Jeffrey P. Gold, MD: Hello. This is Dr. Jeff Gold, and I'm the Chancellor of the University of Nebraska Medical Center. And I want to welcome you to "Health Care Heart to Heart," providing insights into the medical and the scientific issues of the day. As you may know, I'm a recovering cardiothoracic surgeon, a longtime medical educator and a firm believer in the ability of science to change lives for the better. Our guest is Dr. Atul Grover, and Dr. Grover and I have known each other for a very long time. Your current role at the AAMC as I understand it, is the executive director for the Research and Action Institute. And what does that mean, Atul?

Atul Grover, MD: It's relatively new in terms of the double AAMC's 150 year-plus history. We've only had this institute for just over two years now, and it's our version of a think tank. Really trying to look at some of the intractable problems that you deal with here on the ground or through your policy work in Washington or here in the state. And historically the AAMC has really focused on things that were urgent, on fire, kind of right now.

Dr. Gold: No shortage of those.

Dr. Grover: No shortage of those, right. But we didn't necessarily have the extra bandwidth to think about, how do we work on some of the long-term issues, like cost and access, things that come up recurrently in our history, like access to mental health care. So this was really an attempt to try and figure out if we could bring some of the expertise to bear in longer-term thinking about how to deal with some of these problems. And the hope is that it really is a matrixed organization across the AAMC and the hundreds of experts we have, but then also bringing people like you into the conversation to say, 'How does this really work on the ground outside of Washington, D.C., and what's realistic to achieve over the next couple of years.'

Dr. Gold: Super. And as I understand it, it's really an academic pursuit.

Dr. Grover: It is a much more academic pursuit, but I like to think about it as a think-and-do tank. So, one of the benefits of having been around for so long and getting to know each other over the years as we have is that I've had the opportunity to spend time both working with and within academic health centers, and so I understand how physicians and hospitals and health systems work. But also I have worked in the federal government off and on for decades, and really understand how policy works.

And I'm an academic. I still maintain my academic appointments at schools of public health and medicine. And so I hope to bring a unique perspective that really talks in simple English about the tradeoffs that we have to make when we want to achieve new policy solutions and to really be honest with the American people and policymakers about the hard decisions that have to be made, and where some of that is going to hurt, but where some of its going to really help us achieve longer lasting health into the coming decades.

Dr. Gold: Well, kudos to you …

Dr. Grover: Thanks, it's a lot of fun.

Dr. Gold: And kudos to Dr. Scorton for having the vision to work with you to address some of these critical long-term issues, because everybody keeps saying that the current health care system or systems are not sustainable …

Dr. Grover: Here we are.

Dr. Gold: But operational solutions are not really readily available.

Dr. Grover: And I think part of the challenge is – you are a surgeon by training, but you have learned how to be an administrator in a health care system, but hopefully have the understanding of what it's like to deal with patients and the real-life intricacies of health care. It's a heavily regulated industry, its one where there's a huge imbalance of information between us as clinicians and patients and the public. But it's too easy for economists to say. 'Well, you're just inefficient.' Well, I'd like to see the economists come here….

Dr. Gold: Yeah, go to the operating room.

Dr. Grover: Or just run the medical center for a couple of months, because I would love for them to show us how we do this more effectively and efficiently.

Dr. Gold: So, I'm interested in your thoughts about the importance of strategic planning.

Dr. Grover: I think one of the challenges that we have is that when we have strategic planning, most institutions or organizations tend to do this every five or 10 years, sometimes longer. A lot changes in that time. I liken this a little bit to the policy world that I spend a lot of time in, where we either have our noses right in front of us to deal with the crisis of the day, or we believe we can think about a problem 10 or 15 years in the future, when the truth is conditions on the ground change.

I think about the first time I came out here to Nebraska to visit you, and I think it was before Ebola, right? So Ebola changed things, you've got this huge infrastructure where people are coming from all over the country to come and learn from Nebraska about how to do pandemic preparedness, and yet, as a nation, we still didn't do that great when COVID came along. During COVID, we had Mpox, or Monkeypox; I was not thrilled with the reaction of the U.S. government during that.

Dr. Gold: And our system wasn't, either.

Dr. Grover: So I think part of this is figuring out how we don't just kind of plan for a future in which we hope the best or worst will materialize, but to really do constant course corrections. Anybody who's an engineer or an architect, it's a lot easier to make these little adjustments as you move forward rather than try to figure out how you've gone 600 miles off course and try to fix things retrospectively.

