

Training a New Generation of America's Doctors – How HCA Healthcare is Changing the Graduate Medical Education Landscape – Hospitals In Focus Transcript

Chip Kahn: [00:11] Today we are in Nashville, at the headquarters of HCA, a company with over 180 hospitals and an extremely large ambulatory platform across the country with ambulatory surgery centers and remote ERRs and other kinds of facilities to serve patients across, really, much of the United States. Our guest today is Dr. Mike Cuffe, president of the Physician Services Group at HCA. He joined HCA a little more than seven years ago, before he served in various positions at Duke University Health Systems, including a stint as vice president for ambulatory services and chief medical officer there. In his current role at HCA, he oversees 10,000 providers and handles everything from physician strategy and urgent care to clinic services and graduate medical education.

We're gonna focus on graduate medical education, the training of young doctors in hospitals. Traditionally, HCA has been a company of community hospitals. They always had a few teaching hospitals in certain cities across the country, and they did have training of residents in a hospital here or a hospital there. But there's something new that the company made a decision to undertake a number of years ago, and that was an endeavor to adopt, in their system, a graduate medical education program that really integrated the training of residents across a broad platform across the country in various hospitals. And that's what we want to focus on today with Dr. Cuffe. He is in charge of this program, this program is frankly something new. Traditionally the training of graduate medical education was done in large teaching hospitals, with sometime outposts in community hospital small programs. But frankly, HCA here is really up to something completely different, a new model.

And this is particularly important at this point in time because across much of the country, experts believe that we have a physician shortage, particularly in primary care and certain specialties that are critical for patient care. And so HCA has looked and analyzed that problem and decided they can provide a service to patients, a service to their communities, and frankly a service to the healthcare system generally that is quite unique. With that introduction, Mike, tell us about what you're about in this area of graduate medical education.

Mike Cuffe: [03:01] Thanks, Chip, and I appreciate you being here with us today. As you pointed out, we see this problem of a national physician shortage really up close and personal. At the moment there's maybe a million, 1.1 million physicians in this country, 900,000 or less who are actually practicing. And we're already seeing shortages play out in areas, certain specialties, like psychiatry and certain surgeries and primary care, as you mentioned. But we're seeing it play out regionally in some of our rural areas, where we've always known there's a healthcare gap in this country. And then we're seeing it play out even in the major metroplexes by payer mix as well. Doctors who are, perhaps, increasingly opting out of Medicaid or Medicare participation.

So recognizing that and recognizing that we've always had some amount of graduate medical education, we really decided to reevaluate that space. And we realized that we had an opportunity to do the right thing here. So at the present time we have about 253

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GME programs in about 50 of our hospitals, encompassing over 3,300 medical residents. So for the listeners, as most people understand, after medical school you may have your MD or DO, but you can't practice medicine until you've done a residency. And while US medical schools have grown by some 30%, their positions over the last decade and a half, the choke point now in the US physician supply is clearly medical residencies.

And in fact, there's, I would say, some ethically bothering data, or it almost feels like an injustice, but if you look at the match, which is how medical students find residencies, this past year there were over 1,000 US medical graduates of medical schools who could not find a residency position in this country. These kids are graduating with debts of \$150,000 to \$200,000, they're freshly minted MDs or DOs. If they can't find a residency position, they're not gonna be able to progress and help alleviate that burden or take care of patients.

So we saw that and we viewed GME, really, in two different ways. One way is, as you know, our company does everything at scale. We look for scale efficiencies. And we felt there was an opportunity to look at GME differently that way. And then the other was, as you said, we've often and always had some amount of GME, either with academic partners or in some stand-alone programs of our own. But we have a lot of really good physicians and faculty members in our hospitals. We always have had nursing students, medical students, advanced practice provider students coming through our clinical platform, and we realized we had an opportunity to grow in GME. So while we're 3,300 residents today, by next July we'll be 45, and in about five to seven years, we should have over 7,000 residents. We're already the largest graduate medical education program in the country, and we think we'll probably be more than twice as big in a very short period of time.

Chip: [06:07] So what are you gonna do different from what's generally done at, obviously, smaller institutions scale-wise that have hundreds of residents but not thousands, in the case of your programs?

