

Lewis E. Foxhall, M.D.

Interview #47

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Lewis E. Foxhall, M.D.

Interview Profile

Interview #47

Interview Information:

Five interview sessions: 5 February 2014; 13 February 2014; 11 March 2014; 9 April 2014; 13 May 2014

Total approximate duration, 4 hours.

Interviewer: Tacey A. Rosolowski, PhD

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About the Interview Subject:

Dr. Lewis Foxhall (b. November 17, 1950, Memphis, Texas) came to MD Anderson in 1993 to join the Department of Clinical Cancer Prevention in the Division of Cancer Prevention and Population Sciences. During his many years in private practice prior to this time, Dr. Foxhall had become known for developing networks with community physicians to improve communication and patient care. His work in this area continued to expand at MD Anderson, and in 1994 he was appointed Associate VP for Health Policy. Since 2005 Dr. Foxhall has served as Vice President for Health Policy.

Major Topics Covered:

Personal and educational background; a Texas upbringing and education

Interests in primary clinical care, health populations, cancer prevention, and tobacco

The Physician Relations Program

Health policy work at MD Anderson

Charity care programs

External networks and initiatives with health care providers

Texas state law, health care delivery, the Affordable Care Act, healthcare economics

Survivorship Programs

Value based care

**University of Texas MD Anderson Cancer Center
Making Cancer History Voices® Oral History Project**

Research Medical Library: Historical Resources Center

Original Interview Profile # 47: Lewis E. Foxhall, M.D.
Submitted by: Tacey A. Rosolowski, Ph.D.
Date: 5 13 2014

This interview with Dr. Lewis Foxhall (b. November 17, 1950, Memphis, Texas) takes place in over five sessions in spring of 2014 (approximate total duration, 4 hours).

Dr. Foxhall came to MD Anderson in 1993 to join the Department of Clinical Cancer Prevention in the Division of Cancer Prevention and Population Sciences. Since 2005 he has served as Vice President for Health Policy. This interview takes place in Dr. Foxhall's Office in the Office of Health Policy in Pickens Academic Tower on the Main Campus of MD Anderson. Tacey A. Rosolowski, Ph.D. is the interviewer.

Dr. Foxhall received his B.S. in 1973 from the University of Texas at Austin, Texas, and his M.D. in Family Medicine in 1976 from the Baylor College of Medicine in Houston, Texas. During his many years in private practice, Dr. Foxhall was increasingly active working with community physicians on a range of topics, collaborating at times with Dr. Joseph Painter, who recruited him to MD Anderson in 1993. In 1994 Dr. Foxhall was appointed Associate VP for Health Policy and in July 2005 he became VP for Health Policy.

In this interview, Dr. Foxhall traces the growth of his interest in primary clinical care, health populations, cancer prevention, and the risks of tobacco use. He traces his early work with Dr. Joseph Painter and describes his first task at MD Anderson: to set up the Physician Relations Program. Dr. Foxhall gives a portrait of the range of activities that health policy encompasses: education and information access; charity care programs, building external networks with health care providers; finding collaborative partners to fund and advance MD Anderson initiatives; working with stakeholders to work with challenges that Texas state law presents to health care delivery, building programs for survivorship care. He also discusses the Affordable Care Act and its impact on MD Anderson and patients in Texas. Throughout, Dr. Foxhall is able to provide insight into how MD Anderson addresses the needs of communities outside the institution's walls, as well as responding to pressures from external economic and political factors that shape the growth of programs and how patients' needs are addressed. He gives particular insight into the growing survivorship management initiatives, a relatively new and increasingly important arena of activity at MD Anderson and around the world.

Lewis E. Foxhall, M.D.

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Lewis E. Foxhall, M.D.

