

NATIONAL PRESS CLUB LUNCHEON WITH DR. EDWARD MILLER

SUBJECT: THE NEW HEALTHCARE LAW AND HEALTHCARE DELIVERY

MODERATOR: ALAN BJERGA, PRESIDENT, NATIONAL PRESS CLUB

LOCATION: NATIONAL PRESS CLUB BALLROOM, WASHINGTON, D.C.

TIME: 12:30 P.M. EDT

DATE: MONDAY, JUNE 21, 2010

(C) COPYRIGHT 2008, NATIONAL PRESS CLUB, 529 14TH STREET, WASHINGTON, DC - 20045, USA. ALL RIGHTS RESERVED. ANY REPRODUCTION, REDISTRIBUTION OR RETRANSMISSION IS EXPRESSLY PROHIBITED.

UNAUTHORIZED REPRODUCTION, REDISTRIBUTION OR RETRANSMISSION CONSTITUTES A MISAPPROPRIATION UNDER APPLICABLE UNFAIR COMPETITION LAW, AND THE NATIONAL PRESS CLUB RESERVES THE RIGHT TO PURSUE ALL REMEDIES AVAILABLE TO IT IN RESPECT TO SUCH MISAPPROPRIATION.

FOR INFORMATION ON BECOMING A MEMBER OF THE NATIONAL PRESS CLUB, PLEASE CALL 202-662-7505.

ALAN BJERGA: (Sounds gavel.) Good afternoon, and welcome to the National Press Club. My name is Alan Bjerga. I'm a reporter for Bloomberg News, and the President of the National Press Club. We're the world's leading professional organization for journalists and are committed to our profession's future through our programming and by fostering a free press worldwide. For more information about the National Press Club, please visit our website at www.press.org. To donate to our professional training programs, please visit www.press.org/library.

On behalf of our members worldwide, I'd like to welcome our speaker and attendees to today's event, which includes guests of our speaker as well as working journalists. I'd also like to welcome our C-SPAN and Public Radio audiences. After the speech concludes, I will ask as many audience questions as time permits. I'd now like to introduce to you our head table guests.

From your right, Marc Raimondi, Director of Communications for Harris Healthcare Solutions; Matt DoBias, Washington bureau chief for Modern Healthcare; Patrice Hill, chief economic correspondent for the *Washington Times*; Sharon Rockefeller, a member of the Board of Trustees of Johns Hopkins Medicine, and President and CEO of WETA TV and FM, a guest of the speaker; Dr. Bob Kocher, special assistant to the President for healthcare and economic policy from the Executive Office of the President of the United States, and a guest of the speaker. Andrew Schneider, associate editor for Kiplinger, and Chairman of the Speakers Committee.

Skipping over our speaker for the moment, Matthew Mlynarczyk, President of Advocatus Group, LLC, and the Speakers Committee member who organized this event; Wendell Primus, senior policy advisor on budget and healthcare issues, the Office of the Speaker for the U.S. House of Representatives, and a guest of the speaker; Vic Carter, anchor for WJZ-TV at Baltimore; Martha Craver, associate editor for Kiplinger Washington Editors; and Retha Sharrod, Director of Public Relations for the Association of American Medical Colleges. (Applause)

Our speaker today will certainly have a unique perspective on the landmark healthcare legislation passed this spring. Dr. Edward Miller joined Johns Hopkins in 1994 as professor and director of the Department of Anesthesiology and Critical Care Medicine, and was named interim Dean of the School of Medicine in 1996. The next year, he was named Chief Executive Officer of Johns Hopkins Medicine, Dean of the Johns Hopkins University School of Medicine, and Vice President for Medicine of the Johns Hopkins University.

These appointments followed a year-long search for the first ever CEO of Johns Hopkins Medicine, a then-new organization that formally integrated operations and planning of the School of Medicine with the Johns Hopkins health system and hospital. As CEO, Dr. Miller is responsible for the school and the health system. The Johns Hopkins School of Medicine and hospital both continue to be among the highest ranked in the nation by *U.S. News and World Report*. And, since 2001, the school has been ranked first in research funding from the National Institutes of Health.

According to a June, 2010, study by the Ram Corp., provisions in the new healthcare reform law that called for Medicaid expansion will add approximately 28 million new Medicaid beneficiaries to the waiting rooms of America's healthcare workforce by 2016. Johns Hopkins Medicine has been caring for numerous Medicaid patients in a managed care setting for over a decade, giving Dr. Miller an understanding of the impact such a dramatic expansion of Medicaid can have on the system.

Today, he will outline Johns Hopkins delivery reform efforts in managing a large Medicaid population and explain how Johns Hopkins Medicine plans to train the new and expanded workforce needed to care for this unprecedented expansion of the formerly insured. Please welcome to the National Press Club, Dr. Edward Miller. (Applause)

DR. MILLER: Well, good afternoon everyone. I'm pleased to be here and I want to thank you very much for coming. Let me start with a short story. It was the summer of 1972 and I had just finished my training at the Peter Bent Brigham Hospital and was about to embark on a two-year fellowship in physiology at Harvard. I was asked to be the anesthesiologist for the month of August on Martha's Vineyard. It was part vacation and part work, and to be quite honest, I needed the money.