Mike Cuffe: [06:23] Right. So there's sort of two differences. If you think about one of our hospitals versus a traditional academic medical center, you think about some of the hospitals here in town or that I've practiced at before. They often have a resident-to-bed ratio of about one to one. 800-bed hospital, they might have 800 residents. And in fact, that is the core workforce of their hospitals. One could argue that if you pulled those residents out catastrophically in one day, I'm not sure they were well prepared to provide care to all those patients.

In our case we're building programs that have ratios more like one resident for every three or four beds. Our hospitals are fully staffed, they're working. This is additional workforce that we're blending in. So on a scale standpoint, we're not necessarily trying to recreate academic medical centers. The other side of it is, in my experience in dealing with both institutions I've been at as well as deans of other programs, even in a big institution that might have 60, 80 residents, 60 or 80 residency programs, kind of the

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major academic medical centers, each of these programs operates historically in a little bit of isolation. They are who they are, they've always been that way, 40, 50 years. The training program and curricula has been locally determined. But you know, when you think about HCA and the way we view sepsis or infection prevention, or the work we've done around 39-week delivery versus 38 and 37-week delivery of newborns, there are lessons to be learned at scale. And we knew this from big data decades ago.

And so our approach has been to, if there's a national curriculum that is best, we simply adopt that curriculum in general surgery, in OB, across every one of our programs. In addition, if there's not a best known curriculum that's sort of published, then we get together thought leaders, faculty, and we figure out what that should be, and then we push that across broadly. The fact that we're starting from scratch, Chip, is also interesting, because if you think about my parent institution of Duke University, where I did medical school and my residency training, they have a certain number of psychiatry residents, certain number of pedes residents, general surgery, and so on. But over the decades the clinical care that occurs at those hospitals evolves. And sometimes maybe they don't have as many newborns as they might like to have, or they don't have as much pediatrics as they might like to have.

That's good, and they often have to send those residents to other institutions to get that training. By starting from scratch, we can look at our hospitals and think "Wow, we have 120 psychiatric behavioral beds here, this is a perfect place to start a psychiatry program." And really match the current clinical environment to what they would be best at training.

And so there's a dozen other ways that we're looking at scale in graduate medical education, but I think the difference is, in these historic programs they are who they are, they've been that way a long time. And even across departments, say the neurology department creates a neurology for dummies that really every resident should understand. They have difficulty pushing that across all the programs, even in an institution. For us, we're approaching it that way. We need to learn about sepsis, we have an infectious disease fellowship. They're gonna put together the best module, and then we can push out national grand rounds, national speakers, locally facilitated, and really approach graduate medical education at scale. Almost, not just looking internally, but looking at broadly what's going on in education, not medical education, but education broadly in this country. How much has been made virtual, how much has been made standard, how much you can get online. And begin to think about what that means for graduate medical education as well.

Chip: [10:17] Let's take that down to the individual resident level. And I think it's June usually when you have your turnovers.

Mike Cuffe: [10:24] That's right.

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Chip: [10:25] And the new residents come on. So let's sort of look at next June and think about the model, and the models that you're developing. What would be similar for someone who matched with an HCA hospital to the traditional teaching hospital, what would be unique about their experience when they enter in that June? And then maybe over the period of their multi-year residency?

Mike Cuffe: [10:52] Sure. So let me first talk about who these kids are, because I think it's different. When you look at medical student graduates 30 and 40 years ago, and you just sort of think about the milieu, you had a lot of kids that went on that pathway because that was a pathway to be a small businessman. It was a pathway to be successful, maybe a leader in your community. And while it had some amount of debt tied to it, it wasn't of the type that you think about today. Nowadays, if you think about a young kid in college who wants to be a small businessperson, a leader in their community, maybe medicine isn't the only option any more. You can go into business, you can go into marketing, you can go into IT. There's a lot of additional pathways. So we have had the sense that the kids coming out of medical school are different than they used to be, and we did a survey of well over 1,000 third and fourth-year medical students and first and second-year residents. And we asked them "What are you looking for in a residency?"