Interview #47

Segment Summaries

Interview Session One: 5 February 2014

Segment 00A

Interview Identifier

[00:00:00]

Segment 01

A: Educational Path;

Growing Up in a Small Town; Medical Education

00:01:20

Story Codes

A: Personal Background;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

A: Professional Path;

D: Cultural/Social Influences;

Dr. Foxhall gives a brief overview of his family life then notes his first interests in science. He touches on his experiences at the Baylor College of Medicine and explains that his interest in primary clinical care and in health populations began at this time, particularly when he spent time in his home town working with family physicians and saw a wide range of health problems. He also cites the influence of school integration –the seventies were a time when the nation was changing and there were opportunities to learn and grow.

Dr. Foxhall notes that his interest in cancer and cancer prevention grew during his residency and the first years of his private practice at Houston Northwest Medical Center where he was able to follow patients over many years and recognized the missed opportunities to intervene with patient and avert cancer risk.

Segment 02

A: Professional Path;

A Growing Interest in Cancer, Cancer Prevention, and First Connections with MD Anderson

00:13:50

Story Codes

A: The Clinician;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

A: Professional Path;

C: The Professional at Work;

D: Cultural/Social Influences;
D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;
A: Joining MD Anderson;

Dr. Foxhall notes that his interest in cancer (and tobacco) began during his private practice; he mentions other professionals in Houston who were also focusing on tobacco. He lists the projects he implemented during this time and notes his involvement in the Texas Academy of Family Physicians and its subgroups focused on prevention.

Dr. Foxhall then explains that he met and worked with Dr. Joseph Painter of MD Anderson was also interested in community outreach at the time. He describes the projects they worked on to educate physicians (part of a national movement). Dr. Foxhall also explains that it was key to demonstrate to physicians the value of collaborating with a large cancer center. He explains the previous mindset physicians held about their relationship to cancer centers.

Segment 03

A: Joining MD Anderson/Coming to Texas;
An Opportunity to Leave Private Practice for MD Anderson
00:23:01

Story Codes

A: Joining MD Anderson;
A: Professional Path;
C: Evolution of Career;

Dr. Foxhall first describes the ways in which he and Dr. Joseph Painter worked together in the late 80s. He then explains why he decided to leave private practice at that time: Dr. Foxhall first took a faculty position with UT Health Science in Family Medicine in 1991. In 1993 Dr. Foxhall was hired to help Dr. Painter with outreach and educating primary care physicians.

Segment 04

B: Building the Institution;
MD Anderson's Outreach Programs—the Physician Relations Programs
00:28:45

Story Codes

A: The Clinician;
A: The Educator;
B: Building/Transforming the Institution;
B: MD Anderson History;
B: MD Anderson Impact;
B: Institutional Mission and Values;
B: Beyond the Institution;
B: MD Anderson and Government;

Here, Dr. Foxhall describes what was involved in the Outreach Programs, which resulted in the Physicians Relations Programs. He notes the ill will created immediately after the Texas Legislature's 1995 decision to allow patients to self-refer. He talks about the scope of the

programs set up to preserve patients' connection to the primary care physician during and after cancer treatment; he also outlines the significance of the primary care physician's role in this process.

Segment 05

B: An Institutional Unit;
The Charity Care Program
00:40:07

Story Codes

B: MD Anderson History;
B: Institutional Mission and Values;
B: The Business of MD Anderson;
B: MD Anderson and Government;
D: Fiscal Realities in Healthcare;
B: Building/Transforming the Institution;
D: The History of Health Care, Patient Care;

Dr. Foxhall describes MD Anderson's work with indigent patients and the Charity Care Program.

He notes that MD Anderson was founded as a charity care institution and sketches the later history of this obligation. He explains the financial stresses this caused the institution. He explains that he worked with the Charity Care Program to reduce costs while paying for care, helping to stabilize the financial situation. He notes the partnership with the Lyndon Baines Johnson Community Hospital to serve charity cases.

Dr. Foxhall observes that patients at MD Anderson in general represent the cancer levels in the general population, though MD Anderson sees insured patients and the rates of the uninsured in Houston are very high (1/3 of population). He explains why the level of uninsured is so high.