So shortly after arriving, a young woman who now runs a well known tavern in that community needed a surgical procedure. She had no insurance, but she was able to pay the medical bills out of pocket. She, however, could not afford the normal three-day

stay in the hospital. And she pleaded with me to have minimal amounts of medicine so that she could be discharged the same day. To this day, I vividly recall helping her out to her car so that she could recover at home.

So you see, at that time, there was really no such thing as outpatient surgery. Thanks to a revolution in anesthetics, outpatient surgery is very common today. In fact, at Johns Hopkins Medical facilities, we performed 2,400 such procedures just last month. My point here is to demonstrate the ceaseless, ongoing research and discovery that is truly the promise of medicine. And you will find the promise of medicine at Johns Hopkins. And you will also find it in labs and classes and operating rooms in the 127 academic medical centers throughout this nation. Research, education and patient care are our missions. That's the first and the last anecdote you're going to hear from me. That's because science and medicine cannot, and do not, rely on anecdotes. Instead, we rely on experimentation, action, and results that endure.

All of us in this room are very familiar, if not weary, with the year-long healthcare debate. We at Hopkins supported the final legislation because its goal is to increase coverage for those unable to afford healthcare. That ethos was the single-minded driver of our founder, Johns Hopkins, who established Johns Hopkins Hospital 120 years ago to specifically care for the poor in the Baltimore community. We were caring for the disadvantaged 75 years before the creation of Medicaid.

The central themes of the new law are very clear; coverage, quality and cost. The central number of the bill, for those of us at Hopkins, are clear as well; 32 and 16. Thirty-two million is the number of individuals that gained healthcare insurance by 2019, and 16 million is the number of individuals who will gain insurance through Medicaid eligibility. And let me emphasize, this Medicaid expansion could be the most important, problematic, and I want to underscore this, the most rewarding aspect of the entire law.

What I'd like to address today is a basic question: how do these themes of coverage, quality and cost in the law relate to the real world growth of Medicaid? We at Johns Hopkins Medical believe we have a model that could provide that answer. Before I explain, let me tell you about Johns Hopkins Medicine. Probably all of you have had a sketchy idea of who we are, and let me just fill in some of the blanks.

Johns Hopkins has been a leading force in discovery and excellence in medicine for more than half the life of this nation. Yes, we have many firsts: the first direct heart surgery, the first breast cancer surgery, the first medical school to allow women equal status with male medical students, the first developers of CPR, the first to implant a battery operated internal defibrillator. And just a year ago, we had an historic eight-way kidney swap among 16 patients.

U.S. News and World Report has ranked us as number one hospital in the United States for 19 years in a row. We receive nearly a half a billion dollars in National Institutes of funding, we are affiliated with two institutions in the top of their class; the Johns Hopkins School of Nursing, and the Bloomberg School of Public Health. And just

eight months ago, a Hopkins researcher by the name of Carol Greider, won our institution's 20th Nobel Prize for her discovery of telomerase, which maintains the integrity of chromosomes and is critical for the health and survival of all living cells and organisms.

I'd venture to say that many of you in this room, as well as your family members and friends, have benefited from a Johns Hopkins discovery. But Hopkins is more than awards. Johns Hopkins Medical is a vast, integrated health system. We manage four hospitals and are on the verge of integrating with Sibley Hospital just six miles away from this room. We run a comprehensive statewide network of 25 outpatient and surgery centers, staffed by more than 230 primary care physicians. We are sometimes noted for not producing enough primary care physicians, but we make every effort to have them in our system.

We have a thriving homecare business serving 85,000 patients and we have a large international operations in more than a dozen nations. And most important for this audience, we do something that few academic medical centers do: we run managed care plans. Our employee health plan has 51,000 members. We run a health plan for 32,000 military retirees and their families. And then last, we run a very large Medicaid managed care organization called Priority Partners, responsible for 175,000 lives.

Why did a research and educational engine get involved in such an endeavor? We decided to administer our own program because we had a nascent system of care in place and because we thought we could do better than the other insurers in the marketplace. And we believed we wouldn't lose money typically associated with caring for the disadvantaged populations.

Now, running a managed care operation is a world away from research labs, classrooms and Nobel Prizes. In fact, the real heart of managed care is a shop floor. Big, loud rooms full of customer service reps on the phone, handling claims, appointments, health plan dynamics and, yes, customer feedback. In 1995, Priority Partners was created and within its first few years enrolled approximately 25 percent of Maryland's Medicaid beneficiaries. And here's what happened, it's a cautionary tale for every policymaker in this room. A flood of new patients came to see us seeking services. Many had never seen a doctor on more than a sporadic basis, and some had multiple and costly chronic conditions. And almost all came from the poor and disadvantaged backgrounds.

This, with all its considerable medical, social and economic challenges, is the population poised to enter the healthcare system in 2014. Well, what happened when this new wave of newly insured broke upon Hopkins? And I'll be frank, because we in this profession sometimes have to deliver the bad news. We lost \$57 million in nine years taking care of these patients. Although these losses were not enough to place the entire enterprise at risk, the situation certainly made us wonder if we could continue to honor our mission to care for the poor under this economic model.