And being of that latter era, I was expecting geography, cost of living, my debt load, the pay, I want to be at the top AAMC, or an academic medical center. And in fact, that's not what we heard. For over 2/3 of these kids, and I call them kids 'cause they're in their 20s, they're young doctors. For over 2/3 of these young doctors, the number one dominant theme was, they were looking to be part of something bigger and to make a difference in the world. And I think that's a good description of who's going to medical school these days. It's been shifting over the years. And so I think about it, then, from what do my programs have to deliver in terms of one, I have to be who they're looking for. But I am. Our mission here at HCA is to improve the care of, really, humans not just in this country, but broadly, by setting standards and doing better and serving our communities.

So as I think about who we are, I actually think we're well matched. And you'll be interested to know that over 65% of all physician graduates last year applied to at least one of our programs. So 2/3 of all medical school graduates applied to at least one of the HCA GME programs. We matched 100%. Our programs are really good. When you come in, then, I hope that we're offering an experience that's on par with any of the big programs. We've been able to recruit and retain faculty from these academic centers and do very well.

But then beyond that, we give them the opportunity to participate in national grand rounds that we have in many specialties that we push out, so that they can hear from thought leaders, not just thought leaders at their institution, and then have the discussion locally facilitated. They have access to simulation centers because our hospitals are rather less likely to be the single hospital in town, but much more likely to be part of a system of eight, 10, 12 hospitals that can share simulation centers, that can

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share simulation centers with nurses, that can get together, say, all the psychiatry residents in town in ways that are academically productive and educationally productive for them.

And then if they do need to rotate to another hospital, say to get trauma experience, they don't have to fly across the country, or you're not searching for that. You've got that in one of your sister hospitals on the same EHR with a lot of the same faculty, the same the rest. And so I think that we can offer ... these are accredited programs, so we have to be able to offer an accredited program that is good and at least on par with everybody else. We're looking for those advantages and those things that we can do because of our scale that make them better.

So far our students are, frankly, overall US average. And I would hope to do better over time, but it's still in the early years, and these are new programs. And as they build reputation, I hope that we'll do much better.

Chip: [15:07] Most of the hospitals at HCA have voluntary medical staffs, which means that the hospitals, the doctors have privileges to practice there, but they may practice other places in whatever town they live in, other hospitals. Some are on the staff, but they're mostly in the community, then practicing in the hospital. Even the specialists. So you're bringing into these community hospitals with these voluntary medical staff residents. What's the dynamic between those physicians and how they relate to now the new programs that you're building at the hospitals where they've been practicing?

Mike Cuffe: [15:44] Yeah, I think that's a very germane question. We've been thinking about GME both in terms of if we're excellent and we can deliver a fantastic training program, what is the impact on our medical staff, what's the impact on our patients, what's the impact on our business? And so we've been looking at that, as you would suspect, very, very carefully. In some markets the voluntary medical staff has been a little gun shy, a little concerned and uncertain. But when we reassure them that we're not trying to recreate a one resident to one bed, where they're the dominant provider in the hospital, I think they understand it better. They talk to their peers where we've been successful in doing this. And in fact, we have found that they have almost uniformly embraced this over time. They end up helping in the emergency room, in the operating room, in other forums.

And remember, all of our doctors trained somewhere. They're familiar with the model. They may have left an academic medical center and gone into private practice, usually not because of the presence of learners, but more because of administrative burden, pay, other things like that.

The other thing, Chip, to remember is that we actually do employ a lot of doctors, and we contract for hospitalist services or ER services or anesthesia services. And so there is a not unsubstantial portion of our medical staff that is already closely aligned, high

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quality, that we've recruited, not in independent practice, and are eager to focus on this as part of their job under our auspices.

The other two points of it is the impact on the patient and their understanding. And this is not an uncommon construct, and because, again, we're not going in such an intense ratio of residents to beds, our patients, we think, have been greatly accepting of this. In fact, if anything, we've seen an increase in patient experience because there's more people there to be present, ask and answer questions, and make sure that customer practices, service recovery and the rest are followed.

And then we've looked at the clinical medicine. And an anecdote, I think there's nothing better than a naïve second-year general surgery resident to remind that big gun surgeon to wash his hands or wash her hands. Because the surgeon knows they should wash their hands, and a medical student or a young resident reminding them is a wonderful thing. And they're really trying hard to do their best as well and follow protocol and research and the rest. And so what we've seen so far is that, if anything, care is better, it's lifted. We have folks focusing on the quality aspects of our agenda and patient experience seems to be certainly no worse, if not better.