The challenge that I've seen in most institutions and organizations is that the strategic plan is kind of formulated and tested for some period of time and then kind of abandoned and revisited, right, because the day-to-day work is really critical, particularly if you are in a health care environment. So one of the challenges that I think we've always had in thinking about things like errors and quality and safety in health care is, we hold up the aviation industry as an example. I can ground those planes. I can train people on the ground. We don't often have a full air stop like we did after 911, or when the FAA had their problems recently.

But we can't do that with the health care system. If anything, we have to respond on a dime even more intensely, like we did in COVID. We didn't stop the health care system, we said 'Alright, we've got to do all this stuff right here.' And I think, you know, that the challenge for me is usually easier overcome with

good data collection and constant monitoring, because I think if you don't measure, you don't really know how you're doing. And so to me the key is coming up with a solid conceptual framework or pathway, so you can do a path analysis and say, 'If I'm making a decision about what I believe is best for our patients in Nebraska and in this nation,' part of that tracks back to, what do I need to do to have not only the best trained and equipped personnel, but the most supported and resilient. So I think about things like wellness from the standpoint that, I need to be able to track that back to the health of the patient, because people are going to ask, 'Why are you doing these things?' I think it is similar with diversity and equity and inclusion and mentorship, allyship, sponsorship. I think if you sit down with people and explain the pathway as to why what I am working on right here is critical to the health of the patient, to the health of the institutions, to the health of Nebraskans, down the line it's a lot easier to get buy-in. And I think we all have to keep revisiting that pathway; it's almost like a clinical pathway or a physical pathway that you need to constantly study, adjust and measure to say, OK, did we get where we thought we were going to get? Did we get the results that we thought? How does that affect the next six steps in this path. And that's why I think we often fail as organizations. We don't keep collecting the data. We don't adjust to say, 'Oh, turns out the data we're collecting is the wrong data.' And I think the openness and the constant revisiting of these things collectively as a team of people who really have to carry out the vision for the medical center and Nebraska Medicine and the university is really critical.

Dr. Gold: We are as mission driven an organization as I have ever been I've been part of, and care deeply about the communities that we serve. As a matter fact, one of the things that we define ourselves as is, as we make decisions, we always ask the question of what's best for the communities that we serve. And you know, 99.9% that's also what's best for our faculty, our staff, our students, for the budget, etc. It's all about what we can do to serve this community.

Dr. Grover: But communicating that to the community and the policymakers and the people who help fund this important work is really critical. And I think the more we can be aligned as an enterprise … because the people in your Simulation Center, and the people who are working epidemic preparedness, and the people who are doing lab research, are not the same people in the OR, but if they have a common vision and can articulate that to each other, so that the psychiatrists and substance abuse counselors understand why they are just as important as the cardiothoracic surgeon…

Dr. Gold: In many ways more important, I would argue.

Dr. Grover: Yes, and actually they support the cardiothoracic surgeons and the patients. What do the surgeons need to be supported and be effective? I think that's where it's good to have somebody who is a good communicator like you in this position, because we don't do that uniformly across the country, and it's hard because the politics are different and the concerns are different, but we have to get people to understand why we are making the choices we are making.

Dr. Gold: You and I have done a lot of work on defining the role of academic medicine, academic health care centers as different from, not better or worse, but as a critically important part of workforce development, of course pushing back the frontiers of discovery around better diagnosis, better cures and of course caring for patients that frankly can't get cared for elsewhere. And how do you think that message is going as we're trying to share that broadly?

Dr. Grover: You know, for the first time that I can remember, I've seen more advertisments, in D.C., around the country as I travel, where people use the word 'academic medicine,' 'academic health center,' 'academic medical center.' And that wasn't the case 20-30 years ago. And in fact, we were

reluctant to use that terminology because we thought people just didn't get what that meant. I think there's a little bit of a better understanding of how these pieces fit together. The pandemic certainly showed people – you know, think of a place like Nebraska, where the department of public health is tightly linked to the university medical center, that your state laboratories are embedded and those pathologists are here at UNMC.

I held that example up to the people in Washington to say, 'Look, there's a better way to do this stuff.' Even where we don't have the data systems in place yet, you get a trusted partner – and I think we are trusted partners in communities. We are anchor institutions, right? We are here to educate and lift up not only from a pure clinical standpoint, but I think from a broader health perspective. Because you employ tens of thousands of people – you are probably the largest or the second largest employer ….

Dr. Gold: The largest in the state.

