already

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taking place in our state as you conduct your work.

For over six years, Michigan hospitals have voluntarily participated in a public report that portrays hospital specific data on mortality and length of stay for key procedures and patient diagnoses. In 2001, Michigan hospitals received one of only two "Cheers" awards given by the Institute for Safe Medication Practices, for the outstanding level of participation in a national medication safety improvement project. Michigan's performance was more than double the national average with fully 80 percent of our hospitals participating in the medication safety effort.

When To Err is Human was first published by the Institute of Medicine, Michigan health care providers, including the MHA and its members, joined forces to develop a collaborative approach to patient safety.

The Michigan Health and Safety Coalition brings together providers, purchasers, employers and the State of Michigan in an open dialogue and an aggressive work plan to improve quality and safety. Some of the many activities of the Coalition include that in 2001, an educational luncheon was held for legislators, with Dr. William Richardson from the Kellogg Foundation and the Institute of Michigan keynoting.

In 2002, an education forum co-sponsored by the

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National Agency for Healthcare Research and Quality brought leaders from the IOM and leaders from throughout the

country in the patient safety movement to Michigan to work with our leaders to foster creation of a culture of safety in our hospitals.

In 2003, Dr. Lucian Leape and other national quality and safety leaders will again be in Michigan, working with providers to continue the evolution of our quality and safety efforts.

The coalition has also sponsored pilot projects assessing the impact of handheld technology on physician practices, has written grant proposals to examine the relationship between nurse staffing and patient outcomes.

Most notably, perhaps, the Coalition has worked with Michigan clinicians -- Dr. Jack Billi led one of our expert clinical panels -- to develop quality and safety measures that addressed areas of care that have been deemed most important by employer groups such as Leapfrog. Those guidelines provided the basis for a statewide hospital survey, recently completed, wherein over 114 hospitals have posted detailed hospital specific quality and safety data on a consumer website that is sponsored by the Coalition.

More impressively, over 98 hospitals further agreed to work during 2003 with the Coalition to reassess the guidelines, close the gaps between performance and

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recommended practice. Cost, quality and access to care are all parameters that will be assessed during this next phase of coalition guideline work.

In addition to work with the coalition, Michigan hospitals have partnered with Blue Cross/Blue Shield of Michigan and the University of Michigan in proposing examination of what measures really work to facilitate quality improvement in hospitals. Through one of six national three-year "Rewarding Results" grants, awarded by the Robert Wood Johnson Foundation in late September, Michigan hospitals and our clinical staff will take collaboration to a new level in attempting to learn from each other regarding best practices.

Michigan hospitals are also working together with our partners in public health to address our state's number three killer, stroke. Throughout 2003, MHA will be working to engage all hospitals in an education and awareness campaign based on the role of acute care providers in addressing broader issues of public health; for 2003, most specifically, that emphasis will be on stroke care provided in our hospitals. In each instance of collaboration, the MHA is looking toward the Institute of Medicine and state and national content leaders to carve the path for our initiatives. We would urge that the commission doe their same.

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In several follow-up reports by the institute of Medicine, including Crossing the Quality Chasm in 2001, Leadership by Example earlier in October of this year, and The Future of the Public's Health in the 21st Century, which was just pre-published in November of this year, templates are provided, not only for addressing health care challenges facing us as a nation, but for developing strategies to embed efficiency in our work.

None of the presentations that I've heard thus far

this evening or earlier in the month in Lansing are foreign to what's included in all of those IOM reports. I think that members of this commission as key stakeholders in our state will understand that the pressures we face are imminent and they are mounting. And we would urge, at the MHA, that we turn to the work that's already been done as we build a better future for Michigan.

The only true hope for better health care for the future is through the collective wisdom and willingness of all of us to collaborate on solutions. Most importantly, the IOM reports and the work that Michigan key stakeholders have been engaged in call upon each of us to remember patients as we craft alternatives to system slippages that exist today.