Chip: [18:28] Let's drill down a little bit in terms of the patient. You mentioned, in terms of the patient, having more time now with the physician, with physicians, not just the physician.

Mike Cuffe: [18:38] Yeah, that's right.

Chip: [18:39] What else do you think, from an enrichment standpoint, or from an experiential standpoint, this strikes the patient that might be different from traditionally in an HCA community hospital?

Mike Cuffe: [18:52] Yeah, so I don't know if it's really all that different. When you're a patient in the hospital these days, hospitals are all but towers of ICUs. I mean, the patients that I often took care of 10 and 20 and 30 years ago are now outpatients. And so the patient acuity has gone up. There is a flood of workers when you find yourself a patient in the hospital, from radiation techs and food service, environmental service, and all levels of nursing in addition to physicians. And so this is a good thing, because we have more physicians present moment to moment that helps the nursing workforce. And we hope we'll improve nursing retention and satisfaction as well.

And so from the patient's standpoint, because we're not trying to flood our hospitals so that they "don't see the chief doctor," we see this only as a positive lift so far, and really haven't been able to detect any downside in any way whatsoever.

Chip: [19:48] And in my introduction I mentioned this broad ambulatory platform that HCA has beside, in a sense, the tower where the inpatient services are. Are there special

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ways, or how are you integrating the training programs into the outpatient ambulatory side, which may be on the campus with the building, but it might be at a remote location or at a ambulatory surgery center?

Mike Cuffe: [20:16] Yeah. Well, I'll tell you, this is a ... I'll use that as a bit of a leading question, and I'll pivot you just a moment. About half of residents stay in the markets and the states where they train. If they've done medical school and residency, about 2/3 will stay in the state and the market where they train. In my markets, particularly Florida and Texas, those states have made astonishing investments in medical schools, either at a state level or private level. But they lack for residency positions, so they're net exporters of these young doctors to places like New York and Massachusetts and California. And yet the population growth in this country is exactly there, in Texas and Florida. So unless someone steps up and meets this need in those states, they have a much lower likelihood of retaining these residents.

So to your question about the ambulatory platform, indeed we provide in excess of 15 million ambulatory clinic visits across over 1,000 physician practices, we have 130 urgent cares, we employ a lot of physicians who are both primary care specialists and then hospital-based physicians like hospitalists and pathologists. And so by rotating these residents within these platforms as well, they really gain an understanding of the health systems that we operate in these markets, not just individual hospitals. And then we think they're perfect because they're road-tested. So we can select the best, work hard to retain them, and while it's good for us, so I hope to retain them as my next urgent care doctor, my next hospitalist, my next cardiologist, they've been tested along that way. They know our systems, they know our processes, they know our culture. Hopefully they all want to stay.

If you're a ... we're sitting here in Nashville. If you're a Vanderbilt and you're training and graduating 150+ residents a year, 200, 300 residents a year, you can't keep them all at Vanderbilt. They go all over Nashville. But we're training such a small number of residents, albeit large, compared to our 180+ hospitals, that we can often retain all of them in private practice and employment, by joining our local groups, by joining some of our hospitalist vendors or ER vendors. We can retain them on our medical staff in our markets across our system, and we hope to do so.

And while that hopefully is good for them and it's certainly good for us, it's also the right thing to do for these states that we're in. Because this physician shortage showing up regionally, the driver of the physician shortage, if you boil it down to one factor, it's the economy. As the economy does better and the stock market does better, more senior physicians choose retirement. And they exit the workforce, or they slow down their practice. As the economy improves, healthcare demand increases for various reasons. And so as you think about the demand and the supply of physicians, as the economy's done better, those estimates have been worsening.

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And then you need to think about the geography and where people are moving in this country, and where the growth centers are, which as you know are many of the markets that HCA Healthcare has hospitals in. And that's where we're most worried about the shortages. Those are also the states that have invested in medical schools and don't have enough residency slots. So we see this as a win-win-win for our patients, for our communities, for this national problem, for HCA Healthcare in particular, and just simply the right thing to do.

