

# CEO Viewpoint

AN EXECUTIVE PUBLICATION FROM THE SCOTTSDALE INSTITUTE

APRIL 2012

**W**hen you're a four-generation pediatrician family—his grandfather and father were both pediatric department chairs at Canadian medical schools and his daughter is a pediatrician—you can say pediatrics runs in the family. "We call it a genetic defect," says Alan Goldbloom, MD, 64, who now puts that hereditary gift to work as president and CEO of Children's Hospitals and Clinics of Minnesota. Born and raised in Montreal, he earned his undergraduate degree at McGill University and MD at McMaster University. Trained in pediatrics at Children's Hospital Boston and The Hospital for Sick Children, Toronto, Goldbloom began pediatric practice in Halifax, Nova Scotia, and later became director of residency training. After 10 years in Halifax, he went to Toronto for 15 years, initially as a clinician/educator and associate chair of pediatrics at The Hospital for Sick Children and the University of Toronto. He became involved in hospital management in 1993 and eventually ended up as COO. Children's Hospitals and Clinics of Minnesota recruited him in 2003 as President and CEO. He met his wife Lynn at Boston Children's where she was a Child Life specialist. They have three children: Ellen, a pediatric endocrinologist; Amy, an economist and banker; and Stephen, a TV marketing & communications executive. They also have two grandchildren, Sam and Ben.

## How is Children's Hospitals and Clinics of Minnesota responding to health reform and payment reform?

Like most children's hospitals, we're pretty mission-driven to care for all children, including those who are the most needy and vulnerable. Health reform supports improved access for that population, and we're responding with our own proposals. First, we're creating our own models for pediatric care rather than let outside models be forced on us. We have several demonstration projects to take on risk for Medicaid and address other new payment models, including capitation. In order to prepare for payment reform, we will require much more coordinated care, and that need is driving us to a whole new physician-alignment strategy.

## How are independent children's hospitals integrating care across the spectrum from hospital to home? How does IT play a role?

We're achieving that integration by developing new business relationships, including setting up professional service agreements with physicians and acquiring a number of pediatric practices. The demarcation line between hospitals and practices is becoming increasingly blurred. We're also developing a CIN, or



ALAN GOLDBLOOM,  
MD, PRESIDENT & CEO,  
CHILDREN'S HOSPITALS AND  
CLINICS OF MINNESOTA

clinically integrated network, which would link us with many of the pediatric practices in the Twin Cities to coordinate care, monitor quality, improve outcomes and negotiate payments with payers as a group.

In terms of IT, we need common systems to link all of those practices together focusing on quality and continuity of care, which is going to be a challenge. In order to support a clinically integrated network, we are planning to implement a system that will allow tracking and reporting of quality measures across practices that may themselves have different systems. This component – the tracking and management of quality – will be especially important in allowing the CIN to contract collectively with payors. A future step will allow tracking of a child's care over multiple sites and days.

Also, we find as we develop networks that some practices don't yet have an EMR, so we are assisting them in implementation of a product called eClinical Works. In terms of continuity of care, this implementation will allow individual community-based practices to work as a system rather than as a series of unrelated parts, especially as a child moves from ambulatory to inpatient settings.

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## What are the unique aspects of pediatric markets? How do these impact your physician-integration efforts?

Unlike adult hospitals, children's hospitals have not traditionally developed into integrated delivery systems. Instead, children's hospitals have served as a resource to many other hospitals and systems within their geographic area, a place where they send their sickest children. We've really been a referral destination for unique situations. Therefore the 'traditional' ACO model doesn't easily apply.

We're beginning to create some networks in our market but we face the fact that many of our patients come from outside our immediate community. It's much harder to develop system integration with children's hospitals and will take quite a bit of adaptation.

## Medicaid is a major source of funding of most children's hospitals. What are the risks associated with that?

On average, Medicaid accounts for 50 percent of children's hospitals' revenue and is the single largest insurer of children in the United States. People are often surprised to learn that children comprise 50 percent of Medicaid eligibles—and yet account for only 20 percent of its cost. So, we're very concerned about threats to Medicaid funding. Health reform is likely to increase the number of Medicaid-eligible individuals in the country, but there's no sign that the funding available for Medicaid will increase. So we are very concerned about the continued availability of adequate funding for children's health care.

## Many children's hospitals are taking on obstetrics in addition to pediatrics. Why is that?

Outside my window there's a building going up on our campus for mother & baby care in a new joint venture with Abbott Northwestern Hospital, 72 percent owned by us, 28 percent by them. In a way, newborns are the lifeblood of children's hospitals. Our young patients

with severe prematurity, surgical malformations, congenital heart disease and genetic disorders often come to us as soon as they are born. Having them born on our campus makes sense. In addition, we are developing a major program in fetal diagnosis and treatment (including fetal surgery), so it only makes sense to have the prenatal and postnatal care on one site.

The other reason is that for many adult hospitals, obstetrics is either a break-even or money-losing proposition. They offer it because it gives them a marketing edge. As pediatric caregivers, we have a great interest in the well-being of the infant throughout gestation. That's why more and more children's hospitals are becoming birthing centers, especially for high-risk pregnancies.

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## What's the biggest change you've seen in healthcare over your career?

My answer won't be popular in the United States. Being from Canada I remember when Canada passed the law for universal health insurance, which was as controversial then (late 1960s) as it is here today. However, while there are always some complaints about the system, most Canadians remain fiercely protective of universal health insurance. During my 25 years practicing medicine in Canada, I loved it because everyone had insurance and I never had to worry about any patient not getting the care they needed. That was a huge social advance in health care.

## What is the most rewarding part of the work you do?

That's easy. It's watching children, particularly kids with conditions that used to be fatal, living healthy lives. There's no greater reward.

## What's a favored book that you've recently read?

I'm a voracious eBook reader and had a hard time choosing. An excellent book is "The Emperor of All Maladies: A Biography of Cancer" by Siddhartha Mukherjee, an oncologist who tells the history of cancer through personal stories.



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