It was tempting tonight to present the commission with a laundry list of what we think we need. We need better

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peer review protections for quality databases. We need funding that aligns payment with public health goals, et cetera, et cetera; much of what we've already heard tonight. I -- instead, from the MHA perspective, I decided to urge you to look at what we in Michigan already have, and use the resources and the history that we have as you determine what you think we need to move forward.

In closing, I'd encourage the commission to draw upon the fine work that is already being done in Michigan and nationally, to highlight the spirit of cooperation that has inspired the success we've enjoyed thus far And that when you consider the quality and safety challenges that face you, you acknowledge that Michigan hospitals are ready, willing and able to be at the table with you. No one wants this more than we do, and no one recognizes, more than a system that has been invested in providing acute care and realizing that that isn't the answer to the question, that the only answers that will be useful and fruitful in the years ahead are ones that we develop together.

I'd be happy to answer any questions.

DR. PORTER: Questions?

MR. HAVEMAN: When the report came out that indicated over -- what? -- 40,- to 100,000 people were dying of medical errors or patient safety really became an issue, then you'd take a look at the numbers of people who, again,

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infections, you know, and how much of that is preventable, do you think the -- and I ask this because I don't know the answer -- do you think the hospitals responded aggressively to that? And do you think some have moved a little quicker than others? And do you think there are examples? You know, one thing I've thought about, I think I mentioned before is that in certificate of need we should say, "Hey, if you want a certificate of need to expand, maybe you have to have a demonstrated medical errors program" or some of these things in place that are working, because we know, as you know, with automated laboratories and bar codes, there's much that could be done to prevent that. And I'm just wondering how much of that is being done.

MS. GOESCHEL: I think that there's a tremendous amount being done. I think the initial hospital reaction to that IOM report was stunning disbelief. No one had

quantified the numbers quite like that before, unless you were reading the scientific literature which had been publishing numbers like that for quite a period of time. In fact, I think very quickly the hospital industry, at least in Michigan, got behind the fact it doesn't matter what the numbers say. The reality is there's a problem. And this is one more piece of evidence that suggests that our current systems are broken.

I think that that ISMP Cheers award that I alluded

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to -- we received one of two Cheers award in 2001, and Lucian Leape received the other one. And part of the reason that Michigan hospitals got that award is that they quickly got on the bandwagon and said regardless of whether it's 44,000 or 98,000, that IOM report said medication errors were a key focus. And very quickly -- again, we didn't try to craft a survey that would assess what hospitals were doing. We looked at the national expert, the Institute for Safe Medication Practices, 194 rather detailed questions that were the foundation for that particular medication safety improvement initiative. And, like I say, the Michigan response rate was stunning in how much higher it was than anywhere else in the country.

And I think that that level of response was not unique to medication safety. I think we've gotten great interaction, not only on medication safety but on some of the other patient safety initiatives. At the MHA, one of my favorite moments -- and I've only been there about two years -- was when we pulled together a patient safety committee. And we had a medical staff executive from the University of Michigan and a medical staff and administrative executive from one of our smaller hospitals that immediately got into a debate about who had it easier in terms of trying to do some of this stuff. And the small hospital was crying "we have no money and resources," and

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the big hospital was crying "we have too much bureaucracy." And very quickly, they realized that they have a lot to learn from each other; that moved the initiative and the collaborative efforts further than we could ever had imagined.

So I think the kind of work that's happening here with mental health services in Washtenaw County, the kind of work that Dr. Billi's doing that he's sharing through the Michigan Health and Safety Coalition, are helping set the tone for an agenda that says it's hospitals, but it's not just hospitals, it's not just teaching hospitals, it's hospitals in our work in the context of the public health agenda; so population care, acute care, chronic care, making Michigan a better place.

And we heard last time at the commission meeting, we heard again tonight, probably most of us in this room -- if I can make a quantum leap -- are of an age where we realize that when baby boomers hit peak health care use years, which is right around the corner, we are really in dire straits. So we need to get on board with addressing some of issues, sooner rather than later.

DR. PORTER: Thank you very much --

MS. GOESCHEL: You're welcome.

DR. PORTER: -- for that insightful presentation. We appreciate it.