Chip: [23:58] What kind of opportunities are there for these students in terms of research and other aspects that really contribute to their growth as physicians and developing physicians?

Mike Cuffe: [24:12] Right. So I think that's an important point. You know, many academic medical centers have a basic sciences medical school sort of attached to it, or an undergraduate medical school. So you think about that in terms of their ability to learn to be teachers, and you think about that in their ability and our faculty's ability to create academic product, papers, research, manuscripts, case studies, things like that. On the learning to be a teacher side, which is important, we have thousands of medical students from top medical schools rotating through our hospitals all the time. And that's something we've always had, we've organized that a little bit more. But there are actually lots of opportunities for advanced practice provider students, nursing students, pharmacy students, and medical students to interact with these residents. And so they will get that opportunity as they might have elsewhere.

And then the other side of it, continued accreditation and excellence in graduate medical education requires both our faculty and our residents have that ability to create academic product. And so I'd like to tell you this is easy and simple and we have big data and snap your fingers, it just works. It's still a tough lift. We do a lot of research here at HCA. We do it in pharma and device, we do it in practices and implementation science, which is important for us to develop the business. And we have begun involving the residents in that. We are building out sort of an academic product research support structure that is astonishingly large, if you were even a Duke or a Mayo or a UCLA. But its goal will be to support these 7,000 resident physicians and their faculty members, who by necessity and by continued accreditation have to participate in research and the creation of academic product. And we're doing that the right way.

We think there's lots of opportunities, because as a company you know our focus has been on sort of implementation science. If you go back to the old days, we all knew heart attack patients should get an Aspirin and were befuddled why 30% didn't. Understanding that and the human factors around it and closing those gaps becomes more about implementation. And so we have an opportunity, I think, to understand the healthcare business even better by turning that group's attention, some of it, towards our own business to understand what best practices could be.

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I often sit here in Nashville and think my job is, when someone calls up and says they have a problem, I know somewhere someone in 180 hospitals has solved that. My job is to find that and pull that across the company. I think actually this activity will help us do that even better.

Chip: [27:02] In terms of particularly building out the program from where you are, with 3,300 up to ...

Mike Cuffe: [27:08] 7,000, yeah.

Chip: [27:09] 7,000, the ultimate goal, and the other aspects, there are management issues. From the aspect of your years of experience of HCA with training and bringing along hospital CEOs and the management staff, what's different for them to now have what really is an academic program inside their hospitals?

Mike Cuffe: [27:33] Yeah, it's both an academic program, it's also an accredited program. And so it's a highly regulated activity on both the financial HR and the accreditation standpoint occurring in a highly regulated space. So there's no doubt there's been a bit of a learning curve and some education for our hospital CEOs. But again, not every hospital CEO has grown up since being a baby in HCA. They've often experienced this at other facilities as they've moved around the country. And so we have found a tremendous number of advocates in chief medical officers, chief nursing officers, CEOs, who had at least basic, if not advanced understanding of this space and are now thrilled to have this as a way to further lift and differentiate their hospital, their clinical care, and really attract and retain not just the best resident doctors, but also the best medical staff doctors.

Chip: [28:32] As you think about building out the program and the changing role for HCA in graduate medical education, obviously there must be implications for this from federal policy. And over the many years Medicare has been both in terms of directly subsidizing the cost of, and the salaries and compensation of those residents, as well as covering the indirect costs of having graduate medical education in a hospital, Medicare policy has been sort of integrally involved with however you design programs. How does Medicare work for you, and what are the implications of sort of going in now in a very scaled way, having to deal with Medicare on the graduate medical education side as well as sort of the conventional side of taking care of patients and being paid for Medicare services?

Mike Cuffe: [29:32] Yeah, so this is our life, our job, our work, is interacting with Medicare, Medicaid, state programs, national programs, and the federal government. And there is that clear complexity here. Part of the magic of our situation, while there is this physician shortage, the choke point being US residencies and this out-migration from certain states where the shortages are worsening, there hasn't been a lot of movement in the last almost three decades now in, well, certainly two and a half decades in terms

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of policy in this space, or reallocation or a willingness to increase dramatically the funding to allow more residencies to emerge.