Interview Session Two: 13 February 2014

Segment 00B

Interview Identifier
00:00:00

Segment 06

B: An Institutional Unit;
The Office of Health Policy: Focusing on Outreach
00:00:24

Story Codes

A: The Administrator;
B: MD Anderson History;
B: Beyond the Institution;
B: Information for Patients and the Public;

B: Education;

Dr. Foxhall lays out the history of the Office of Health Policy.

He explains that it originated in the need to reach out to community physicians and develop their relationships with MD Anderson. He explains how a team was created to conduct surveys and also to work with programs internal to MD Anderson. Dr. Foxhall explains the issues that community physicians had in sending their patients to MD Anderson, largely in the area of need for more communication with the institution after their patients went into treatment at the institution.

Segment 07

B: An Institutional Unit;

The Office of Health Policy: Focusing on Survivorship

Story Codes

A: The Administrator;

B: MD Anderson History;

B: Beyond the Institution;

C: Patients;

C: Patients, Treatment, Survivors;

B: Institutional Mission and Values;

C: Professional Practice;

C: The Professional at Work;

D: The History of Health Care, Patient Care;

B: Information for Patients and the Public;

B: Education;

Dr. Foxhall goes into detail about the Office's focus on survivorship, including connections with community physicians and mechanisms for survivorship information to community physicians so they can partner in a cancer patient's after care.

He explains the origins of the Survivorship Initiative and discusses his role on the Survivorship Committee and other programs designed to create an integrated approach to care.

He lists health policy challenges that have an impact on survivors. He describes results of studies that have confirmed the benefits of survivorship programs for patients.

Dr. Foxhall sketches the history of thinking about survivorship. He lists key people at MD Anderson involved in the survivorship program. He also lists some of the places he has been globally (through the GAP program--Global Academic Programs--MD Anderson's network of sister institutions) to speak about survivorship, stressing that the focus on survivorship is a world issue.

Segment 08

A: Character and Personal Philosophy;

Work that Takes Eternal Optimism

00:35:12

Story Codes

A: Character, Values, Beliefs, Talents;
B: Institutional Mission and Values;
B: MD Anderson History;
B: Beyond the Institution;
C: The Institution and Finances;

Dr. Foxhall responds to a question about those particular gifts that suit him and others to policy work. He explains that a focus on outreach beyond the institution is key, as well as a comfort with collaboration. He also talks about the commitment to the institution and to its mission to cure cancer and a commitment to a sense of equity in reaching out to all patients. It's a challenge financially to do that in an environment of limited funding and requires a high level of patience, persistence, and optimism to move issues forward.

Segment 09

B: An Institutional Unit;
Associate Vice President of the Office of Health Policy
00:38:19

Story Codes

A: Character, Values, Beliefs, Talents;
B: Institutional Mission and Values;
B: MD Anderson History;
B: Information for Patients and the Public;
B: Beyond the Institution;
C: The Institution and Finances;

Dr. Foxhall talks about his role as Associate VP for Health Policy.

He defines the scope of "health policy" and gives examples of policy issues addressed in collaboration with other health organizations. He stresses MD Anderson's role as a resource and support for public officials who lobby for health policy in the legislature.

Dr. Foxhall next explains the relationship between the Office of Referral Relations the Office of Health Policy.

Dr. Foxhall next talks about the big projects he undertook as Associate Vice President: creating the network of physician referrals; a program to educate physicians about cancer screening; creating an internet based educational outreach program.

Segment 10

B: An Institutional Unit;
The Texas Cancer Data Center
00:55:55

Story Codes

A: Overview;
B: MD Anderson History;

B: MD Anderson Impact;
B: Education;
B: Information for Patients and the Public;
B: Institutional Mission and Values;
B: Beyond the Institution;

Dr. Foxhall recounts the history of the Texas Cancer Data Center.

He explains the funding and mission to collect information from the state cancer registry and convert it to a searchable system that includes statistics on patients and other information. He explains how the system evolved, shifts in its management, and the programs it includes. He notes that a related education program has reached about 500 nurses and 1000 social workers with information about programs for patients. He notes that this was one of the first data centers of this type in the country.

