Dr. Herrod began the presentation with some historical notes. During the 1960s and '70s, UT chose not to build a university hospital, in large measure because Methodist and Baptist already had a large presence, with both downtown in the heart of the medical center area. It was thought that building a separate hospital competing with these two would not be feasible, so collaboration appeared to be the superior option.

Initially the stronger partnership was with Baptist Central. In the mid-90s, discussions with BMH focused on merging with UT; thereafter, the proposed combination would add the Med. As that proposal failed, due in part to the County Commission's resistance, Baptist decided to move its focus to East Memphis and DeSoto County.

At that point, discussions with Methodist Health Systems (MH) grew, partly fueled by recognition that the Med, VA, and LeBonheur alone would not be sufficient for UT's mission. The move toward alliance with MH was based on mutual needs and goals. UT needed a private hospital, access to adequate patient population for training, and private patient access for UTMG physicians. MH, with a commitment to its historical mission, needed a downtown medical center; additionally MH needed to develop underdeveloped services while reducing duplicated services. MH's willingness to collaborate was also fueled by a successful experience with the LeBonheur/UT alliance, which includes a solid blend of private and UT physicians.

Since their agreement to partner, UT and MH have reached several accomplishments:

- March '02: agreement signed
- Nov. '02: MH takes Bowld management
- July '02 - present: planning for surgical program
- projected Jan '04: ambulatory clinics move to Eastmoreland
  (office complex will be directly behind Meth Univ Hosp'l)
- projected summer '04: Transplant program moves to MUH
- projected July '04: Merge Radiology residency

Dr. Herrod then focused more specifically on the collaboration between UT and Methodist University Hospital (MUH). Key areas of partnership include: UT Cancer Institute (with Boston Baskin); Pathology (moving toward increased collaboration with Duckworth Pathology group); Infectious Disease (Mike Gelfand of MH is now working with UT faculty); Neurosurgery (residency education will now be focused at MUH and the Med rather than at all Memphis hospitals); Orthopedics (as with neuro, residency education will now be focused at MUH and the Med rather than at all Memphis hospitals); School of Nursing (UT's program has mainly focused on masters and doctoral training, while MH had focused on nurse training without baccalaureate degree; new combined program will provide all levels).

Additional collaboration is being forged between UT and private physicians, via active discussions with radiology, surgical oncology, CV surgery, and anesthesia.

Alongside these goals and achievements, Dr. Herrod identified several frustrations:
*slow pace of credentialing: MH has rigorous credentialing bylaws that require, e.g.,
direct production of documents such as diplomas; this process is a good one but can be very
time-consuming; a more collaborative, efficient approach is being explored
*slow movement of UT physicians to adopt integration as a goal
*100% support from top leadership of both organizations has not been followed up with
energetic efforts on either side to encourage support; "50% buy-in from remaining faculty and
staff"

Dr. Herrod then described the Strategic Planning Meeting that was held in September,
2003, with key administrators from MH (CEO, COO, CFO, MUH administrator, EVP Marketing
and Comm., SVP Human Resources, President of LeBonheur) and from UT (including the
Dean, Chairman of Medicine, and a number of other participants).

Mr. Shorb then identified "Strategic Planning Goals for UT/MUH Affiliation." He
identified three general goals: [1] continue to improve quality of care and patient satisfaction;

Mr. Shorb also discussed a number of more specific goals:
*Move the transplant program to MUH, as the first step in moving several major services
into MUH; others will be neurosurgery/neurosciences and cancer. Moving the transplant
program will cost about $15M, and will probably will require a CoN (certificate of need). A
working timetable is expected in next 30 days.
*Develop an integrated governance structure and processes for the UT/MUH affiliation.
This is needed to ensure that results and oversight will occur, by tracking each priority
specifically and frequently.
*Develop and implement a physician/workforce deployment plan. Several recruitment
packages have been approved, e.g. for pediatric CV surgery and selected other areas that need
additional talent. This process will involve working with department chairs to develop
appropriate plans for identifying and recruiting needed faculty.
*Develop OB services plan within the "Medical Center." At this time MH and UT are
working with Med to develop a plan that can be implemented fairly quickly, to consolidate OB
services; specifics of the plan are to be announced soon.
*Improve clinical services at MUH, including OR renovations, equipment for radiology,
equipment for neurosciences and orthopedics, among other planned acquisitions.
*Consolidate the clinical research infrastructure; in part this will involve reducing
duplicate services and resources.
*Develop a plan for a consolidated and high-quality CME program.
*Develop a high-powered joint lobbying effort on all levels. Mr. Shorb noted that the
eastern part of Tennessee gets a disproportionate share of graduate funding and other state
resources. This needs to be remedied.

Dr. Herrod concluded by discussing the UMCA (University Medical Center Alliance),
consisting of the Med, MH, the VA, and UT. This group has come together to take on issues of
quality assessment and improvement. This will begin with measuring local performance against
national standards (e.g. whether our physicians prescribe aspirin after an MI, and appropriate
antimicrobial Rx for hip surgery). These numbers will be made public, for purposes of
accountability, as efforts to improve quality move forward. Encouraging results are already being
seen in some areas at MUH.

Formal remarks were followed by discussion and an opportunity for Q&A. One question
concerned the need for office space to be created at MUH, to accommodate UT faculty for
research and academic space as well as practice space. Mr. Shorb noted that the CRC and other academic activities will receive space as part of planned renovations that will take place over a time-frame of perhaps 10-15 years. Additionally he noted that administrative offices are being moved off-campus, to make more room for academic purposes.

Another question concerned fellowship programs, including the number of slots and their funding. Mr. Shorb said that he anticipates all fellowship slots will be captured and kept, though it is not certain whether the current distribution will be retained.

Concerning the future of research, Dr. Herrod pointed out that a large clinical research activity is essential to being a true university hospital, and that future planning will focus on how to do large clinical trials at the university hospital. Developing a substantial clinical trials unit should be a focus for growth.

Mr. Shorb observed that the success of these projected programs will require the financial success of MUH hospital. Although the other MH hospitals are financially successful, Central/MUH is not currently breaking even. Careful financial management at that facility must be accompanied by decisions regarding which programs are best positioned to be successful.

Further discussion pointed out that the plans for moving transplant services to MUH are not simply focused on surgery, but on the broader disciplines involved in treating people with end-stage organ failure.

Additional clarification on the improvement in quality of care for clinical services: the informatics department now has 15 FTE employees. The new system currently being deployed has the capacity to track data, implement evidence-based medicine, and the like.

The meeting concluded at approximately 6:15pm
Respectfully submitted,
Haavi Morreim, PhD