MR. HAVEMAN: Thank you.
MS. GOESCHEL: My pleasure.
DR. PORTER: The final presentation -- well, I don't know if it's the final one, somebody else may want to say something, but in the absence of the final presentation, Janet Olszewski, Vice President, Government Programs and Regulations for MCARE will talk about the managed care standpoint.

TESTIMONY BY MS. JANET OLSZEWSKI:
MS. OLSZEWSKI: Thank you very much, Dr. Porter, commissioners, Director Haveman. It's a pleasure to be able to address you this evening. My esteemed colleagues from the University have done an excellent job of making all the points I planned to make, so I think my comments will be very brief. Obviously we work together; we're an integrated health system and so our thoughts follow similar lines.
I wanted to give you a little bit of background information about MCARE. We are a not-for-profit managed care organization, owned by the University of Michigan regents. And in that, we are rather unique in the country. There are only perhaps one or two organizations like ours around.
We serve 204,000 members at this point in time,

largely in southeastern Michigan. We have a service area that is -- encompasses southeast Michigan, goes up to Flint, and then over to the Lansing area. I'm not here to talk about our commercial business today, but you will see from my remarks that that does influence how we are able to serve Medicaid members through the various contracts we have.
In addition to our commercial business, we have a contract with the Department of Community Health to provide service to Medicaid beneficiaries. And at this point in time we serve approximately 14,600 of those beneficiaries. And then as of October 1st of this year, we're very proud to join with the University in providing the administrative services for Kids Care, which is one of the two special health plans that exist in the state, Children's Choice of Michigan is the other, for children with special health care needs. Now, that program's been in existence for four or five years, but we're -- MCARE's role in the program is new. And today I want to focus my remarks on the Kids Care program and then on Medicaid as well.
I think that the promise of managed care which is, you know, essentially the right care at the right time for the right price, and really high quality care, has the most benefit to offer people with serious chronic illnesses who use the health care system a great deal. Those of us who

are healthy and have intermittent contact with the health care system probably can do reasonably well on our own. But folks who need a lot of health care really have the

most to gain from the promise of managed care. And that's one of the reasons why we're very interested to be involved with the Kids Care program, because we believe that we have a lot to offer that group of people. I think we are probably an example of an excellent experiment that Dr. Billi has suggested in his remarks that the State undertake with these -- for these populations. Kids Care of Michigan is an excellent experiment in this.

In Kids Care, we partner with the families of children as well as the adults themselves who are eligible for the program. The principal coordinating physician for these individuals, we partner with local care coordinators, nurses who are part of health departments or home health agencies in their local communities. And we work to develop a plan of care, implement a plan of care, coordinate that, monitor it, change it as things go along so that the child or the adult continues to get the best care for their particular set of conditions. And I think it's important to remember that most of these children don't have just one condition, they have multiple conditions, so you're managing many different things at once.

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We operate in 39 counties of Michigan with this program, so we are in this program in a much wider geographic area than we operate through our health plan through our licensed HMO activity. And I think through this program we, together with the University, are able to use the extensive clinical pediatric expertise of both the medical school, the Mott Children's Hospital, and the other components of the University of Michigan health system so that we can help families and providers throughout the state get the best care, get the best state of the art pediatric care that's possible. And that's our goal, is to help families and physicians provide the best care.

What I have shared with you today are some of the consumer survey results. One of the things I always like to do -- I've been in this business awhile, and one of the things that's always important to me is what do our families think about us? You know, when I worked for the State that was my concern. And that still is my concern at MCARE. If you look at the results of that survey -- I'll just highlight a couple of them for you -- 94 percent of our members, and we have about 2500 members at this point in time, not too big because this is a relatively small program; there are only 27,000 children eligible statewide for the program. And this is a program that is entirely operated on voluntary enrollment. No family is required to

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join our health plan. They are offered the opportunity. So 2500 people have joined and we have not been taking new enrollments recently because we were in a transition period, moving from Health Alliance Plan doing the administrative services to us, and we did not want to bring in new families at a time when we were learning how to set up phones and all of that kind of stuff.

