

BUILDING SUPPORT FOR MEDICAL EDUCATION:

A NEW TOOL IN THE CAO'S AND CEO'S TOOLBOXES

AIAMC Annual Meeting
March 31, 2016

Presenters



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What is the Tool?

- Government Relations
- Advocacy
- Lobbying
- Government Affairs
- Public Policy
- External Relations
- Legislative Affairs
- Grassroots

Amy Perry, President, Sinai Hospital



Amy Perry

**LifeBridge Health Executive Vice President
Sinai Hospital President**

Video Transcript - Amy Perry, President of Sinai Hospital of Baltimore

Good Afternoon, I'm Amy Perry, President of Sinai Hospital of Baltimore and Executive Vice President of LifeBridge Health. I'm so pleased that Sinai is a member of the Alliance of Independent Academic Medical Centers, so that we can work together with hospitals that face similar challenges to ours.

Sinai was founded in 1866 primarily to serve the Jewish population of patients and physicians who, due to discrimination, faced difficulty in obtaining or providing health care. Our history helps us recognize the importance of making health care accessible to all. Sinai Hospital serves one of Baltimore's most distressed neighborhoods, and we see evidence that the economic disparities experienced by these communities impact their overall quality of life and health status.

As Independent Academic Medical Centers, we provide access to a level of care our communities would not have otherwise. We love our more than 160 residents and fellows who they deliver the most up-to-date medical approaches and represent Maryland's future health care workforce. But most importantly, our faculty and residents bring our communities the specialty and subspecialty care that would otherwise not be available to them. These patients know that when they come to Sinai, they are treated by physicians who prioritize clinical care over administrative and research endeavors, who have chosen Sinai because they want to stay closely connected to their patients.

I know you will find the presentation on advocacy and government relations interesting and helpful as your GME programs face strategic and economic challenges. This process – this tool in your toolkit – provides a powerful way to change the course of our programs and enhances our ability to provide high-quality health care services to those in need. Engaging our government and community leaders in supporting our programs is a critical step to success, and I thank you for taking the time today to learn from these experts about how it's done.

Why Use This Tool?

- Health systems receive government funds through **reimbursement** for services furnished to patients and **grants** to provide services (operating and capital).
- Health systems are subject to **legislative** and **regulatory** oversight.



Why? *(continued)*

- Health systems **proactively**

- Work with **legislators and agency officials** and staff
- Determine appropriate **law, policy and budget** positions, and
- Obtain **appropriations** to meet the needs of patients served by our employees and physicians throughout the community.

Why? *(continued)*

- Solve specific problems
 - Ask: ***Can a change in law, regulation, policy, or funding, pursue or protect our interests?***

What Types of Issues?

- Medical Liability
- Population Health
- 340B
- FQHCs
- Certificate of Need
- Self-Referral
- Community Health Workers
- Behavioral Health

What? *(continued)*

- Capital (State/Local) and Program Support
- Community Development
- Tax Exempt Status
- Health Disparities Reduction
- Graduate Medical Education



Who is Involved?

- Internal Legislative Policy Workgroup
 - (President(s)/CFO/General Counsel/Planning/Government Relations)
- Full Exec Team, Directors, Managers and staff as needed to define and flesh out issues
- Elected and agency officials and staff
- Lay Leaders
- Patients
- Physicians/Residents

Who? *(continued)*

- Contract Lobbyists
- External sources
 - Legislative Committees/
workgroups
 - Associations
 - Industry and general
press
 - Community
- Ally or Enemy?



Where Do We Work?

- **Local legislative and regulatory bodies**
 - City Council
 - City Health Department
- **State legislative and regulatory bodies**
 - State Legislature
 - State Department of Health
 - State Health Planning Commission
- **US Congress/Agencies - CMS, HRSA**

How is The Tool Used?