Many of the institutions, the academic medical centers, because of the resident to bed ratio they're already at, or the availability of enough pediatric patients or psychiatry patients or new OB, don't often have the capacity to even grow any more. That's why they extend out to community hospitals and push their residents out, or to VA, veterans affairs hospitals. And so we have the ability to do this. So far our interactions with the AAMC, with CMS and others have been very encouraging, because we're addressing what they perceive as a problem here. And part of the magic is that, you know, we have many hospitals that are 500, 800, 1,000-bed hospitals, and they've never had a resident ever in their entire history.

And that has always struck me, coming to HCA, as a lost opportunity. There's an opportunity for training, and so when we looked at this overall situation of an impending physician shortage, the choke point being GME, we realized that within existing law, if nothing was gonna change, there was a huge opportunity for us to do the right thing, participate in this program, add new residencies in these hospitals, and then use the existing statutes to sort of build that capacity and that cap.

The way this works is, when we start a new residency, we have five years to ramp up, and then wherever we are at the end of five years, that's where that hospital is. So if I ramp up to five residents, in perpetuity we'll have five. If I ramp up to 100 or 150, in perpetuity we'll have 100, 150 until statute changes. So we have looked broadly, we've looked where we have educational opportunity, where the medical staff is ready, where we have the talent, where we can recruit the talent. Easier in some of the major metro areas than some of the more rural areas, and then where we think we are gonna see that need, because the residents are likely to stay in those markets. And then have worked under existing law and gone ahead and built out in those ways. Ultimately, I think that allows us to get ahead, solve the problem without a need for further changes in Washington.

Chip: [32:29] So you're gonna be adding residents in many communities across the country. And you mentioned veterans administration hospitals, which existing teaching hospitals generally have cooperative arrangements with, and other hospitals. What kind of cooperative arrangements do you anticipate with your growing base of residents, or will it be just HCA-centric?

Mike Cuffe: [32:57] So it's really an all of the above. In some of our Florida markets, our hospitals look more like a community hospital, and they're a little smaller. And even with the support from Nashville and national grand rounds and curriculum and the ITNS infrastructure and the best practices, we still feel like they're maybe a little too isolated. And so in many cases with major universities, some of the Florida universities there, we create a consortium, an academic partnership, and build it out together so it's a joint program of the university and of HCA.

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In other markets where that academic partner is a clear competitor to our health system, we still sometimes do a partnership there. In other places, though, we're here in Nashville, right across the way there's an 800+ bed hospital that is full of doctors from the top 10 academic medical centers, it's one of ours. And the only academic partner here in town is our major competitor. In cases like that, and as well in other places where ... St. David's Healthcare in Austin is a Baldrige Award-winning system with a national reputation. There are places where we think that we don't need a partner, where what we have intrinsically in the hospital, in the system, in our reputation and the rest, and we can feel more comfortable proceeding ahead alone.

So it's really an all of the above, where we're looking at it very carefully. With the issues of the best education, the presence of a system around them, simulation centers, assets, other things like that, and the right faculty leaders being the primary determinant.

Chip: [34:40] Great. Mike, you know, healthcare and the perception of particularly traditional hospital care is changing. The focus now is on the continuum, the, in a sense, birth to death, sort of every aspect. And the hospital obviously is a way station we, as patients, want to avoid, but sometimes have to go to for our healthcare. But so much now is being sort of pushed out, and we're thinking about how to take care of individuals as part of larger populations and in terms of prevention and lifestyle shifts, and thinking about patients in different ways, not just when they walk in the emergency room, is something that the students, the medical students, are hearing a lot about in their training. How is your program, whether it's terms of an organized group of patients or the in-and-out patients, how is it gonna help these training physicians prepare for an environment in which they just don't want to worry about the episode, they want to worry about the whole patient over some period of time?

Mike Cuffe: [35:54] Yeah, that's a great question, Chip. It is clear that the practice of medicine is changing and evolving. Years ago we talked about this with some tension in family medicine around whether the job of the family medicine provider was to see one patient at a time, or really be the leader of a team taking care of a population of patients. And so at one level, for us at HCA Healthcare, it's important that we're not just hospitals. We have these ambulatory platforms, we are systems, we have ACOs and Medicare Advantage plans and clinically integrated networks and the tools to manage populations upon those, and the rest.