And there was plenty of reason to panic, but we didn't. Instead, we turned it around. And how did we do it? Well, what you do, world famous researchers and policy experts do when confronted with a challenge like this, we turn to data, facts and experimentation. And we designed, and more importantly to you sitting here, we actually put the test in the real world, the population health model. Population health, it's a term we're going to get used to. I think it will become ubiquitous, like the term bending the cost curve.

Generally defined, population health examines coverage through the lens of cost data in order to identify quality health outcomes. Sound familiar? It's an echo of Law's themes: coverage, quality and cost. Let me outline our Priority Partners population health strategy in very general terms. First, for each member, we develop a risk score, taking into account numerous factors; age, gender, frailty, medication patterns, lab results, claims histories, clinical events, secondary medical conditions and hospital dominant conditions. We give each person in our program, all 175,000, a risk score every month. we determine who needs what kind of help, focusing on self management, behavior modification, and when necessary, intervention. We use a team approach; caregivers, family members, social workers, nurses, nurse practitioners, with a primary care physician acting as the quarterback.

We have found an informed and motivated patient with an action plan, backed up by a proactive medical team, backstopped by electronic health records and transitional care, is going to have improved, higher quality health outcomes.

Second, we stratified this population from low scores to high. Think of it as a pyramid. At the base of the pyramid are our low-severity patients, approximately 70 to 80 percent of the population. In the middle of the pyramid, we have the more challenging patients; approximately 15 to 20 percent of our population where we combine specific interventions including technology, assisted home monitoring, health coaching, care coordination, to encourage people to manage their own health.

And then at the top of the pyramid, there are approximately five to seven percent of our patients. And these are with high severity with multiple chronic conditions. And these are, of course, our most costly patients. For these, we have individual case management plans, registered nurse, telemonitoring and visits by R. N. case managers. This is intensive, complex case management.

Well, it all sounds good in theory; good intentions and a PowerPoint displayed at Congressional hearings and think tank briefings. That's why I come back again to the idea of a promise in medicine. At Hopkins, we translate theories into real world action and results. And we've done it for our priority partner members. I'd like to give you two examples. In two of the Medicaid programs, the most difficult and costly areas, the first is end stage renal disease, or ESRD. And the second is prenatal and high risk infant care. End stage renal disease occurs when the kidneys are no longer able to function at a level to meet day to day life. It's treated with renal dialysis which Hopkins researchers first developed 98 years ago.

The most common causes of ESRD in the United States are diabetes, and high blood pressure. These are all too common in the Medicaid population, and increasingly in the United States population as a whole. And actually, throughout the world as a whole. Traditionally, ESRD Medicaid population has overall poor compliance, lower literacy rates, and many comorbid conditions. In the past four years in Priority Partners through the methods I've described above, namely data compilation, intervention, care coordination, we have addressed coverage, quality and cost with these results. We have reduced the total cost of our end stage renal disease patients by 47 percent.

And let me give you an idea and the magnitude of ESRD costs. At enrollment, ESRD treatment for one patient costs more than \$10,000 a month. Yes, \$10,000 a month. After three years in our program, we've been able to reduce that figure to \$5,900 per month. Nine out of our ten of ESRD patients meet or exceed measures defined by dialysis outcome quality initiatives, and are better than all the numbers for all ESRD patients nationally. Consider that for a moment. Our Medicaid population, on a quality measure, is outperforming the national population.

Example two, our work in prenatal and high risk infant care. We know that every year, 12 percent of the babies in this nation are born premature, and 8 percent are born with low or very low birth weights. These very low birth weight babies account for half the spending on births annually. They remain in the hospital 15 times longer than a normal weight baby. For very low birth weight babies, the cost is \$84,000 per birth. For the normal weight, the cost is \$2,300 per birth. Four out of ten babies are paid for by Medicaid in the state. Because these women are of low social economic status, they have a strong potential for very low birth weight outcomes. Hence, a frustratingly large percentage of Medicaid dollars are spent on the neonatal care units, or the NICUs.

We run a program called Partners with Mom. Sounds like just another catchy, well meaning term in the pantheon of social program speak. It's not that. It's action into results. Partner with Mom begins with data. We identify expectant mothers within Priority Partners. We already know their risk factors, maternal age, substance abuse, smoking, poor nutrition, low levels of education, jarring life expense and chronic conditions. What we want to do is improve maternal fetal wellness so that we can cut down on low birth weight babies.

What we do is we do face to face assessment and follow up on the member's condition, determine the available benefits, develop care management plans with goals, monitor the expectant mother and intervene when necessary. We even do postpartum care management to guard against readmissions.

As with our ESRD population, we get quantifiable and solid cost and quality results. Priority Partners has very low birth rates similar to the national average for the U.S. population. Consider that for the moment. We are almost even in outcome in a Medicaid population with the entire American population, despite the fact that we are treating a high percentage of very high risk women. We have a NICU admission rate that

is lower than those of the state's Medicaid population as a whole, and lower than the national Medicaid population.

Our length of stay numbers related to maternal risk factors are lower than the national Medicaid average. And our program shows the higher rates of prenatal care compliance than the national Medicaid average. I don't have time to go into it here, but Priority Partners has other quality and cost successes. We've reduced the odds of hospital admissions for patients at the end of life, and have reduced per member per month expenditures for patients with a history of substance abuse and highly complex medical needs.