- Hospitals don't vote – people do (relationships)
- One-on-one communication
- Invite Members to hospital events
- Invite Members to hospital-sponsored community events (small grants, scholarship awards, employee awards)
- Economic impact

How? *(continued)*

- Campaign events
- Lobbying
- Fundraising
 - Board PAC
 - Association PAC



Your New Tool!

- Solve specific problems
 - Ask: ***Can a change in law, regulation, policy, or funding, pursue or protect our interests?***

Appropriations Opportunities

- Add funding to an agency for specific purposes (but not earmarks).
- Stop funding for a specific program or purpose.
- Include policy recommendations or directives in committee reports.
- Require an agency to report on a certain activity.
- Raise issues at hearings.

Role of Committees

- **Budget** Committee: Set broad overall annual spending limits.
- **Appropriations** Committee: Approve or modify the President's Budget request for annual discretionary spending on a program-by-program basis.
- **Authorizing** Committees: Create programs, agencies, policy legislation. Provide direct spending for mandatory or entitlement programs such as Medicare, SCHIP. They DO NOT provide discretionary funding.

Mandatory Spending

- Spending level for programs is governed by formulas or set forth by law rather than by appropriations action.
- Examples include: Social Security, Medicare, veterans' pensions, food stamps, school lunch and payment of interest on the public debt.
- Accounts for 2/3 of all Federal spending.

Discretionary Spending

- Spending made available annually through the appropriations process.
- 1/3 of the Federal budget.
- Defense spending accounts for roughly 1/2 of discretionary spending.

Typical Appropriations Schedule

- 1st Monday, February: President submits budget to Congress
- February – May: Hearings
- March/April: Wish lists due to Subcommittees
- May – June: Sub & Full Committee markup
- June – July: Floor action
- August: Recess
- September- December: Conference Committee sends bills to President
- October 1: Fiscal year begins (bill completed or begin continuing resolutions)

Laura Green, M.D.

Ophthalmology Residency Program Director, Krieger Eye Institute at Sinai Hospital of Baltimore



Laura Green, M.D.

Ophthalmology Residency Program
Director Krieger Eye Institute
Sinai Hospital of Baltimore

Video Transcript - Dr. Laura Green, Ophthalmology Residency Program Director at the Krieger Eye Institute at Sinai Hospital of Baltimore

Good afternoon, I'm Dr. Laura Green, Ophthalmology Residency Program Director at the Krieger Eye Institute at Sinai Hospital of Baltimore.

I've been at Sinai Hospital for nearly nine years, beginning as a comprehensive ophthalmologist.

Because of my interest in resident education, I worked more and more with our residents in their clinic and the operating room.

I was asked to be the Associate Residency Program Director, and about five years ago was promoted to Residency Program Director after a successful ACGME site visit, which I organized and led.

I'm currently enrolled in the Leadership Development Program of The American Academy of Ophthalmology. I was nominated to this program by my state ophthalmology society, where I chaired the Education Committee.

I also serve as Secretary of the Board for the Maryland Society for Eye Physicians and Surgeons.