Dr. Grover: And so you have not only an obligation, but an investment and a real motivation to keep that workforce engaged and healthy and active and producing for each other in the community and for the state of Nebraska and the world. So I think people are beginning to connect a little better the fact that we had very quick vaccine development and deployment of antiviral medications, and they got to see how, kind of the fits and starts of scientific progress.

Dr. Gold: The good, the bad and the ugly.

Dr. Grover: Some of it very ugly. But I think they gained an appreciation for how we operate in this space bringing discovery and education and training and really the most advanced compassionate clinical care possible to everybody in the community. When you're the only academic health center, or one of just two in the state, maybe the primary one, I think about all of the – You are the safety net not just for individual patients who may be financially or medically underserved, but you are a medical and scientific safety net for all of health care in this region. And I think we saw that during COVID as well, and the fact that we are able to scale up where we can find the staff, the ability to care for critically ill patients and do it in a safe way, and that, you know, you keep training people across the country on how to do this effectively and safely, I think people saw that. Now, we've got to get back to some of the other problems, like inequities in care, and I still don't quite understand why we have such maternal and infant mortality rates in this country, but other stuff we can figure out and we just need to keep working on it.

Dr. Gold: You know, one of the biggest challenges we face here in Nebraska is the incredible challenges of rural health care. We are a 500-mile wide state, but we have counties that, and cities and small towns that have just a couple hundred people. As a matter fact, the president of our student government, who you'll meet, comes from a town of under 1,000 people. It's an amazing story how she got into college and then stayed here and now is about to graduate from our med school. We have a number of very significant educational training programs for the rural parts of our state. But do you have any thoughts on how that's going to evolve over the future, because the current models, as you say, what got us here, we're just never going to be able to deliver the breadth and depth of workforce, facilities, diagnostics, out in rural America.

Dr. Grover: Every nation just about has this problem. Australia, a country of 30 million people, very spread out. And what we've tried, which is essentially, we've tried to put a family doc on every corner in every neighborhood in every county, has not worked. We do not have the people to do that. And so I

think we need a serious conversation about what is the thing that we are trying to provide to people. And sometimes a doctor is going to be the best thing to actually achieve it, but in other cases – you know, we've got infrastructure money there now, we ought to think about how to prioritize health as we lay that last one, two, five miles of broadband fiber. I think particularly in the plains and in parts of this country, getting that last bit of that information superhighway to everybody is going to be critical. Now, even if you do that, you've got to figure out who's on the other end of that pipeline. I know University of Nebraska Medical Center is on this end. Who is on that end? And I think we need to really be willing to experiment with not only the mode of how we communicate with people in those areas, but who on the other end is going to be our eyes, ears and hands. So maybe it is not a family practitioner or general surgeon. Maybe it's not an NP or a PA. Maybe its an RN that spent 10 years in the ED here on the med surge floor, maybe it's a really fantastic EMT. And then we've got to think about regionalizing systems, similar to what we've done with stroke over the years. We're not perfect but we figure out – and trauma, right? We have regionalized trauma systems.

Dr. Gold: Yeah, we actually handle 90% of the farming and ranching trauma in the state right on this campus.

Dr. Grover: So. We know how to do this. The challenge we have in talking to EMTs in rural communities is that we have one ambulance. If I have to transport to you from three hours away, my ambulance is out of commission for the day. So how do I …. And I think this is the kind, rather than just saying 'Yeah, we'll just get a doctor in (inaudible), we should keep working on that stuff. Keep doing loan repayments, keep doing scholarships, keep figuring out how we put campuses out there, but let's also think about what we do with the people who are really important to health care in this country, who are a lot cheaper and faster to train than you and I.

Dr. Gold: And embrace the technology.

Dr. Grover: Absolutely. And I think, you know, where I really hope we get some more civic responsibility is from all the electronic health record vendors. Think about, there's two or three vendors out there that have 90% of our information. And we didn't have them at the table to the extent that we needed them for the last public health emergency that's about to end. I think they could be doing a lot more here, and even in places that are reluctant to share their own personal health information, we do have ways of doing this that are going to be safe and relatively protective of people's individual histories and problems. And I think they need to be at the table too. They need to come give something back for all the money we've invested into them, whether you as an individual medical center or the federal government through their IT and infrastructure.

Dr. Gold: Well, sounds like a great set of thoughts and I think it's going to be an exciting discussion.

Dr. Grover: I'm looking forward to it.

Dr. Gold: And thank you for tuning into this episode of 'Health Care Heart to Heart' with Dr. Jeff Gold. And until next time, stay healthy.