Because these doctors that we're training have to become experts in telemedicine, which we have. They have to understand ... I like to call it asynchronous patient care, it's not the patient in front of you, it's the population and who might get sick next week and the week after. They need to understand team leadership and train together with nursing trainees and advanced practice providers and pharmacists and others so that they understand the best aspects of team-based care, and kind of all those shared learnings and the deep connection to population management.

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I believe that because we're designing these from scratch, we can both meet the needs of accreditation, provide best practice if that young doctor's gonna choose to be an intensivist and sort of isolate themselves in the acuity of that medicine to the degree that that's true. But at the same time we can make sure that through this and simulation centers and our technology and our focus ourselves on population and team-based care, that we'll be turning out a doctor who's the product of a program, that they're so much more capable at practicing tomorrow's medicine and what may be asked of them.

Chip: [37:45] In terms of tomorrow's medicine, how is digitization, whether it's electronic health records or all the other ways that data is captured today around patient care and for patients, how is that gonna impact training? And then how is that going to impact patient care over time?

Mike Cuffe: [38:04] Yeah, and so many people see that on the surface as a burden. Because the documentation serves a reimbursement system as much as it does the patient continuity of care, and best care in the moment. And that's true in the inpatient and the outpatient setting. But you know, we have been optimistic about things like virtual visits for a long time, but most consumers don't turn to them. And they've had relatively limited utility, and we're doing an audio podcast here, and many people don't want video yet, right? But we are learning that there are opportunities here. Our own work internally leveraged that data into sepsis detection and prevention. By understanding that data and the academic work in GME that will come out of it, I think what we're gonna find is that there are AI tools around the doctors, not just these young doctors, but all of our medical staff, that helps ensure moment to moment that the best care is provided.

We are seeing the emergence of some other utilities here that I think are becoming important. There's not gonna be a stroke doctor at every hospital, so the virtual visits for an ICU for stroke are very important, and our doctors have to be good at both performing those and interacting with those because of the shortage of some specialists we're seeing. And then I think most fascinating to me is behavioral health. A terrible shortage of psychiatrists, an increasing burden in this country, and yet of all of the medicine, the patient with a behavior psychiatric issue is actually often more likely to want a virtual interaction with a screen. It adds to the comfort rather than being put right across from another human being in the same room.

And so there are opportunities in so many of our specialties to move the data to the cloud, whether it's a visit, whether it's a radiology study, whether it's a pathology specimen, and then get the right person at the right moment as quickly as possible to interpret, to do the visit, to what have you. And since we're on the cutting edge of a lot of these things in pilots everywhere, our small pilots are large initiatives for most systems, but we hope that as these become more commonplace we'll be right there integrating them into our training.

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Chip: [40:25] Well, I think we've covered a lot. Mike, is there anything else, do you think, we should talk about so that we can really educate people about this unique program that I'm not sure many of our listeners probably were aware of, or would have necessarily expected from HCA?

Mike Cuffe: [40:44] The only thing I'll close on, Chip, is that I have to tell you, we feel really good about this. As we look at the existing residency programs in this country, they are typically resource-constrained, they often operate at a tremendous loss to their parent hospital, their academic medical center. They're often unable to grow, either because of resources, space, or simply the patients who are available within their walls. And they're deciding very locally what's best. My time at my parent institution, we had 110 different residency fellow programs, and every time a program director changed, it felt like the new program director was rediscovering graduate medical education. That's not the way to run the best educational program or a best business.

And so our ability to both address this national problem, but attack GME differently, recognizing its education, it is clinical and medical education, but exploring all the ways we can do it at scale from scratch, I think, is really exciting.

Chip: [41:51] Great. Well, thank you, Mike, and I found this really helpful, and my understanding of what HCA's trying to accomplish here is expanded by our conversation, and I hope our listening audience also will have learned something today.

Mike Cuffe: [42:06] Thanks a lot.

Chip: [42:07] Thanks so much for listening, and be sure to subscribe to Hospitals In Focus on Apple Podcasts or Google Play, or visit our website, FAH.org. It is so important that we get your feedback on our show. Please rate us and give us a review. And if you like what you hear, tell a friend. Until next time, this is Chip Kahn with Hospitals in Focus.