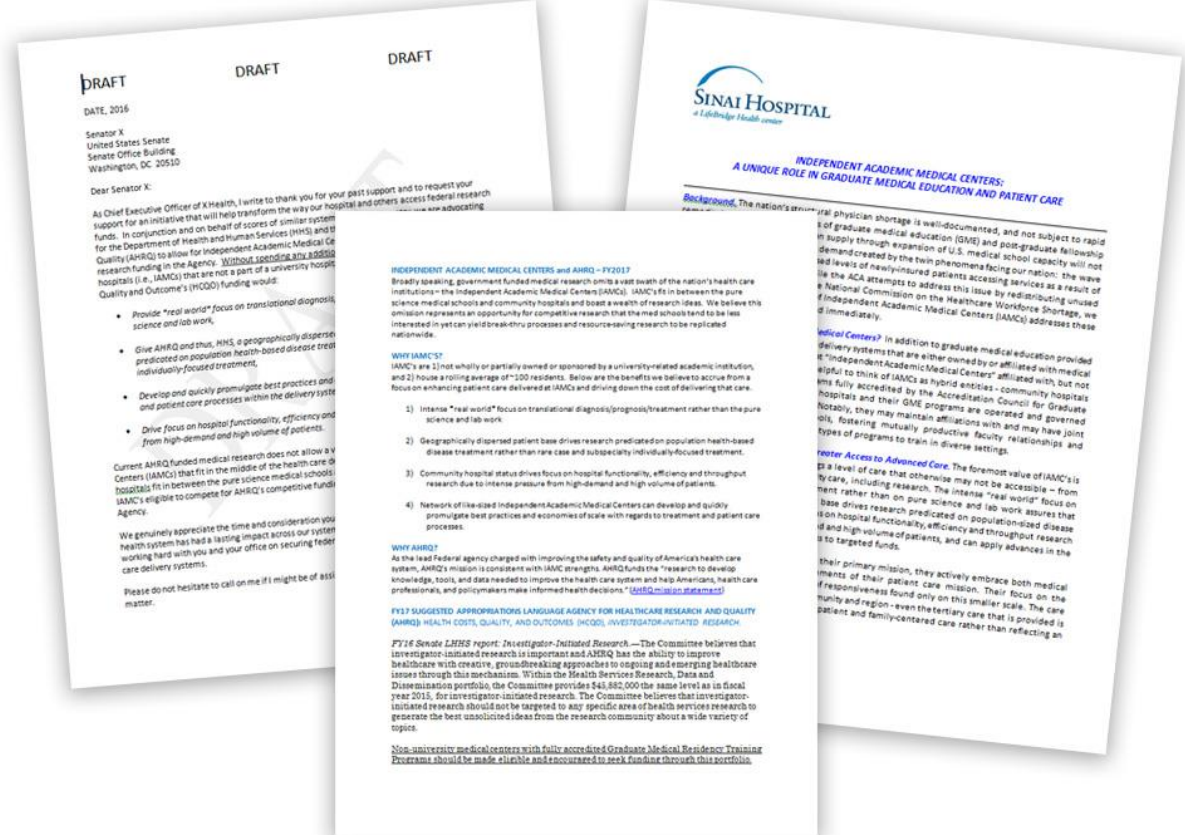
This leadership program is giving me the tools to become an effective advocate for our patients and our profession.

In April, we head to Washington, D.C., to meet with the legislators and other officials who write laws and policies that affect our patients and residents.

My first experience with advocacy came during my time on the board of my state ophthalmology society.

Through this work, I learned the impact that medical educators and resident physicians can have with our elected officials.

Enhancing Funding for IAMCs



DRAFT

DATE, 2016

Senator X
United States Senate
Senate Office Building
Washington, DC 20510

Dear Senator X:

As Chief Executive Officer of XHealth, I write to thank you for your past support and to request your support for an initiative that will help transform the way our hospital and others access federal research funds. In conjunction and on behalf of scores of similar system hospitals (IAMCs) that are not a part of a university hospital research funding in the Agency. Without legislative and AHRQ research funding in the Agency. Without legislative and AHRQ research funding in the Agency.

- Provide "real world" focus on translational diagnosis, science and lab work.
- Give AHRQ and thus, HHS, a geographically dispersed population health-based disease treat individually-focused treatment.
- Develop and quickly promulgate best practices and patient care processes within the delivery system.
- Drive focus on hospital functionality, efficiency and from high-demand and high volume of patients.

Current AHRQ funded medical research does not allow a Center (IAMCs) that fit in the middle of the health care system. IAMCs fit in between the pure science medical schools. IAMCs eligible to compete for AHRQ's competitive funds Agency.

We genuinely appreciate the time and consideration your health system has had a lasting impact across our system working hard with you and your office on securing better care delivery systems.

Please do not hesitate to call on me if I might be of any matter.