And finally, and perhaps most importantly, our patient satisfaction rates, I am proud to say, are equal to the satisfaction rate of private plans in Maryland and the private plans nationwide, as measured by J. D. Powers and Associates just two months ago. Now, to follow the themes of the new law, I've talked about coverage, I've explained our quality outcomes. And now let's talk a little bit about cost.

You may recall we lost \$57 million in nine years as we began to implement the population health model. And as of today, I've noted, we care for 175,000 Medicaid beneficiaries. To give you an idea of the scope of our population, Priority Partners is caring for 1 ½ times the total number of Medicaid individuals in the District of Columbia where we meet today. Moreover, of the total, approximately 30,000 patients were added to our plan in 2009 by the state of Maryland. And yes, these are the kinds of patients that consume enormous resources before our population health model can assist them. Nevertheless, in spite of the surging challenged population, we are showing a small profit in calendar year 2010. Now don't get me wrong, we had to do a lot of things, like insure that the payments coming from the state matched the acuity of the population we served. We also had to insure that we were using the most cost effective venues for service. And unfortunately, we had to reduce payment to some of our providers.

But the fact remains, and it deserves greater emphasis here. All of these cost management strategies, and our quality outcomes, were done in the context of a population health patient-centered care model.

So if I could capture all the good works of Priority Partners and put it in one building, that would be the Harriet Lane Clinic. Staffed by pediatric residents and young doctors in training, and offering a wide range of clinical and social services right across from our new hospital building that's being built right now, 85 percent of the clinic patient load is Priority Partners. And its operations are a model of primary care teamwork and intervention that is the key to quality health outcomes.

In fact, in the HETUS scores used to measure health plan quality, Harriet Lane is in the 90th percentile nationally on several measures, and in the 98th percentile for the all-important measure of primary care physician access.

So I began these remarks with a decades-old anecdote. And I have ended with a quantifiable, real world results achieved in some of the toughest environments in healthcare. Tying these examples together is the promise of medicine, the ability of Johns Hopkins Medical clinicians, researchers and administrators to confront and discover new ways to solve healthcare challenge. Against the backdrop of the new healthcare law's theme of coverage, quality and cost is our population health model. It's in place and it works. It's a system of care that can be duplicated around the nation. It's a model that can inform the federal government, the states and healthcare systems around the nation as they begin planning for Medicaid expansion.

The new healthcare law is a huge step for citizens, physicians and the hospitals of this country. As I have said at the beginning of my remarks, to those of us who have historically provided care to the less fortunate population, the expansion of Medicaid, done correctly, could well be the most rewarding result of this historic legislation. Thank you very much. (Applause)

MR. BJERGA: And thank you very much for your time today. Our audience has many questions for you, I'm sure, and we certainly are looking forward to hearing your responses to them. First question, many providers say they are concerned by the Medicaid expansion because of the underpayments associated with that government program. While Hopkins might be better situated to absorb this particular patient base, do you share the concern of some of your fellow providers, that Medicaid patients might be cost prohibitive?

DR. MILLER: Well, I think it comes back to the question, are you getting adequate reimbursement from the state? And I think you have to establish that not all patients are the same and there's a tiered response in how you get paid for that. I think because so many of the states are in financial difficulties, they can't look and start cutting Medicaid payments as one way to balance the budget. It's just not going to work if this system is really going to provide care for a significant number of the uninsured.

MR. BJERGA: President Obama made the decision to focus more on coverage than on cost in his healthcare proposal. While there are programs in the new law to begin payment reform, do you think it was a mistake to focus on coverage expansion before tackling cost of care?

DR. MILLER: You don't want to disagree with the President, do you? I guess one of my feelings, and I think most of us would agree, that this whole issue of fee for service is really where the problem lies in the system. And that's why I think population health works. I understand politically the issue of touching that, essentially going after Medicare recipients and changing how physicians and services would be paid for, was a tough question. But politically, it was decided to go for coverage because the roles continue to increase. And you kept hearing it year after year after year. I think this country, as rich as it is, should be able to take care of the people that are not fortunate enough to be able to pay for healthcare.

MR. BJERGA: Critics of healthcare reform argue that the new reform will cause wait lines in doctors offices to increase. Please address this issue in terms of what Johns Hopkins will do to meet the needs of its patients.

DR. MILLER: This is a big issue. The manpower issue is not a small issue. And I think the first thing that I would like to see is an increase in the number of resident slots in this country. We talk about training more medical students, but that's eight years away before they get into the pipeline. Right now, the biggest thing we could do would be increase the number of resident slots in this country, and then you would have almost immediate rollout.

The second thing that we've seen, of course, is that physicians change. When I went to medical school almost 40 years ago, you either went into academia or private practice. You were often with two or three people. The new generation comes out and is much more used to working in groups. Steve Privett is here, runs a Johns Hopkins community physicians. He's been able to recruit, I think around 40 or 50 primary care physicians in the last 16 months because he's been able to provide them with things that physicians want to do. They want less paperwork, they want electronic record, they want to have a stable income and they don't want to worry about all the other details that we can take care of on the administrative side.