94 percent say they're very satisfied with the program. 91 percent say they're very satisfied or satisfied with the care coordination they receive. And one

of the things that I think is very important is 94 percent say they would recommend to somebody else that they join Kids Care. I mean, that's always what says it to me. If you're willing to tell somebody else about this and say, "Gee, I think you should sign up," that's what's really important. And we're very proud of that.

I think the benefits that the State gets from this kind of program -- you've heard the statistics. The money is in the aged, blind and disabled. The money is in people who have a lot of health care conditions. I think what the State gets from this program is the experiment, the promise of working out a model that will provide excellent care for this group and will be able to do it within reasonable, fiscal and administrative bounds.

You also get the expertise of an academic medical

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center being filtered out and disseminated throughout the state. The clinical guideline development, the support to physicians in communities, whether it's through consultation, guideline development and dissemination, provider advisory groups, et cetera. That promise is there. I think you also benefit from the fact that we, as kind of a central coordinating agency, have more contact with those local care coordinators who operate in the communities and are closest to the families. And so we're able to provide them more support in the care coordination function. So we're able to provide support in the medical functions as well as the care coordination functions.

I do think -- I do agree with Dr. Billi that in this kind of a population, you cannot operate it on a fiscal model like we have for the general Medicaid population, in terms of capitated managed care. 2500 seriously ill members just does not work for the type of capitated managed care model that exists for the general population. But I think we have lots of opportunities to look at what does work with this group.

I'd like to, now, just turn my remarks, for a couple of minutes, to Medicaid. I mentioned that we have 14,600 Medicaid members. MCARE serves about 72 or 73 percent of the managed care Medicaid beneficiaries in Washtenaw County. We have 72 or 73 percent of those enrolled in

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health plans in Washtenaw County. The University, through its contract with other health plans, has another 12 percent. So us, together with the health system, serve about 82, 83 percent of the Medicaid beneficiaries in Washtenaw and Livingston Counties. We are the primary health plan.

I think that this is an important piece of information, and one that is both something that's good and bad. One of the ways we got this distinction was by being a very high quality provider. Because our quality scores are so high, the State has us at the top of the list to receive automatic enrollments; people who do not choose a health plan automatically get assigned to MCARE. We receive many of our members through that vehicle. In addition, we had another health plan in this county -- actually in both counties -- that had frozen enrollment for quite some time, for over a year. So even voluntary

enrollments were coming in our direction. It can be good to get all the members, because you don't necessarily get adverse selection, you get all the selection. But on the other hand, you are taking care of a very ill population in many ways. And without payment methodologies that recognize risk and reimburse for risk associated with that, it can be an overwhelming responsibility.

I think that we have demonstrated, through our

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Medicaid contracts, the ability to provide high quality care to those beneficiaries. We, as a commercial health plan with excellent NCQA accreditation, apply the same discipline to measuring quality for our Medicaid members as we do for our commercial members. We analyze patterns of care and outcomes for our members. We identify problems. We implement quality improvement initiatives. We remeasure. We do all of the basic quality checks that exist.

And I think our status as a health plan in the Medicaid program really demonstrates our success. For the second year in a row, we have received the highest score possible in the Department of Community Health's consumer guide to health plans. We are also in line, for the second year in a row, to receive a benchmark bonus from the State. In developing that benchmark bonus, the State measures us on 14 different types of performance measures. And of the 14, MCARE ranks 1st in seven of them; we rank 2nd in one, we rank 3rd in three and we rank 4th in two. So, you know, we're really a very high quality plan. And I think a lot of that comes from the infrastructure and the experience we've built up with our commercial population.

