

June 14, 2001

MEMORANDUM

TO: The Health Affairs Committee:

Charles M. Caravati, Jr., M.D., Chair  
H. Christopher Alexander, III, M.D.  
Thomas J. Bliley, Jr.  
Vincent F. Callahan, Jr.  
William G. Crutchfield, Jr.  
William H. Goodwin, Jr.  
Terence P. Ross  
Thomas A. Saunders, III  
Elizabeth A. Twohy  
Harry J. G. van Beek  
John P. Ackerly, III, Ex Officio

and

The Remaining Members of the Board:

Thomas F. Farrell, II	Timothy B. Robertson
Charles L. Glazer	Benjamin P.A. Warthen
T. Keister Greer	Joseph E. Wolfe
Elsie Goodwyn Holland	Sasha L. Wilson
Gordon F. Rainey, Jr.	

FROM: Alexander G. Gilliam, Jr.

SUBJECT: Minutes of the Meeting of the Health Affairs  
Committee on June 14, 2001

The Health Affairs Committee of the Board of Visitors of the University of Virginia met, in Open Session, at 4:05 p.m., Thursday, June 14, 2001, in the Board Room of the Rotunda; Charles M. Caravati, Jr., Chair, presided. H. Christopher Alexander, III, M.D., Harry J.G. van Beek, Thomas J. Bliley, Jr., William G. Crutchfield, Jr., William H. Goodwin, Jr., Terence P. Ross, Thomas A. Saunders, III, Ms. Elizabeth A. Twohy, and John P. Ackerly, III, Rector, were present.

Also present were Charles L. Glazer, Timothy B. Robertson, Benjamin P.A. Warthen, and Joseph E. Wolfe.

Present as well were John T. Casteen, III, Leonard W. Sandridge, Jr., Alexander G. Gilliam, Jr., Paul J. Forch, Robert W. Cantrell, M.D., Ms. Yoke San L. Reynolds, Jerry Short, M.D., Larry Fitzgerald, John Jackson, George E. Culbertson, and Ms. Jeanne Flippo Bailes.

Charles Crowder, M.D., George A. Beller, M.D., and Bruce J. Hillman, M.D., were present as special guests.

The Chair asked Mr. Sandridge, Executive Vice President and Chief Operating Officer, to present a financial report on the Medical Center.

Mr. Sandridge pointed out that the Medical Center budget would be considered in detail in the meeting of the Finance Committee, immediately following the Health Affairs Committee meeting (see the Minutes of the meeting of the Finance Committee, June 14, 2001). He then asked Mr. Fitzgerald, Chief Financial Officer for the Health System, to present the customary financial report.

Mr. Fitzgerald noted that the financial report covered all but the last two months of the current fiscal year.

Patient discharges - which drive revenues at the Medical Center - are down from last year and below budget for this year; the decline is the result of fewer beds available because of the shortage of nurses. The average length of stay of patients is 5.5 days, up from last year and above budget for this year. The number of outpatients and Emergency Room visits is above budget and up from last year. Net operating revenue is above budget and significantly up from last year, but so are operating expenses. The number of full time employees is up from last year and above budget for this year. The operating margin for the first ten months of this year stands at 2.5%, below the 4.6% for this time last year and below the 4.8% budgeted for this year.

Mr. Fitzgerald observed that personnel costs, which include contract labor (29% or \$3.8million above budget) - primarily the expense of "traveling" nurses - account for 50% of the Medical

Center's operating expenses. Because of the shortage of nurses, the rate of pay for nurses has been increased above what was budgeted. On the other hand, overtime pay and traveling nurse expense were down in April from March, and a further decline is expected when the May figures are in.

Dr. Jerry Short, Associate Dean of the School of Medicine, introduced Mr. John Jackson of the Office of Medical Education. Mr. Jackson spoke to the Committee about applications of the web to medical education.

Dr. Cantrell, Provost and Vice President for Health Sciences, then gave his customary report, this time as a valedictory discourse on the challenges and problems facing the Hospital and the Schools of Medicine and Nursing as well as academic medicine throughout the country. Dr. Cantrell's remarks are appended to these Minutes as an Attachment.

Both the Chair and the Rector thanked and commended Dr. Cantrell for his service and leadership.

On motion, the meeting was adjourned at 4:50 p.m.