So I think Hopkins is going to be able to do well because we've been able to recruit those kinds of primary care docs. We also at the same time have a significant number of physician extenders, nurse practitioners, nurses, and so forth, that are all a very important part of this. And I think what you're seeing is that the delivery of healthcare is going to change and I think it's important that the patient get the right care at the right place with the right provider. And that's one of the tricks of this whole system.

MR. BJERGA: Following a question about long waits, here's a question about long hours. One of the major issues of concern in healthcare and medical education is the effect of long hours on interns and residents. How will it be possible to address this concern as the number of newly insured patients increases in coming years?

DR. MILLER: Well, remember that it's only in "House" they have to have the hour limit. The rest of us don't have those limits. So I think you're going to have to be more efficient in your care. You're not going to have to spend as much time. If you have electronic record, you're going to be able to more effectively see what the patient has and you can cut through some of those things. I think you'll see that some of the technologies that we have available to us will allow us to take care of patients more rapidly. That's how we're going to do it.

MR. BJERGA: This is a question from a person personally concerned about Medicare coverage. Many of the best practices in the D.C. area are dumping out their longtime Medicare patients with little notice. Many of us are in our 80s and older with multiple medical problems. Finding a competent new M.D. who will take Medicare is almost impossible. How can Medicare even survive when this is happening?

DR. MILLER: Well, this is not an uncommon project in just the D.C. region, it's across the country. The fact that Congress has not moved on sustained SGR right now, and there's a 21 percent potential that we're in actually effect, decrease of Medicare reimbursement to physicians is going to make it hard. You're going to have to pay physicians appropriate amounts of reimbursement for their services so that physicians will not shun Medicare patients.

MR. BJERGA: What is your prognosis for higher reimbursement payments given the current deficit environment?

DR. MILLER: I just think it has to be a national priority. The population is getting older, they need access to physicians. That's something that just has to be passed. Not only in three month or five month increments, there has to be a long plan to solve this issue. Every year, we keep delaying, we put it off year after year. Now we passed the June 1 date and physician reimbursement has not been fixed. It's got to be fixed. It's a national priority.

MR. BJERGA: Hopkins primarily works with an urban clientele. And there's always been a question of rural Medicare reimbursement being at a higher rate than urban Medicare reimbursements. Is rural reimbursement a specific concern right now that is a more acute crisis than urban areas? And what are the different issues between urban reimbursement and rural reimbursement?

DR. MILLER: I've had no experience with rural reimbursement, so I'm really out of my league. I think you're dealing with a whole different set of issues there. The distances between providers is much greater. It's harder for patients to have follow-up. Again, I think in those areas, technology is going to be one of the ways we're going to solve. Telemedicine becomes more important.

For example, we have someone who's coming to Hopkins from the Rochester area. Upstate New York, there's a lot of small, little towns, nursing homes and so forth. Patients have Parkinsonism, they can't go 70, 80 miles to see their doc every couple of weeks to adjust their medicine. But this program has been set up where you can do it with telemedicine. And so I think those are the kinds of new ways to think about how do you deliver high quality care in relatively rural areas, actually, and be able to do it effectively.

MR. BJERGA: Following on questions of geographic coverage, what are some of Hopkins' plans for expanding its own services possibly through acquisitions or organic expansion?

DR. MILLER: We've never really tried to expand just for the sake of getting greater. I think the Suburban transaction that we had a year ago, and Brian Gragnoloti is here, the CEO of Suburban, and the discussions we're having with Sibley, were only done because we saw that we could take care of a population of individuals within the Baltimore/Washington region. And so for us, having that whole region covered with

facilities, both hospital facilities and outpatient facilities, made sense. But to just get bigger for the sake of getting big, doesn't make sense to us at all.

MR. BJERGA: Johns Hopkins Medical was an early adapter of electronic healthcare records. Could you talk about some of the early adapter issues you may be facing? And do you find the challenge now in transitioning to newer technology?

DR. MILLER: Probably the biggest is not \$64,000, but maybe \$64 million question, is this whole electronic record. And I think as most of you know, most of the electronic records were developed for hospital use, in-hospital use and we have had a very sophisticated one for over 20 years. As more and more of the procedures and what goes on as an outpatient setting, being able to link the outpatient record and the inpatient record are key. And whether you go with different vendors or the same vendor is a very difficult decision. And when you have multiple hospitals in your system, many hospitals have invested greatly in their electronic records. And to try to throw one out and bring a whole new system in with all the complexities of putting a new IT system in place, is not a small undertaking. And it is very expensive.

MR. BJERGA: Now that the reform debate has moved off of Capitol Hill to the agency level, where will Hopkins put its effort in shaping some of the implementation aspects of the new law?

DR. MILLER: That's, I think, a very good question in that I guess over 500 regs. will have to be written for really implementation of the law. And I think our role has been how can Hopkins provide not only a platform to try some new experimentation. But as the discussion today outlined, where is population in health? So we will try to work with HHS to try to make sure that we have policies in place, or help them develop policies, that make sense for those of us who are really on the delivery side of it.

MR. BJERGA: Will you be expanding the Priority Partners population health model to your non-Medicaid patients?

DR. MILLER: Yeah, we already do in a form in that we have the U.S. family health plan, which about 32,000 members right now, and we have our own employee EHP plan. I actually think the next step probably is to partner with an insurance company and see how you could manage a population. We have a small pilot project already with Care First, but I think this is probably going to be the next step and I think over the next five years, you're going to see more and more of that.

