

# The Medical Commencement Archive

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Commencement Address

### *Building a People-Centered Health Care System*

Richard J. Gilfillan, M.D., is the current President and CEO of Trinity Health, the \$13.5 billion Catholic health system that serves communities in 21 states with 86 hospitals, 126 continuing care facilities and home health and hospice programs that provide more than 2.2 million home health and hospice visits annually.

Gilfillan began his career as a family medicine physician and later became a medical director and a chief medical officer. He earned his undergraduate and medical degrees from Georgetown University and an MBA from the Wharton School of the University of Pennsylvania. He launched and became the first director of the Center for Medicare and Medicaid Innovation (CMMI) in 2010 and worked with payers and providers to develop innovative models for improving patient care and reducing costs.

Thank you, President DeGioia, Dr. Federoff and Dr. Mitchell for inviting me here today, and thank you all for that warm welcome! I am very honored to be back at Georgetown, and humbled to be part of this ceremony. Parents, grandparents, family, friends, deans and faculty, thank you ALL for supporting these young women and men on their long journey. YOU helped them get here—now they become your gifts to the world. Let's all give these very important people a nice hand.

In the spirit of a Jesuit University, I feel compelled to confess something—I admit that, yes, I WAS part of a crew that painted the John Carroll statue as Santa Claus for the Christmas of 1967. We DID use water-based paint, though. It was beautiful, but short-lived. The police rapidly dispersed us. I served my penance that night sleeping next to the dumpster in back of “Wisemiller’s Deli.” Thanks—I will take that as forgiveness!

I am proud to be here today as part of American Catholic Health Care – a ministry started by small groups of religious women and men more than 160 years ago. Many came from Europe in small numbers. They had minimal resources and no health care training. They became nurses, teachers, and administrators. Some rode horses to remote mining camps, others served on Civil War hospital ships. These founders were called to care for people however, wherever, and whenever they needed it. Catholic health care, Georgetown included, now provides 16 percent of all hospital care in America.

Today I want to talk about how we can continue this remarkable legacy of bringing health care to as many people as possible. Before I do, let me express my thanks for the excellent undergraduate and medical school education I received here. My greatest debt of gratitude to Georgetown is because they accepted Carmen Caneda, my wife, friend and partner of 47 years into the class of 1971. I am certain that were it not for meeting Carmen at Georgetown, I would not be standing here today.

Acceptance into medical school was, for me, and probably will be for you, one of the most fortunate occurrences of your life—aside from meeting your life partner. As a family physician, I experienced the deep personal satisfaction derived from serving thousands of individuals and families when they needed it most; along with the sadness, at times, when all I could do wasn't enough. Or, for some reason, I did not rise up and give a patient my best.

Every job I have had provided opportunities to positively impact people's lives, for one patient at a time in practice, and sometimes for millions in policy work. Each was deeply rewarding in its own way. In all, I was guided by the commitment to always do the right thing for patients. I learned that here at Georgetown. From my experience, I would say you have made a wise choice. It is a real privilege and honor to become a physician. I was very fortunate to be admitted to medical school.

All of us, of course, worked very hard to reach this point. While I know you come from varied backgrounds, I suspect that most of you have also been fortunate in important ways. We are all products of the gifts we are born with, the efforts we make, and the good fortune we experience along the way in life.

There are others, of course, who work equally hard, but are not so fortunate. That is why a social safety net is a critical part of a just society. As our last four generations of Americans worked hard to create the world's most advanced economy, they also systematically extended our social safety net.

My grandparents' generation gave us Social Security. Our parents created Medicare and Medicaid, to ensure that seniors and the poor had access to health care. But these safety net improvements still left many Americans without health coverage. In 1994, we Baby Boomers took our shot at universal health care coverage, and we DID NOT get it done.

By 2008, 48 million Americans were uninsured, twice as many as in the 70's. That year led by our children's generation—including you Millennials in record numbers—we did get it done. We elected a president and a congress that through the Affordable Care Act created the potential to close this gap in our safety net.

But that was only the beginning of ensuring that all Americans have access to quality, affordable health-care—not the end. Expansion is being contested in the Supreme Court. Regardless of the judgment, there will be no turning back the clock on expanded access to care.

On now to the next challenge. How can we as a country cover the bill that is coming due for health care – not just for the newly covered but for all of us?

I fly a lot and have TSA Pre-check—it's great. I pass right through security. Recently, as I approached the metal detector, a pleasant young man looked me up

and down and said, “Do you have any artificial joints?” I said, “No. All original parts, thanks!” One thing you can count on, Baby Boomers will not age cheaply. New hips, new knees—we'll take two of everything, thank you very much! Health care, with the increasingly bionic Baby Boomers afoot, could consume the majority of the federal budget if we continue to provide care as we do today. Already we pay twice as much for each person as any other country. Improving the quality and cost of health care is an essential national priority.

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Aside from demographics, there are two major drivers of high costs. The first is the ineffective marketplace and insurance benefit structures which insulate patients from the cost of services. These are being addressed through marketplace reform. The second major driver of excessive cost is the way we pay providers. Today, we are paid for the services or the fragments of care we deliver, not the outcomes. A hospital admission, an x-ray or a doctor visit results in a payment. An effective transition from hospital to home or a CHF admission avoided equals no payment.

The explosion in diagnostic and therapeutic technology over the past 30 years has given us many more fragments of care to provide and be paid for. Our delivery system has adapted. We now have “SNFists,” hospitalists, intensivists, even “laborists” to cover moms in labor. “Deliverists” may be just around the corner. You all have so many more career options than we did!

We have consciously fragmented care – and left the patient and family to fill the resulting gaps—integrating and coordinating their own care. No wonder almost 20 percent of Medicare patients, leaving the hospital with an average of 12 different medications, are readmitted within 30 days. Despite our best intentions, we do what we are paid to do—the result is an expensive, fragmented care system.