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AGG:jfb

- Copies to: Mr. John T. Casteen, III
- Mr. Gene D. Block
- Dr. Robert W. Cantrell
- Mr. George E. Culbertson
- Ms. Louise Dudley
- Mr. Paul J. Forch
- Mr. William W. Harmon
- Mr. Terry Holland
- Mr. Peter W. Low
- Dr. Robert E. Reynolds
- Ms. Yoke San L. Reynolds
- Mr. Leonard W. Sandridge
- Ms. Colette Sheehy
- Mr. Robert D. Sweeney
- Dr. George Beller
- Dr. Bruce Hillman
- Dr. Robert Carey
- Dr. Charles H. Crowder

ATTACHMENT

VICE PRESIDENT AND PROVOST FOR THE HEALTH SYSTEM

Remarks to the  
Health Affairs Committee of the University of Virginia Board of  
Visitors  
June 14, 2001

*Mr. Rector, Mr. Chairman, Members of the Committee, Ladies and Gentlemen*

- In two weeks I will conclude seven years as the Vice President and Provost for the Health System. My tenure started in 1994 when I was asked by President Casteen to serve in that important role in an interim capacity. I am deeply honored and grateful for the trust placed in me, and I thank you and Mr. Casteen for this opportunity to serve at a time of great challenge for the health field in general and the University of Virginia Health System specifically. These have been very interesting times, and I am reminded of the old Chinese curse, "May you live in interesting times."
- It is from the perspective of the Vice President and Provost that I would like to share observations made during these seven years and offer some thoughts about the current state of the delivery of health care. My hope is that this will prove helpful as you deal with health issues.
- Beginning in the late 1980s health care expenditures were inflating in double digits. This prompted many in both government and the business sector to search for ways to control costs. By the mid-1990s, particularly fast-paced change has characterized national health policy that clearly impacted our Health System. On the positive side, the need for biomedical research to address many diseases was widely recognized and supported with significantly increased funding from the National Institutes of Health and other sources. For many of these diseases, however, the costs of the treatments discovered as a result of this research can, in many cases, be quite high. Health-related technologies and new, truly "wonder drugs" are being developed and are becoming more sophisticated and more effective but also much more expensive. Organ transplantation, mapping of the Human Genome, saving lives of very tiny premature infants and extending the life expectancy of senior citizens are just a few of the phenomenal results of this research revolution and improved medical care.

- All of this came at a very great price. The cost of an average length of stay in our Newborn Intensive Care unit runs around \$70,000. Life expectancy in the U.S. grew from about 42 years in 1900 to around 75 years today. People are living longer only to die of debilitating diseases that are very expensive to treat, and many life-saving procedures and those designed to improve the quality of life are being performed more and more frequently, especially in the elderly. For example, total hip replacement, a procedure that costs in excess of \$25,000, was performed in 143 of every 100,000 women over age 85 in 1987. By 1995, the number had risen to 1,444 of every 100,000 in this same group, more than a 1000 percent increase. It was determined a few years ago that one half of all Medicare money was spent on people in their last six months of life. As an aside, it curious to me why the government would conduct such a survey and what they intend to do with the results. I suppose some government financial analyst could be thinking, "If only we could determine when that last six months begins....."
- But I stray from my topic. While these developments, coupled with increased utilization of the health system were occurring, the rising health care costs generated heated debate over national health policy. Hillary Clinton's ill-fated attempt at rectifying the situation was doomed from the beginning since she decided to reform the insurance industry, the drug industry and the health care "industry" all at the same time. Interestingly, she included no physicians on the panel studying this. Regardless, the mounting national debt, of which health care was a big part, demanded attention. The Balanced Budget Act (BBA) of 1995 was designed to address the national debt. One little known aspect of this act was how much of it was dependent on reducing health care expenditures by the federal government. Of the total savings projected in BBA 1995, more than 63% was to come from reductions in medical costs. BBA 1995 did not pass, and when BBA 1997 was introduced and became law, the improved economy reduced the total savings required. However, the amount to be saved from health care providers rose to 89.5% of the total over 5 years and 118% over seven years. The consequence of this, whether intended or unintended, was to severely curtail funding for academic health centers (AHC). Although all hospitals and physicians were impacted, academic medical centers were adversely impacted disproportionately. AHCs receive payment from Medicare for the services rendered by physicians in residency training and this was reduced in addition to the