I think that -- just to put a little personal face on this, there are a couple of cases we've had recently that I think demonstrate, sort of, the unique role that we can

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play in this. We have a situation -- had a situation recently where a 36-year-old woman who's an asthmatic -- and she is what, I think, all of us would describe as a frequent flyer -- she's using the ER all the time. She's got $11,000 in prescription drug costs this year alone. She's shown up at different providers. And I think the role we can play is whenever she hits anywhere in the system, we see a bill. We see a request for a prior authorization. We see something. And we've been able to sort of wrap our arms around her through our asthma disease management program and our care management activities. And when she -- we've hooked her up with a primary care physician, but, you know, we can't force somebody to go. We provide transportation, we try and get them to go, we try and encourage them. But they can still show up in an emergency room anywhere. And our ability is to hit her every -- to sort of see wherever she hits the system and influence what's going on at that point in time with that inpatient hospital admission, with that emergency room visit and always try and rope her back into the appropriate follow-up care. And we've been able to do that with her. And we're actually starting to see her go to her primary care physician. But this, you know, one person at a time.

And this -- I was here when Dr. Freed and his

colleagues were talking, it takes a lot of work to get

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people to change their historic patterns of use, in using the emergency room. It's not overnight. And it takes effort to do that. But we've been able to do that, because we can see it throughout the system. A provider would only see the admissions that were hitting their particular facility. And a primary care physician might or might not get reports back from other places. So that's one case in which we have demonstrated, I think, a real value to the system.

The -- another one is a 26-year-old woman, who's a single mother of three who is a serious diabetic. And her primary care physician's office actually called us and asked us to help, because it was becoming too much for them to handle. And what we discovered in doing the intervention was her own mother had served as her primary care giver as well as the care giver for her children, and her mother had recently died. And so we got involved with the primary care physician's office, with the Washtenaw County Health Organization which you heard about recently, and we put -- together, all of us got together, did a basically a case conference in the home, did interventions, set up a plan of care. This woman was someone who needed mental health care and was not getting it. We've gotten her into a group home. She is -- her children are in temporary foster care while she is in this group home.

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We've gotten her into diabetic education programs. The group home is helping her manage her diabetes. We're getting her to see her primary care physician. Again, because we saw all different pieces of the picture, we were able to have a unique constant, as it were, in terms of coordinating the transportation to the medical services.

I think that's one of the things that gets lost often when we talk about health plans. We talk about, quote, "administrative costs" as if they add no value to the system. But what we're talking about here are those case managers I described who are actually interacting with our members. We're talking about those health educators, those nurses who are on the phone with our members teaching them how to use their -- how to manage their diabetes, how to manage their asthma, et cetera. We're talking about the public accountability in terms of -- or the measuring of our activities, et cetera; the fact that we are willing to stand up and be counted for the performance we have.

And not all of our performance is good. We know that there are other areas where we are not doing a good job. For example, we're not doing a good enough job in blood lead screening. And we're trying to identify what the problem is and trying to identify interventions that would help us identify the children who are in need of screening as well as care for blood lead poisoning.

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I think one of -- I guess my final remark would be that we have done all this at, essentially, a price that both the State and we agreed to was reasonable in 2000. We've now gone two years without a rate increase for our

Medicaid contract. And I think that it would be foolish to not recognize that funding adequacy going forward is a concern. We certainly have seen double-digit increase in costs with this product like we have seen with anything else. We have been very pleased to work with this administration on the quality assurance assessment program, which we believe will have some opportunity, we hope, to help us maintain the adequacy of funding for this project. We're very pleased with the recent legislative activity last week that, you know, made some modifications to language that was necessary for CMS approval. But I think it's important that we are able to go forward with that. And we'll look forward to working with the administration to finally get that CMS approval. But I think that is one of the concerns going forward is just generally the funding adequacy for the Medicaid program. Thank you.

DR. PORTER: Thank you very much. Your ratio of Medicaid participants to your commercial is about -- what? -- 10 percent Medicaid? And I presume, to some extent, that's how you sort of balance all of these things, is it, to some extent on your relative percentages. Do you

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think for most of the managed care companies, that is the sort of percentage that works?