Dr. Foxhall notes partnerships with the American Cancer Society and with other public health agencies to educate patients about cancer risk. He also notes the work with the Harris County Healthcare Alliance to support prevention programs in community clinics and improve access to healthcare for low income patients. (Additional information on the Texas Cancer Data Center is presented in Segment 09.)

Interview Session Three: 11 March 2014

Segment 00C
Interview Identifier
00:00:00

Segment 11
B: An Institutional Unit;
Grant-Funded Projects in the Office of Health Policy: The Texas Cancer Data Center
00:00:26

Story Codes
A: Overview;
B: MD Anderson History;
B: MD Anderson Impact;
B: MD Anderson and the Texas Legislature;
B: Education;
B: Information for Patients and the Public;
B: Institutional Mission and Values;
B: Beyond the Institution;
A: Character, Values, Beliefs, Talents;
A: Professional Values, Ethics, Purpose;

Here Dr. Foxhall talks about a number of key projects run by the Office of Health Policy. He first follows up on a discussion of the Texas Cancer Data Center (discussed in Segment 10), explaining difficulties in collecting information in the early days of the project and then sketching how services have evolved and been updated since the late eighties. He lists the kinds of information that the Center provides, its heavy use (around one million hits per year) and its

impact. Dr. Foxhall notes that it is used as a platform for educational programs supported via CPRIT money. He also describes how the Center provides information for individuals with no insurance and education for nurses and social worker to help people get access to care. This need has been intensified since Texas made the decision not to participate in the Medicaid portion of the Affordable Care Act.

Segment 12

B: An Institutional Unit;

Grant-Funded Projects in the Office of Health Policy: Services for the Uninsured

00:08:09

Story Codes

A: Overview;

B: MD Anderson History;

B: MD Anderson Impact;

B: MD Anderson and the Texas Legislature;

B: Education;

B: Information for Patients and the Public;

B: Institutional Mission and Values;

B: Beyond the Institution;

Here, Dr. Foxhall describes initiatives supported by the institution and by federal money that are designed to reduce cancer risk among low-income individuals. He first talks about the tobacco program, mentioning the ASPIRE program designed to reach maximize tobacco avoidance/cessation in adolescents. Dr. Foxhall explained how the Office of Health Policy helped support this project. Next he talks about the project, Ask, Advise, Connect, a quit line service that services HIV patients. Dr. Foxhall notes that this is a good example of how the Office of Health Policy identifies a government program that can provide funding for initiatives relevant to the needs of at-risk individuals. He describes the individuals involved in organizing the funding mechanisms and notes where difficulties arise in the process. Dr. Foxhall explains that this is a slow and often frustrating process, but the benefits come when “you see that you help someone” and can track progress with use rates.

Segment 13

B: An Institutional Unit;

Grant-Funded Projects in the Office of Health Policy: Screening for Colorectal Cancer and Breast Cancer

00:17:53

Story Codes

A: Overview;

B: MD Anderson History;

B: MD Anderson Impact;

B: MD Anderson and the Texas Legislature;

B: Education;

B: Information for Patients and the Public;

B: Institutional Mission and Values;

B: Beyond the Institution;

In this segment, Dr. Foxhall talks about projects that support screening for colorectal cancer and for breast cancer (via a mobile unit). The Office of Health Policy “provides the infrastructure,” identifying an opportunity and partners who can help accomplish goals that fit with MD Anderson’s mission. He provides additional information about both of these screening programs.