reduced reimbursements for care delivered. Additionally, since academic medical centers treat a disproportionate share of indigent and Medicaid patients, the reductions in reimbursements from this program impacted academic medical centers from three directions. Not surprisingly, many AHCs began to lose money, and in 1997 and 1998, nearly half of all academic medical centers were in the red. Many of those that were not were able to survive only because of income from investments and interest on their operating cash balances, something that UVA does not receive. We, and all AHCs, owe a debt of gratitude to current BOV member Tom Bliley, who in 1999 as Congressman Bliley and Chair of the House Commerce Committee, spearheaded revisions to the BBA 1997. These revisions provided significant financial relief for academic medical centers, but the provisions of the act that are phased in over a period of years will continue to reduce in a major way the amount of money AHCs will receive from the federal government.

- At this same time, in the private sector, businesses and their health care insurers were casting about to find other ways to reduce medical costs. One scheme was to develop more Health Maintenance Organizations and increase the amount of "managed care." In principle, this sounded good. A primary care physician (PCP) would "manage" all the care of the insured person assigned to her/him, and only refer the seriously ill to the presumably more expensive specialists when needed. As it turns out, highly trained specialists are not more expensive in many cases when overall costs are calculated, but that was not the "conventional wisdom." Regardless, by insuring large groups of people who would pay fixed sums for health insurance annually, and with a relatively small percentage becoming seriously ill with a disease expensive to treat, the plans would be profitable and overall insurance costs could be reduced. The problem with this scheme was that there were not enough PCPs, and there was a plethora of highly trained specialists that the government had spent billions of dollars training. Since these highly trained specialists populated most academic medical centers, this change in the way care was delivered profoundly impacted academic health centers. Managed care was originally profitable when the HMO cared for large populations concentrated in major cities, but it posed a particular challenge for academic health centers such as ours located in an essentially a rural area with a smaller population base. The insurers also began demanding a shift to more outpatient treatments and shorter lengths of inpatient stays. The decreased hospital length of stay

resulted in those in the hospital being sicker and requiring more attention. Patients were not happy with this type of care to include their ability to select a specialist of their own choosing, and many complained to their legislators who, in turn, enacted legislation mandating lengths of stay for certain types of care, especially obstetrical deliveries, plus open access to specialists. The patient "bill of rights" bill has been debated in the Congress for the past several years, and is to be introduced again this year. We in medicine are caught in the middle; we receive decreased reimbursements if we don't shorten stays, and complaints from patients plus increased regulation if we do.

- Additionally, decreased reimbursements per patient means that physicians must see more patients in shorter periods of time to maintain a stable income. Previously, clinical income from paying patients was adequate to support time spent in medical education and treating the uninsured for which little or no reimbursement was received. Reductions in the reimbursements from insurers resulted in clinical faculty spending more time seeing patients and thus less able to devote time to teaching. This shift to a more "business-like" approach to physician behavior meant that the Dean of Medicine was now required to pay the faculty for time spent teaching with the attendant budget implications, and the government(s) need to reimburse physicians for the care they deliver to indigent patients. All this was occurring at a time when medical knowledge was expanding geometrically. Also, the expanded role of primary care physicians increased the demand for such practitioners, necessitating a change in medical education, in our case mandated by the State Council on Higher Education. UVA successfully met that requirement, and our School of Medicine has been very successful in increasing the number of its graduates entering primary care specialties.
- Accountability for healthcare processes and outcomes has heightened and is a matter of public interest as never before. Healthcare is now the most highly regulated of all endeavors, and malpractice actions with huge awards are so commonplace that they no longer make the news (e.g., awards in excess of \$1M increased 40% last year). Malpractice insurance costs by St. Paul (the largest insurer) increased 35 - 40% in some states this year and are expected to continue in double digits into the future. Some medical malpractice insurers have filed for reorganization, such as Phico who formerly insured both our medical center and the HSF. Others are pulling out of some states as St. Paul did in Georgia last year. The cap on

malpractice awards here in Virginia, and the formation of our own malpractice insurance company has mitigated the impact of these increases in rates somewhat, but our surgeons here still pay between \$9,000 and \$28,000 annually for their coverage depending on the insurance risk data.