MS. OLSZEWSKI: Well, this percentage, for us, has a lot to do with how we're set up with our network. For the Medicaid product, the University of Michigan health system and its related, you know, faculty group practice and related practices are the sole delivery system. So our capacity for Medicaid is really very much --

DR. PORTER: Constrained --

MS. OLSZEWSKI: -- determined by that; whereas for our commercial product, we have a, --

DR. PORTER: Wider range --

MS. OLSZEWSKI: -- you know, a much wider network. So I don't know if that particular percentage would apply for most managed care companies.

DR. PORTER: Thank you.

MR. HAVEMAN: I remember in 1996 I was giving a talk in Detroit, and a mother came up to me and -- I'll never forget it. She was about 28 and had a 4-year-old multiple handicapped child. And she was just at her wit's end. She was dealing with eight physicians, had no car, had five case managers, 15 appointments she'd have to keep over a two- or three-week period. And I asked her how many names just connected with that child. There were 76 individuals, all trying to make her life easier. And she had to quit

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her job to keep it all straight. Now, it made no sense to me. We were going backwards so I just want to give that as a reference, as the genesis that started this type of program.

DR. PORTER: It's a great program.

MR. HAVEMAN: And you've done great around the state and the western part, and this is how it should be for all 27,000. And we fought with the legislature about whether it should be a voluntary or a mandatory program. But, you know, it's the parents who are going to sell this program. And it's really neat to see that type of satisfaction.

That's really great. Nice work.
MS. OLSZEWSKI: Thank you.
DR. PORTER: Thank you very much. I like to have meetings that conclude on time. Are there any other comments that anyone would like to make at this juncture? Hearing none, I'd just like to take -- oh, sorry, sir.
DR. MEGHNOT: The session is not finished yet?
DR. PORTER: No.
DR. MEGHNOT: I would like -- I'm a solo practitioner.
DR. PORTER: Please.
DR. MEGHNOT: I found an opportunity to come before you. I'm a low man on the totem pole, and I'm a "johnny come lately," too, so that doesn't excuse --
DR. PORTER: I'm sorry -- I didn't have your name, so

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I apologize I didn't call --
DR. MEGHNOT: I know. I apologize because I didn't fill it in.

TESTIMONY OF DR. PERRY MEGHNOT:
DR. MEGHNOT: I'm a gynecologist in the State of Michigan and I practice in Ann Arbor, Michigan. I have been in practice almost 35 years. For the last two years, I had to stop doing obstetrics. I just do gynecology. This letter that you sent to me interested me to come over before you and make a few comments how to improve the health care system from my point of view.
In order to be more pragmatic about it, I think in this day and age medicine has become very -- overly commercialized. When there's a pocket, pickpocket people go after it as a matter of lawsuit or where there's benefit, everybody wants to cut the corners to give you the least, get the most. Most HMO's including our biggest, the offerer of the insurance which is Medicare, nobody covers the preventive medicine, including MCARE. MCARE offers you preventive medicine once a year and this happens to be second time around, three weeks later, a woman started bleeding, "No, you have to get a referral," whereas Michigan has offered us a specific article that any woman -- any insurer that insures a woman or man, they have

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to offer the ability to that woman to go to a gynecologist and primary care physician. One doesn't have to give the permission to the other. But MCARE doesn't recognize that. Most of the other insurance companies don't -- HMO's don't recognize that. In order to improve these kind of things, we need to improve, especially through Medicare, that they go for -- they pay for preventive medicine, number one, to prevent. An ounce of cure is better than a pound of treatment. But these people, they don't believe it, they don't fix it until it breaks. That is not right.
And the insurance companies, the Medicare, if the State would be able to, have them to provide drug coverage for the patients, that would be a great improvement. Also, through the force of the legislature, if they make drug companies don't increase the cost of medicine in the United States, whereas they make the same medicine they take to Canada for about 40, 50 percent less than what they sell. That's not right. The provider, as a citizen, we give

contribution, we give them money, the legislature, the government, to make them -- possible to create that medication, then they should be able to make it for lesser cost or the same cost that they sell it in Europe. There's no point to increase the cost. That is one thing.