If we want to transform into a system that provides better outcomes, more efficiently, we will have to reward providers to deliver it. The Affordable Care Act created tests of new payment models that do just that. ACOs and episode-based payment systems are intended to support preventive, coordinated care models. Private payers are moving this way as well. There is growing momentum nationally to make these payment models the norm.

Let's assume that we will successfully change our payment systems over the next three-to-five years, while you complete your training. You will begin practice, then, in a system that rewards us for delivering better health, better care and lower costs for the people we serve.

That leaves one big question—how do we transform our care delivery system—create new care models—that produce those outcomes?

Across the U.S., there are 18 million health care workers, including 3.9 million nurses and 900,000 physicians. They work in 5,000 hospitals and across hundreds of thousands of other locations. They are the ones who have to understand and implement these new models. Institutional and individual change is difficult.

This is MASSIVE change that will ultimately impact every person in the system. These new care models must be designed to meet all of a patient's needs, not just a symptom, or condition. To accomplish this we need to understand those needs as the patient feels them.

I recently recalled an embarrassing medical school lesson about this. My third year medical rotation was with John Harvey, along with Proctor Harvey, one of the great Georgetown internists of that period. We were gathered around a bed thoroughly captivated as he interviewed and examined a patient.

When we left the room Dr. Harvey directed us to a nearby empty room, looked at me and said, "Rick, lay down on the bed." He put his foot up on the rail of the bed and shook it and he said, "Imagine you're that patient Rick, how does that feel?" Apparently I had put my foot on the patient's bed – and I didn't even know it. I am sure the patient did. To design and operate our new system, to really understand our patient's needs, we have to start by "putting ourselves in the bed."

At Trinity Health, we have framed this change effort as, "Building a People-Centered Health System Together." It means we design and deliver care starting from the patient's needs, not from ours – the providers—as we have so often done in the past.

I come to you today with a simple request. Please help us build a people-centered health system. People-centered thinking is not the norm for us in health care – at least not yet. At our system, we are now including consumers directly in our planning processes. We also recently created a simple tool – the "People-Centered Time Out" to help us maintain this focus. You all are aware of the "Time Out" concept from the OR—when the surgeon says, "Time Out," and the team runs through the pre-op checklist.

This tool has significantly improved patient safety and outcomes. Now, when we are debating priorities, thinking about designing a new lab process, or discussing visiting hours, any member of our team is empowered to call a "People-Centered Timeout."

Our discussion then starts anew. Taking the perspective of a person or family being cared for in our system we ask ourselves how would we choose priorities, design the lab, or set visiting hours sensibly? We integrate the resulting ideas into our conversation. Doing this significantly expands our thinking and will lead to better decisions.

As you move on to new lives in new institutions, try this out for yourselves. It works at almost any level or on any issue. When you are uncertain about how to talk to a patient or construct a coverage schedule, take a People-Centered Time Out. Pause. See yourself as the patient in the bed or in a wheelchair and ask, "How would I want to hear about my diagnosis? How would I want to be covered over the weekend?" Use that reflection to guide your discussion.

I know you may think this sounds simple. Surely there are more important technical things to think about. There are—but technical answers are easy. Changing behavior is hard—we have to systematically work at it. Like the surgical checklist, this could be a simple but powerful tool to help you be sure your work is grounded in the needs of the people you serve.

Here is an example of what care could look like in a people-centered health system. In Atlanta, there is a small village of shacks, next to a swamp, that have been constructed by homeless people. They call it Hut City. At dusk one evening, I was with a mobile care team from Mercy Care making a "home call" for a couple in their late 50s. We were standing under a plastic tarp that served as an awning over the dirt floor patio. A rusted table was circled by four mismatched old patio chairs. Behind the patio was a small hut, about six-by-eighteen feet.

An Emory medical student sat at the table, her headlamp shining on the woman's arm as she checked her blood pressure. The dusk scene was further illuminated by the glow of a laptop PC, wirelessly connected to our electronic medical record and to Grady Hospital a few miles away. The woman expressed concern about her spouse's need for follow-up at our clinic. At the end of the visit, we left a prescription for blood pressure meds and made an appointment for her spouse at our clinic. Care can be very different if we design around the needs of patients, not around our own needs.

In a few weeks as interns and residents, you will be more directly responsible for clinical decisions. I know some of you are wondering, "Am I ready?" "What happens if I make a mistake?" Remember the sisters in the mining camps and the hospital ships? Many had NO training. Imagine THEIR doubts!

Recently a very wise advisor said to me, "Every leader has doubts and feels like a fraud at times." Surgeons excluded of course. The reality is that while you have much to learn, you are very well trained. And you are part of a team. On a good team, your colleagues will be there for you, particularly the nurses who are so much more experienced than you will be. So be an effective team member: Be humble. Be curious. Be bold. Laugh a lot, enjoy your work, and celebrate your team. And remember that listening well to your patients is the starting point of great patient care.

The transformation of our health care system is now possible. We HAVE all of the elements to succeed. You are entering a wonderful profession at an extraordinary time. When I graduated from medical school in 1976, we thought we would create a system that would be accessible to all. We tried a lot and learned a lot. The science of health care has progressed tremendously, but we did not get that done.

You can. You are the FIRST generation of post ACA physicians. You will be coming of age in a transformed system poised like never before to provide every American an equal opportunity to reach their potential for a healthy life. I am confident it will happen—you started it—and you will get it done. America will be stronger as a result.

Enjoy this special day with your family. Congratulations to each and every one of you—the Georgetown Medical School Class of 2015—on your special achievement. Thank you all very much.