- The University of Virginia Health System was successful in meeting these challenges in creative ways. Reaching into Western and Central Virginia, we acquired the services of about fifty primary care physicians. This stabilized and advanced our referral base, and extended our capabilities to better serve the communities and people of the Commonwealth. We have led in the development and deployment of telemedicine into the correctional system, into SW Virginia, and have had teleconferencing connections to other countries. Our land and aero medical (Pegasus) evacuation system, second to none, has served to transport injured and seriously ill from throughout Virginia effectively bringing us closer to those we serve throughout the state. Similarly, the School of Nursing's primary care nurse practitioner program has increased the number of graduates able to perform their important tasks as physician extenders.
- A variety of joint ventures such as those with Culpeper Hospital that acquired 14 primary care physicians in that area; Valiance, where we partnered with Augusta Hospital and Rockingham Memorial Hospital to gain some purchasing clout, and our membership in the Richmond-based Central Virginia Health Network strengthened important relationships. We constructed the state-of-the-art UVA-HEALTHSOUTH Rehabilitation Hospital as a 50-50 joint venture with HEALTHSOUTH Rehabilitation Company.
- We continue our intense efforts to cut costs without sacrificing quality, but astronomical rises in drug costs along with increased utilization of the newer, very expensive drugs has kept our medical supply costs above budget. "Codified Autonomy" in state regulatory procedures was granted by the State and implemented in 1996. This was helpful in providing the flexibility in purchasing, personnel policies, and contracting demanded in the increasingly competitive health care marketplace. The Department of Health Evaluation Sciences was established in the School of Medicine to sharpen our focus on outcome measurements and related issues.

- We continue the major initiative to obtain and install an electronic patient record and a state-of-the-art health information system essential for capturing and managing the mountains of clinical and financial data required to operate the Health System and to meet the increasing and ever-changing regulatory requirements. An indication of our success in establishing a sophisticated information system was our recognition as one of the "Most Wired" Hospitals in the United States. The newly renovated and expanded Health Sciences Library serves not only our local clientele, but also users throughout Virginia by placing increased reliance on electronic databases. We have placed outreach librarians in Danville and in the UVA's College at Wise.
- Owing to the emphasis on technology, concern about cost effectiveness, and the need to see increased numbers of patients under these new practice paradigms poses the inherent risk of losing the personal touch so essential to providing compassionate and responsive care. We have emphasized for the past seven years a more personalized approach in the delivery of care through a twenty-part process known as the "Ideal Patient Encounter". In addition, services previously provided through multiple departments in multiple locations, have become more "patient friendly" and effective by bringing together multiple specialists in one clinical area in such patient care service centers as the Children's' Medical Center, the Women's Midlife Center, the Digestive Health Center, the Heart Center, the Cancer Center and the Musculo-Skeletal Center. This provides "one stop shopping" for the patients, and it is very well received. We continue to serve increasing numbers of patients from throughout Central Virginia in our Emergency Room, supported by the Department of Emergency Medicine formed in 1995. That department had over 1000 applications for its eight residency positions this year. These are only a few examples that clearly demonstrate that efficiency and quality are not mutually exclusive.
- Research has significantly expanded and diversified at the Health System. As of June, the School of Medicine had received \$123.8 million this fiscal year from the National Institutes of Health and other sources, a 51.3% increase over the \$81.8 million received at the end of FY 1996. The Schools of Medicine and Nursing continue to build upon well-established basic science research programs while expanding their clinical research efforts. Emphasis is also being given to expediting the outcomes of research to the bedside - an

approach known as "translational" research. Further expansion of our research effort is limited only by the shortage of laboratory space. We have been working hard to overcome this barrier, and Medical Research Building #5 (MR5) will be completed in December of this year. Although this will provide 80,000 square feet of new research space, it will only allow us to meet current needs. Expansion of research will not only bring money into this region since each \$1M of research creates 35 jobs, but national rankings of medical schools are closely aligned with the amount of research dollars garnered. MR6 that will permit us to continue to expand our research operation is in the planning phase, but was a victim of the budget impasse in Richmond. It cannot be started until this time next year, assuming approval in Richmond in the next session of the legislature. I urge all of you to use your good offices to push the partial funding and approval of this critically needed structure.