DRAFT

DRAFT

INDEPENDENT ACADEMIC MEDICAL CENTERS and AHRQ - FY2017

Broadly speaking, government funded medical research omits a vast swath of the nation's health care institutions - the Independent Academic Medical Centers (IAMCs). IAMCs fit in between the pure science medical schools and community hospitals and boast a wealth of research ideas. We believe this omission represents an opportunity for competitive research that the med schools tend to be less interested in yet can yield breakthrough processes and resource-saving research to be replicated nationwide.

WHAT IAMCs?

IAMCs are 1) not wholly or partially owned or sponsored by a university-related academic institution, and 2) house a rolling average of ~100 residents. Below are the benefits we believe to accrue from a focus on enhancing patient care delivered at IAMCs and driving down the cost of delivering that care.

- 1) Intense "real world" focus on translational diagnosis/prognosis/treatment rather than the pure science and lab work.
- 2) Geographically dispersed patient base drives research predicated on population health-based disease treatment rather than rare case and subspecialty individually-focused treatment.
- 3) Community hospital status drives focus on hospital functionality, efficiency and throughput research due to intense pressure from high-demand and high volume of patients.
- 4) Network of like-minded Independent Academic Medical Centers can develop and quickly promulgate best practices and economies of scale with regards to treatment and patient care processes.

WHY AHRQ?

As the lead Federal agency charged with improving the safety and quality of America's health care system, AHRQ's mission is consistent with IAMC strengths. AHRQ funds the "research to develop knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions." (AHRQ Mission Statement)

FY13 SUGGESTED APPROPRIATIONS LANGUAGE AGENCY FOR HEALTH CARE RESEARCH AND QUALITY (AHRQ): HEALTH COSTS, QUALITY, AND OUTCOMES (HCQO), INVESTIGATOR-INITIATED RESEARCH.

FY16 Senate LHRB Report: Investigator-Initiated Research. - The Committee believes that investigator-initiated research is important and AHRQ has the ability to improve healthcare with creative, groundbreaking approaches to ongoing and emerging healthcare issues through this mechanism. Within the Health Services Research, Data and Dissemination portfolio, the Committee provides \$48,882,000 the same level as in fiscal year 2015, for investigator-initiated research. The Committee believes that investigator-initiated research should not be capped to any specific area of health services research to generate the best unsolicited ideas from the research community about a wide variety of topics.

Non-university medical centers with fully accredited Graduate Medical Residency Training Programs should be made eligible and encouraged to seek funding through this portfolio.



INDEPENDENT ACADEMIC MEDICAL CENTERS: A UNIQUE ROLE IN GRADUATE MEDICAL EDUCATION AND PATIENT CARE

Background. The nation's current physician shortage is well-documented, and not subject to rapid supply through expansion of U.S. medical school capacity will not address the twin phenomena facing our nation: the way the ACA attempts to address this issue by redistributing unused National Commission on the Healthcare Workforce Shortage, we of Independent Academic Medical Centers (IAMCs) addresses these of graduate medical education (GME) and post-graduate fellowship demand created by the twin phenomena facing our nation: the way the ACA attempts to address this issue by redistributing unused National Commission on the Healthcare Workforce Shortage, we of Independent Academic Medical Centers (IAMCs) addresses these of immediately.

Medical Centers? In addition to graduate medical education provided delivery systems that are either owned by or affiliated with medical schools to think of IAMCs as hybrid entities - community hospitals and their GME programs are operated and governed jointly, fostering mutually productive faculty relationships and types of programs to train in diverse settings.

Greater Access to Advanced Care. The foremost value of IAMCs is a level of care that otherwise may not be accessible - from ment rather than on pure science and lab work assures that base drives research predicated on population-sized disease is on hospital functionality, efficiency and throughput research is to targeted funds.

their primary mission, they actively embrace both medical of their patient care mission. Their focus on the community and region - even the tertiary care that is provided is patient and family-centered care rather than reflecting an