And from the doctor's point of view, the people that are administering them, I think they should be given the

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incentive if they increase their volume of their Medicaid and increase the volume of good quality Medicaid -- let's face it. Everybody in this deal from my point of view in practice means a business. If I don't make any money, I can't practice. I need to have an incentive. I'll be glad to give that kind of incentive to the patient. I have been trained, qualified to "first do no harm." I would like to do it. But I get scared I get sued; I'll do the multiple avenue. You become a laboratory doctor. You order this, order that, order that, increase the cost of medicine as a result -- for poor result. There's no reason for that. So I ask you to do something about this. Ask the doctor, if you increase the volume of your patient, Medicaid patient, good quality patient, you get incentive like small business tax. We will take that much off from your small business tax. That will help. And I think there is that possibility of doing that.

And the Medicaid individuals -- I know there is some reason they are on Medicaid. But they're very litigious people. Most doctors, they don't want to see them. They want to sue them. A patient came to me several months ago. A practitioner sent them to me. She needed a hysterectomy. I said that, "Well, I don't want to take her because under the circumstances." The doctor called me, "Why don't you take it? I won't send you any patients anymore." I said,

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"Fine, I'll do it." I knew she had a panniculus about 8 inches high; 350 pounds, 5'2" high. She developed a subcutaneous infection. She tried suing me. These are the kind of things that makes it -- doctors cutting their bill not to take care of these patients. As a result, I think you have the ability to curtail these litigious, nonsensical, non-meritorial lawsuits like Michigan State -- excuse me -- American College of Ob/Gyn has come up with some criteria, which I'm going to hand it to you, how to decrease this type of malpractice.

DR. PORTER: This is very, very valuable. I think it will be useful.

DR. MEGHNOT: It is very valuable. And they send a letter to me that their going to send to all the gynecologists in the State of -- throughout the United States, whoever practice -- whoever becomes a expert witness, whether for plaintiff or for the expert witness for the defense, if their allegation is not correct, it will not support the evidence-based medicine, Michigan State -- excuse me -- the American College of Ob/Gyn is going to turn it into a committee of peer review. You can do the same thing, but don't take up the peer review in the State of Michigan or Ann Arbor, because there are a lot of friends of mine that say, "Hey, Dr. Meghnot all right." No. Pick it up from some place else. They have the same

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quality. They see the peer review, whether from plaintiff point of view or expert witness from point of view of Defense is correct, then they should do that. Don't allow Medicaid person to sue a doctor unless it's approved by you -- first come to you to see if there is a merit to it. You give it five independent doctors. If there is merit, if this doctor did botch it up, if he did the right thing or wrong thing. If it is the wrong thing, it means there's merit they can sue them. If there is not, you should drop it. Any Medicaid person should sign letter in front of you that he will not sue the doctor unless approved by your committee.

DR. PORTER: My malpractice bills to the DMC would change dramatically. No, I think you make some very, very good points. What I would like to -- if you'd like to put them also down on paper and send them in to the commission, we're more than happy to have them. We'll have the transcribed text. Are there questions for the doctor from the commission?

MR. HAVEMAN: Thank you.

DR. PORTER: Thank you very much, Doctor.

DR. MEGHNOT: Thank you very much. I'll hand this down.

DR. PORTER: What I'd like to do now is really thank all the participants who have given testimony today. I'd

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like to thank our host, Larry Warren of the University of Michigan. I'd like to thank the commissioners who have participated here. Our next meeting is going to be in Grand Rapids. Our host will be Commissioner Breon. But before we adjourn tonight -- and that meeting will be, by the way, in January -- but before we adjourn tonight, I'd also like to thank my good friend and our colleague, Director Jim Haveman. This will be his last meeting on the commission. I'm not sure why, I would like him to stay on. But, you know, I think you have done a tremendous job setting us on the right track. We have a tremendous amount of work to do. Your comments have been very, very insightful in getting this commission off the ground. And we thank you for your wise leadership and counsel in the past and I'm sure in the future.

MR. HAVEMAN: Thank you very much. Thank you.

DR. PORTER: At this point, let me call the meeting adjourned. Thank you.

(Hearing concluded at approximately 7:05 p.m.)

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