- The education of health care professionals - physicians, nurses and allied health personnel - is one of our primary missions affected by the rapid rate of change in the delivery of health care and scientific advances. All components of the Health System are deeply involved in providing clinical education to students and residents in classrooms, on the patient care units and clinics, in the laboratories and in the operating rooms. Adapting to the rapid proliferation of knowledge has required smaller class size, departure from the large lecture halls, the use of small groups, and more frequent curriculum overhauls. All of this has significant budgetary implications. We are grateful that the recently concluded capital campaign raised \$246M (197% of our original goal) for the Health System, of which \$213.9M goes to the School of Medicine. Much of this money will be plowed into the educational milieu.
- The Health System has grown in stature, in the numbers of faculty and staff and in services available to patients. Thanks to the support and efforts of many, to include this Board, its physical facilities have grown as well. In the last seven years, 728,991 square feet of new space has been added and 155,450 square feet has been renovated. Several other major projects are on the drawing boards or ready to go forward - all boding well for present and future programs.
- While these challenges and changes have been in progress, the Health System has continued to make its presence felt across the state through its diverse public service efforts

responsive to the needs of Virginia's citizens. These include the conduct of conferences and programs focusing on the health of minorities and those in underserved areas such as SW Virginia; conducting numerous clinics in off-site, underserved areas; working with area rescue squads in training emergency medical technicians; and conducting continuing medical education programs throughout Central and Western VA. I am always impressed by the breadth and scope of our public service efforts, so much of it initiated and accomplished by our faculty and staff who see a pressing need, take the initiative and assume the leadership necessary to meet that need. One sterling example of this is the Charlottesville Free Clinic.

- Despite the intense pressures of the times sometimes accompanied by discouraging events that garner much publicity, the faculty and staff have persisted in achieving impressive results to include; being among the "Top 100 Hospitals" for the past three years, and achieving consistently top rankings by our departments in U.S. News and World Report annual rankings, with 7 departments being ranked in 1997 rising to 11 departments in 2000.
- The School of Medicine's graduates continue to be sought for some of the most competitive specialty residency programs in the country and, conversely, our departments attract top medical students from leading schools. Admission to the Schools of Medicine and Nursing continues to be highly competitive.
- Recently, in preparing for the centennials of the Schools of Nursing and the Hospital, I had occasion to reflect on their fascinating histories. It was the vision of Dr. Paul Barringer that saw the need for the hospital and supported the development of the School of Nursing. He faced many challenges to include lack of funds, but he persisted and the hospital and School of Nursing both opened on April 13, 1901. A nursing shortage, then as now, was one of the driving forces to get the School of Nursing established.
- As in Dr. Barringer's time, I am confident that the Health System today and its components will continue to face, and overcome, challenges. The components of the Health System are interdependent with closely interrelated missions, and it is important that there be practical, integrating mechanisms among them. Leading and supporting the System's outstanding faculty and staff will be more important than ever. While

qualifications and duties may change, the faculty and staff of the Health System expect and require leadership that provides vision, guides them to that vision and rewards them both by remuneration and recognition for their good work. Recruitment and retention, along with maintaining good morale, will be an ongoing priority. Nurses are overworked and many face burnout. Physicians who were formerly confident that they could concentrate on their professional practices and remuneration would follow almost automatically no longer have that confidence. Increasing regulatory requirements demanding more and more paper work enforced by implacable regulators coupled with an increasingly litigious patient population are forcing many physicians and nurses to retire early or abandon medicine and nursing altogether. Less than one third of those with an RN degree are practicing nursing today. Lest anyone think that this is problem limited to and for the medical and nursing profession to solve, I would remind that person that unless these problems are solved, any of us who can become sick or injured at any time might not have available the superb care that is delivered today that we have come to expect.

- Maintaining quality healthcare that is responsive and compassionate poses a real challenge as scientific and electronic advances continue to make major changes in care and treatment. The concept of the "Ideal Patient Encounter" becomes a more important benchmark than ever as competition heightens along with rising expectations and patient knowledge of health issues.
- Finding ways to finance all the health care Americans have grown to expect will persist as an important factor in the healthcare of tomorrow. This was underscored by a task force convened in April by the Commonwealth Fund that reported that the nation's teaching hospitals are increasingly burdened with caring for poor and uninsured patients and that these institutions face a "downward spiral in their financial status" unless steps are taken alleviate the problem.
- Notwithstanding all these challenges, this Health System is built on a strong foundation that has withstood the years. With your support and guidance along with that in Madison Hall, the dedicated men and women in the health system will continue to work diligently in the service of mankind. It was my distinct honor and privilege to be associated with these outstanding, dedicated and committed people for a quarter of a

century. I wish Godspeed to you and all those involved in the Health System in the future.

Respectfully submitted,

Robert W. Cantrell, M.D.  
Vice President and Provost  
for the Health System