Segment 14

B: An Institutional Unit;

Grant-Funded Projects in the Office of Health Policy: Cancer Survivor Management

00:25:42

Story Codes

A: Overview;

B: MD Anderson History;

B: MD Anderson Impact;

B: MD Anderson and the Texas Legislature;

B: Education;

B: Information for Patients and the Public;

B: Institutional Mission and Values;

B: Beyond the Institution;

A: Character, Values, Beliefs, Talents;

A: Professional Values, Ethics, Purpose;

In this segment, Dr. Foxhall talks about a grant that the Office is now preparing for Cancer Survivor Management –a training program that will be instituted in clinical around the state. Dr. Foxhall explains that his “love in life is education,” and that such projects are very significant for him. He explains the elements of the training program: identify survivors; create care plans to maximize the effectiveness of aftercare following MD Anderson guidelines; follow up with providers to help them adhere to best practices; monitor patients receiving services. He discusses a tele-mentoring system that will be used to provide support for health care personnel. He talks about collaborating on the *Cancer Survivorship Manual* that will be published this summer.

Segment 15

B: An Institutional Unit

Educational Projects with Physicians and Medical Students

00:31:38

Story Codes

A: The Administrator

B: MD Anderson Impact

B: Information for Patients and the Public

B: Education

B: Institutional Mission and Values

B: Beyond the Institution

A: Overview

Dr. Foxhall talks about the importance of educational outreach to the mission of the institution.

He lists the impact that educational initiatives have in the community.

Next he describes the Preceptorship Program initiated in the eighties at the UT Medical School in Houston. The challenge, he explains, was (and is) that “we need more primary care physicians” and medical students need to know that family medicine can be a viable career path. Dr. Foxhall explains that the Preceptorship enables medical students to spend a month with a family physician. He talks about the importance of targeting students early. He notes that in a national ranking of states and the availability of primary care physicians, Texas ranks #42. The grant supporting the Preceptorship was renewed several times and the program has been successful at convincing medical students to enter family medicine. Recently funding was cut and then transferred to the Texas Council of Family Physicians.

Segment 16

B: An Institutional Unit;

Projects in Cancer Prevention; the Lung Cancer Moonshot; CYCORE

00:42:38

Story Codes

A: The Administrator;

B: MD Anderson Impact;

B: Information for Patients and the Public;

B: Education;

B: Institutional Mission and Values;

B: Beyond the Institution;

A: Overview;

D: Technology and R&D;

In this segment, Dr. Foxhall talks a cancer prevention programs and the place of the lung cancer screening trial in the Lung Cancer Moon Shot. He then talks about CYCORE, a program that uses electronic devices to address patient needs and treatments. This project was funded by stimulus money and uses a tele-monitoring device created by Time Warner. He describes some of the benefits and also mentions the video conferencing systems that can support patients. Dr. Foxhall notes that the Office tries to keep up with the latest electronic advances that can help patients.

Interview Session Four: 9 April 2014

Segment 00D

Interview Identifier

00:00:00

Segment 17

B: Institutional Change;

A Major Challenge: Serving the Uninsured as Health Care Changes

00:00:32

Story Codes

A: Overview;
A: Definitions, Explanations, Translations;
B: Growth and/or Change;
B: Controversy;
B: Institutional Mission and Values;
B: Beyond the Institution;
B: MD Anderson in the Future;

In this segment, Dr. Foxhall talks about the challenge of expanding access to care, his role as a governor-appointed member of the Texas State Health Services Advisory Council (2009 – present), and the challenge of transitioning from a fee for service system to a value-based care system.

He notes that Texas ranks number one in numbers of uninsured individuals, but there are early signals that the Affordable Care Act is reducing those numbers, though the issue is complicated by the decision Texas made not to participate in the Act.

Dr. Foxhall describes services provided by the Texas State Health Services Advisory Council and gives examples.

He defines value-based care, founded on careful documentation of care provided and outcomes. He explains the related concept of “the triple aim”: to improve quality of care, to reduce cost, to increase levels of patient satisfaction, noting that some policy makers include a fourth aim, insuring equal access to care. He explains why the status quo cannot continue.

Segment 18

B: Institutional Change;
Impact of Institutional Growth on the Office of Health Policy
00:20:47

Story Codes

B: Growth and/or Change;
B: Institutional Mission and Values;
B: Beyond the Institution;
A: The Administrator;
B: MD Anderson Culture;

In this segment, Dr. Foxhall comments on how the MD Anderson’s growth since the nineties has had an impact on the activities of the Office of Health Policy.