MR. BJERGA: In what ways has Johns Hopkins Hospital addressed long-term care and Medicaid managed long-term care?

DR. MILLER: Well, we have a department, a division of geriatric medicine. We have great workings with the School of Public Health and the School of Nursing taking care of the elderly and the frail elderly, which I think is very important, and things in place. I think that we're going to continue to do more of that. I think the other, we're

going to have to address in a more proactive way, is the end of life issues. This population is getting older, we're all getting older, and we're going to have to address it in a more proactive way. I don't think we've probably done as good a job as we could on that.

MR. BJERGA: There is much talk about the over production of specialists. Can you discuss the role of academic medicine and the production of primary care doctors versus specialists, and the unique challenges of pediatrics, which suffers from a shortage of specialists?

DR. MILLER: Well, one of the things I found from going into medicine is that you can never really tell where an individual is going to end up because a lot of things happen in the four years of medical school and the four to seven years of residency training. And to say people are going to be starting out and they're going to be primary care physicians, they may end up being general surgeons or ob/gyn because something in that training made them do that.

I think that primary care is given by a lot of different people. One of the areas of general surgery, ob/gyn often give it, pediatrics gives it, certainly internal medicine gives a lot of primary care. I think Hopkins will continue to make it more attractive. We have an urban health residency program that we've just begun this year which will look at training individuals, both at the School of Public Health and in the Department of Medicine to address urban issues, health issues. Our new curriculum, medical school curriculum, called Genes to Society, takes into account not only the genes, but also the environment in which people live in and how that affects their health.

So I think there's going to be-- and I think we're not the only medical school looking at new ways to train the next future generation. And I actually think we're going to be okay.

MR. BJERGA: Johns Hopkins Medical is a leader in cancer care and research. Are there areas of cancer treatment or early detection that will particularly benefit under the new healthcare reforms, if any?

DR. MILLER: I guess I'm not quite sure if the law would really, other than giving access-- well, let me take that back. One of the issues that we always worry about is early detection. Under the Medicaid expansion, or the new law, patients I hope would be able to come to see a physician earlier, a diagnosis would be made earlier so that treatment could begin earlier. And we know if you diagnosis it earlier and you treat earlier, you're going to get better results. So I think that's where the health law is going to come into effect.

MR. BJERGA: What should we be doing as a society to prevent diabetes and obesity among children?

DR. MILLER: I know a lot of people are working on this issue, and it's certainly one of the biggest problems we have. This whole issue of diet has got to be addressed more clearly. I know Mayor Bloomberg has certainly outlawed smoking in restaurants in New York and everybody said it wouldn't work, and sure enough it worked and everybody's pretty happy about that. I think other major leaders and opinion makers have got to take a bigger stance on the kinds of food we're eating and the whole issue of exercise for kids. Sitting in front of your Nintendo, or whatever it is, the game today, isn't like being out on a soccer field. So exercise, diet, better education. We've got to do it because it's a real crisis.

MR. BJERGA: Please share your views on alternative medicine, acupuncture and other wellness improvement approaches to complement standard medicine?

DR. MILLER: Well, this has always been a big issue. Do we have it as part of our curriculum? We have a small introduction to it in our curriculum, but not a point of it. My point has always been in alternative medicine, let's test it and see if it works scientifically. Hopkins was built on a scientific basis, we test the theory, we start with one, we test it, we see if it works. I would like to see more alternative medicine tested. I realize a lot of people use a lot of different drugs and treatments. Whether they work or not often has not been tested. So my view is if it really works, let's test it and prove it.

MR. BJERGA: This questioner states your health system has become a beacon of quality improvement at the bedside. What advice can you give your fellow CEOs on the importance of quality management?

DR. MILLER: Well, I think the only advice I can give, it's got to be the number one priority of the institution and it has to be-- the finances have to-- you know, somewhere down there, but it shouldn't be the number one thing you're always thinking about. But what are the quality measures? Are you measuring the right things? Are your patients getting the right care at the right time? And when you see things that are not being done right, are you taking appropriate action?

MR. BJERGA: Johns Hopkins Medical has the experience of managing a large Medicaid population. If you could offer only one piece of advice to other hospital systems, what would it be?

DR. MILLER: You'd get Patty Brown, Steve Privett and a whole host of people from Hopkins and let them go do the job right. I think what you need is people that are really dedicated to the mission. People understand that data will drive what you need to do and you have to have good data and then you can manage your population. But without data, you cannot manage this population.

MR. BJERGA: Does our healthcare system spend too much money, or spend too much time, on heroic medicine at the end of life? What should be done to control end of life care costs?

DR. MILLER: Well, I ran an ICU for three years and it was always tough when you knew that the patient was not going to survive and the family would say to you, “Do everything for Uncle Harry,” because that's really what happens. I think it has to start long before that, and people have to understand that end of life does come and there are very excellent alternatives now, whether in home hospice or in a hospice facility, palliative care. Those are things our society has not worked on and I think we're going to have to do a better job. I've lived through it with two of my in-laws and we could have done it better.