He notes the huge expansion of external connections with network affiliates and also with international connections, with MD Anderson adopting the CDC’s Comprehensive Cancer Control Program to organize information provided to the external connections. He sketches the history of that program. He notes that the Lung Cancer Moon Shot is part of the Prevention and Control Platform.

Next, Dr. Foxhall talks about how the institution’s financial structure has changed: healthcare delivery has changed and it is increasingly difficult to secure funding for research and also raise income from patient care. He notes that the institution’s ability to provide personalized and

compassionate care for patients has not changed, because it is imbedded in the culture and tradition of MD Anderson.

He ends this segment with comments on how MD Anderson is seen by the community.

Segment 19

A: View on Career and Accomplishments;
The MD Anderson Presidents; No Plans for Retirement
00:36:59

Story Codes

C: Portraits;
A: Personal Background;

Dr. Foxhall begins this segment with comments on MD Anderson presidents, Dr. Charles LeMaistre, Dr. John Mendelsohn, and Dr. Ronald DePinho. He then notes that he has no immediate plans for retirement (he is “having too much fun”), and explains that intends to further the tobacco agenda and to develop survivorship management, positioning the institution to work within more effective shared care models for survivorship.

Dr. Foxhall comments on the legacy he will leave: a network of collaborative connections designed for cancer control and management. He comments briefly on his love of travel, the enjoyable time he spends with his children, and his hobby, landscape photography.

Interview Session Five: 13 May 2014

Segment 00E

Interview Identifier
00:00:00

Segment 20

B: The Finances and Business of MD Anderson;
Texas and the Affordable Care Act
00:00:21

Story Codes

B: MD Anderson and Government;
D: The Healthcare Industry;
D: Politics and Cancer/Science/Care;
C: The Institution and Finances;
B: Growth and/or Change;
B: MD Anderson History;
D: On Texas and Texans;

In this segment, Dr. Foxhall discusses the Affordable Care Act (ACA) passed on 23 March 2010 and its impact on Texas Health and the activities of MD Anderson. He begins by noting that Texas has the highest rate of uninsured individuals in the nation and that only a limited number of categories of individuals are eligible for Medicaid, with the result that a percentage of

individuals who are diagnosed with cancer are uninsured. He explains the hopes that the ACA would provide coverage to the uninsured, to cancer survivors unable to get affordable insurance, and to low income individuals in need of cancer prevention services. He then goes into more detail about the Texas limitations on Medicaid as well as some alternatives under discussion in the Texas Legislature to provide coverage to ineligible individuals.

Segment 21

B: The Finances and Business of MD Anderson;

MD Anderson's Response to the Affordable Care Act; ACA Requirements; Value-Based Purchasing

00:08:02

Story Codes

B: MD Anderson and Government;

D: The Healthcare Industry;

D: Politics and Cancer/Science/Care;

C: The Institution and Finances;

B: Growth and/or Change;

B: MD Anderson History;

D: On Texas and Texans;

In this segment, Dr. Foxhall continues discussion of the Affordable Care Act.

He sketches MD Anderson's programs to help with financial assistance.

He then talks about the requirement that institutions report on the quality of care. He gives examples to explain what is involved in this process, noting that historically, medical practices have not had enough transparency in care and outcomes. Reporting enables consumers to have a better idea of how well providers are doing. In addition, this information will be used as a basis for determining payment. Next Dr. Foxhall explains that the ACA requires that institutions participate in an Accountable Care Organization. He explains the reasoning for this, and notes that it is not clear how a specialized hospital will engage with them.

Next Dr. Foxhall talks about the ACA's requirement for Value-Based Purchasing, giving examples of how examining processes has revealed unnecessary costs in deliver of care.

Segment 22

B: The Finances and Business of MD Anderson;

The Future Under the Affordable Care Act: the Value of Prevention Services

00:21:45

Story Codes

B: MD Anderson and Government;

D: The Healthcare Industry;

D: Politics and Cancer/Science/Care;

C: The Institution and Finances;

B: Growth and/or Change;

B: MD Anderson History;

D: On Texas and Texans;

In this segment, Dr. Foxhall sketches what the future looks like under the Affordable Care Act, noting that a change in leadership in Texas might change any predictive scenario and the state will continue to have poor and undocumented individuals to cover.

Dr. Foxhall explains that the focus on preventive services is a very positive feature of the ACA. He explains the requirements and notes the benefits that can come from screening services and tobacco cessation programs. He cites statistics for the increase in cancer risk that comes with smoking and obesity. He explains why institutions tend not to invest in prevention, noting that the ACA is unusual in adding this to its requirements.

In conclusion, Dr. Foxhall notes that the ACA is “still a political football” and that politics has an impact on each decision connected with it.

Lewis E. Foxhall, MD

Interview #47

Session 1 — February 5, 2014

About transcription and the transcript

This interview had been transcribed according to oral history best practices to preserve the conversational quality of spoken language (rather than editing it to written standards).

The interview subject has been given the opportunity to review the transcript and make changes: any substantial departures from the audio file are indicated with brackets [].

In addition, the Archives may have redacted portions of the transcript and audio file in compliance with HIPAA and/or interview subject requests.

The views expressed in this interview are solely the perspective of the interview subject. They are not to be interpreted as the official view of any other individual or of The University of Texas MD Anderson Cancer Center.

Chapter 00A

Interview Identifier

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. We are recording, the counter is moving, and I'm Tacey Ann Rosolowski interviewing Dr. Lewis Foxhall. Am I pronouncing your name correctly?

[00:00:12]

Lewis Foxhall, MD

[00:00:12]

Yes, ma'am.

Interview Session: 01
Interview Date: February 5, 2014

[00:00:12]

Tacey Ann Rosolowski, PhD

[00:00:12]

Great. For the Making Cancer History Voices Oral History Project run by the Historical Resources Center at MD Anderson Cancer Center in Houston, Texas. Dr. Foxhall came to MD Anderson in 1993. At that time, he was working in an administrative capacity for Dr. Joseph Painter—and I'm sure we'll be talking about that—and he was also a faculty member in Internal Medicine on his first arrival. Since 2005, Dr. Foxhall has served as Vice President for Health Policy. This interview is taking place—

[00:00:46]

Lewis Foxhall, MD

[00:00:49]

Someone's talking. It sounds like it's on playback.

[00:00:52]

Tacey Ann Rosolowski, PhD

[00:00:53]

It is. That's very weird. How odd. All right. Well.

[00:00:59]

Lewis Foxhall, MD

[00:01:00]

You just recorded over somebody else. No. (laughter)

[00:01:02]

Tacey Ann Rosolowski, PhD

[00:01:03]

Actually, I just want to—

[00:01:04] (end of audio file)

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. So let me just resume. The interview is taking place in Dr. Foxhall's office in Pickens Tower on the main campus of MD Anderson. Today is the first of a number of planned interview sessions. It is February 5th, 2014, and the time is 11:35.

Interview Session: 01
Interview Date: February 5, 2014

Chapter 1

A: Educational Path Growing Up in a Small Town and Medical Education

Story Codes

A: Personal Background
A: Inspirations to Practice Science/Medicine
A: Influences from People and Life Experiences
A: Professional Path
D: Cultural/Social Influences

Tacey Ann Rosolowski, PhD

[00:00:00]+

So, thanks very much for participating in this project. I wanted to just start with some general background questions. I wanted to ask you where you were born and when, and if you could tell me a little bit about where you grew up.

[00:00:40]

Lewis Foxhall, MD

[00:00:40]

So I'm a native Texan, born in a small town in the northern part of the state near Amarillo, Texas, and grew up there and then went to school at the University of Texas in Austin and graduated with a degree in biomedical engineering.