MR. BJERGA: In your opinion, is the government thus far showing enough leadership in transforming the nation's healthcare system? What should they be doing that they currently are not?

DR. MILLER: Well, I think there's almost a pause after the legislation got through and everybody was so tired of it. I think now we have to take a look at this population's going to start coming in in 2014 and are we going to have the right workforce in place? What incentives can we entice people to make sure they put together integrated systems? How do we interact with the private insurance companies to make this work?

Again, I'm going to come back to this issue of the number of resident slots. We need to open up those resident slots. That's been held constant for year after year after year, and that's the workforce that's going to go out there and truly take care of patients. And so if I had one thing to do right now, I'd open up those slots.

MR. BJERGA: In some cases, should medical training be shortened, especially for primary care and shifted to function with skill level training, like other non-medical education programs?

DR. MILLER: This has been a hotly debated series of discussions among a variety of different specialties. Because we know there are fast learners and slow learners, but not everybody learns at the same rate. And can you shorten your residencies to a significant time? I'm not quite sure you can. I don't know the answer in primary care, but I have the feeling that there's an awful lot of information that a primary care physician needs to learn. He needs to learn it, he or she needs to learn it under supervision and I'm not sure shortening it is going to make it work any better.

You as a patient want the most knowledgeable physician caring for you. And you would hope is very well trained. And we have 40 procedures in place so that you know you have a well trained physician taking care of you. That's probably the most important thing.

MR. BJERGA: This questioner asks why is it okay to cut reimbursements for Medicaid doctors but not Medicare physicians?

DR. MILLER: I think the reason lies in the state. It's the difference between feds and state. The state are the ones who fix the Medicaid rates and then the payment side comes, half the payment side or-- not every state's the same-- comes from the feds, but they don't really control the rate within the state. So it's a fed/state issue.

MR. BJERGA: With state budget cuts reducing Medicaid payments, what do you think of the prospects of continued access for enrollees to care among Medicaid enrollees?

DR. MILLER: As I said before, I think this is a major issue. We're going to have to adequately reimburse the providers of care if you really, truly want to take care of the Medicaid population.

MR. BJERGA: What percentage of your payer base is private health insurance? What effect do you think some of the new rules, no preexisting conditions, no recisions, will have on your patient base?

DR. MILLER: The patient base is running about 15 percent Medicaid, 30 percent Medicare and then managed care and then the privates. Those are kind of rough numbers. Our number of patients continually increases a little bit. The biggest growth has been in our Medicaid population. We're putting about 2,500, 2,750 patients per month in Medicaid. Is that right, Patty?

MR. BJERGA: We've talked about the local patient base at Hopkins, but there's also a strong focus on international patients who come to the system for care. Is there a market for treating overseas patients? And what are the health differences you typically see among these types of patients?

DR. MILLER: Hopkins has had a long tradition of taking care of international patients. We see about 30,000 outpatient visits from our international clientele, and about 12 to 1,400 admissions for the year. They often come for orthopedic procedures and many come with comorbidities. Diabetes and obesity are not small issues, they also come to us for cancer, sophisticated cancer care.

If you look in the Middle East, for example, in Saudi Arabia, about 25 percent of their population has obesity and diabetes built in. And it has continued to grow in India and other countries. So we're going to see more of that. We've always treated international patients and continue to do so.

MR. BJERGA: Following on that, our society is becoming more racially and ethnically diverse, as well as older. How do you assure a future healthcare workforce that mirrors the future society and is also culturally competent at dealing with a more diverse population?

DR. MILLER: That's a great question because that's been one of the issues. I think Hopkins has been painted as not very diverse and actually quite the opposite. Over

the last 15 or 20 years, the institution has made a tremendous effort in welcoming people from all over the world to work at Hopkins, whether physicians, nurses, aids, orderlies, whatever. And I think it has to be a priority of the institution because as the population ethnicity changes, we have to be able to somehow mirror that. It's part of a course in our curriculum for our new Genes to Society and it's one of the goals of the hospital and health system to make sure their workforce is also ethnically diverse.

MR. BJERGA: How do we fill up primary care residency slots and also insure that they are actually filled by those who will go into primary care, which is historically underpaid?

DR. MILLER: Well, I think most people would agree that one of the reasons people don't go into primary care has been the poor pay structure. And so one of the things that needs to be addressed, and I believe is being partly addressed, is this issue of adequate reimbursement.

I think the other thing, though, is to make it an environment where primary care is really attractive. And I think Johns Hopkins community of physicians has done a wonderful job of that. Not only do they have electronic record, they know what their salary is, they can work harder and make a little bit more money. But also, they have the ability to educate medical students and others. And part of primary care is just doing the same thing over and over again, it's not what people want. They get a lot of training, they're intellectually stimulated, they want to continue to be stimulated. They want to have new things, and if you have the right leaders in the organization, you can make that happen. Medical students certainly make it much more exciting to be in a private practice environment. The fact that you can do protocols, the fact that you can interrogate your database, that you can have your electronic record, all these things add to the excitement of being there. We need to do more of that.

MR. BJERGA: Going back to healthcare reform legislation, could you describe a bit of how engaged Johns Hopkins Medical was in crafting the healthcare reform bill? What sort of conversations, what sort of input were you having with House and Senate leadership?

DR. MILLER: This goes back a little time ago. The previous dean at Johns Hopkins was Mike Johns, who is the chancellor at Emory. And Mike came to Hopkins, and I were talking and we thought that some academic healthcare centers needed to get together because we provide a lot of care. So we got Partners and we got Columbia Presbyterian and Mount Sinai, Penn, Hopkins, Emory, Michigan, Wash. U., University of Washington, Seattle, University of California, San Francisco, and every Monday, 5:00 tonight, as a matter of fact, we will have a conference call. We have made multiple trips, we've been speaking with people both on the House and Senate side. We were with Wendell one day, Speaker Pelosi. We have met with a lot of people trying to show them what we think are some of the important issues of healthcare reform. So we've been highly involved in this in the last year and a half.

MR. BJERGA: As noted in the introduction and in your address as well, Johns Hopkins is certainly known as number one in a lot of areas, number one hospital, number one for NIH funding. What would you say are the three main factors that have gone into this prestigious ranking that you have received?

DR. MILLER: Well, I think it's a long history of excellence at Hopkins. I think when you go to Hopkins, you are expected to perform at the highest level at all times. And second rate performance is just not tolerated at the institution. You see that in the hiring procedures, you see that in the promotion procedures, and you see it in terms of how patients are treated. And we're pretty tough on those things and we expect everybody to be excellent at what they do.

MR. BJERGA: On healthcare legislation, if you were to rewrite the reform law, or at least make some adjustments to it, where would you start and what would you change? We're assuming that this law was not perfect.

DR. MILLER: Wow. Well, I'm going to come back to this issue of fee for service. The fee for service is just not going to work in the future. There will always be some fee for service, I know that. But the fact that you could use as many services as often as you like and not have any measure of quality just does not make sense to me. And somehow, we've got to change that so that there's some measure of quality and the reimbursement needs to match that.

MR. BJERGA: What do you see as some of the biggest issues that will be faced by hospitals that may not be an elite urban institution under the healthcare reform laws? What are some areas they're going to have to pay some special attention to?

DR. MILLER: I think the thing that's going to have to be paid attention to is they can't be isolated. They're going to have to find new partnerships to be able to survive in this new world. And if they can't forge partnerships, both with physician groups, insurers, whether feds or state or private insurers, they will not be able to survive the new environment.

MR. BJERGA: What will the U.S. healthcare system look like in 2020?

DR. MILLER: Well, I'm not going to-- I think predicting three years ahead is a little difficult. I think that if we get it right over the next five years, and this population health truly works, more systems will start to put together integrated health systems where they can be able to have a small profit, which they can reinvest and the insurers and major providers will have a partnership that we have not seen before.

MR. BJERGA: What would you say is the greatest risk to public health that is not currently receiving the necessary attention?

DR. MILLER: I guess I probably keep going back to the-- and I'm not a pediatrician, but I have the feeling that a lot of this stuff in terms of healthcare starts early

on. And while we talk a lot about obesity and we talk a lot about diabetes, I'm not quite sure we have an action plan to really solve the problem. And if you allow that ten year old to be obese and eat all kinds of terrible food, we know that 30, 40, 50, 60, that's when they're going to have co morbidities. They're going to have vascular disease, heart disease, kidney disease. We've got to stop that process earlier. That's where I think we need to begin.

MR. BJERGA: We're almost out of time, but before asking the last question, we have a couple of important matters to take care for our audience and television audience. First, to remind our members and guests of future speakers. On June 23rd, we'll have Oliver Stone, the award-winning film director whose latest film is "South of the Border," speaking about the movie, the making of it and the political issues that it will address. On July 7th, we have Venus Williams, tennis champion, who will be addressing a luncheon. And on July 16h, following our sports theme, we have Tony Horton, fitness consultant and creator of the P90X home fitness system addressing the nation's obesity epidemic and its impact on declining fitness levels among U.S. military recruits. Hope you're enjoying your heart-shaped cookies today.

The day after that, the National Press Club will once again be hosting the National Press Club's 5k Beat the Deadline Race, benefiting the Eric Friedheim National Journalism Library. To register for the race, and burn off that cookie, go to www.press.org. Second item of business, we'd like to present our guest with the traditional National Press Club mug. (Applause)

DR. MILLER: That will take care of my seat of deprivation. Thank you.

MR. BJERGA: No problem. Our final question, actually, relates on the athletic theme that we've just been discussing. When you think of Johns Hopkins, phrases come to mind: Johns Hopkins, elite medicine. Johns Hopkins, groundbreaking research. Johns Hopkins, sports powerhouse, not so much.

DR. MILLER: Bad year in lacrosse.

MR. BJERGA: And that is our final question. What are your final thoughts on Johns Hopkins not winning the NCAA division I lacrosse championship this year, and when do you think this will happen? (Laughter)

DR. MILLER: That's a nasty question. Next year. Next year, there's always next year.

MR. BJERGA: Dr. Miller, thank you again for coming today. We would also like to thank the National Press Club staff including its library, broadcast center and kitchen-- Just kidding on the cookies-- for organizing today's event. For more information on how to join the National Press Club and on how to acquire a copy of today's program, please go to our website at www.press.org. Thank you. This meeting of the National Press Club today is adjourned. (Sounds gavel.)

END