[00:01:03]

Tacey Ann Rosolowski, PhD

[00:01:04]

What's the small town near Amarillo?

[00:01:06]

Lewis Foxhall, MD

[00:01:06]

Memphis, Texas.

[00:01:07]

Tacey Ann Rosolowski, PhD

[00:01:08]

Memphis, Texas, okay.

[00:01:09]

Lewis Foxhall, MD

[00:01:09]

We have a little bit of everything in Texas.

Commented [T1]: Dr. Foxhall begins this section with a brief overview of his family life. (His father, Lewis, was in the cotton business; his mother, Lois, was a journalist and one of the first women war correspondents.) He notes that his interest in science began early and first expressed itself in an interest in engineering. Dr. Foxhall then briefly touches on his experiences at the Baylor College of Medicine (M.D. 1976, Family Medicine), which was experimenting with an intensive three-year curriculum. Dr. Foxhall explains that his interest in primary clinical care and in health populations began at this time, particularly when he spent time in his home town working with family physicians and saw a wide range of health problems. He also cites the influence of school integration—the seventies were a time when the nation was changing and there were opportunities to learn and grow.

Dr. Foxhall notes that his interest in cancer and cancer prevention grew during his residency and the first years of his private practice at Houston Northwest Medical Center where he was able to follow patients over many years and recognized the missed opportunities to intervene with patient and avert cancer risk.

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[00:01:11]

Tacey Ann Rosolowski, PhD

[00:01:11]

All right. And do you mind sharing your birth date?

[00:01:15]

Lewis Foxhall, MD

[00:01:16]

1950.

[00:01:17]

Tacey Ann Rosolowski, PhD

[00:01:19]

And the actual date?

[00:01:19]

Lewis Foxhall, MD

[00:01:20]

November 17th.

[00:01:21]

Tacey Ann Rosolowski, PhD

[00:01:21]

November 17, 1950. All right. What about your family? What did your parents do? What do your parents do?

[00:01:29]

Lewis Foxhall, MD

[00:01:30]

My father worked in the cotton business and also as a rancher, and he had been also educated at the University of Texas and actually received a law degree, but decided that was not really his calling, and pursued this work after serving in the air force in World War II. Came back to Memphis, where he'd grown up, and decided to raise a family, married my mother, who was from another small town nearby. She was also educated at the University of Texas and had pursued a career in journalism and was one of the first women war correspondents during World War II that traveled to Europe and report on the war. So she continued to write after she came back, and was in the midst of raising a family with three kids.

[00:02:47]

Tacey Ann Rosolowski, PhD

[00:02:48]

And your parents' names?

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[00:02:49]

Lewis Foxhall, MD

[00:02:49]

Lois and Lewis. (laughter)

[00:02:51]

Tacey Ann Rosolowski, PhD

[00:02:53]

That's neat.

[00:02:54]

Lewis Foxhall, MD

[00:02:54]

Good combo.

[00:02:54]

Tacey Ann Rosolowski, PhD

[00:02:55]

There you go. And are you the oldest child, named after your father?

[00:02:58]

Lewis Foxhall, MD

[00:02:58]

Yes. I have two younger sisters, so there were three of us kids growing up.

[00:03:04]

Tacey Ann Rosolowski, PhD

[00:03:05]

When did you realize that you were going to be in the sciences, become a physician? How did that happen?

[00:03:12]

Lewis Foxhall, MD

[00:03:13]

Well, I was interested in science from an early time, and initially was interested in engineering and became more interested in medical sciences in college and pursued a biomedical engineering degree there at the university. During that time, I became acquainted with some physicians who were on the faculty and encouraged me to consider a medical career. The more I thought about it, the more that it sounded pretty good. So I decided to apply and wound up in Baylor College of Medicine here in Houston.

[00:03:56]

Tacey Ann Rosolowski, PhD

[00:03:57]

So just for the record, you received your bachelor's of—is it engineering science?

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[00:04:02]

Lewis Foxhall, MD

[00:04:03]

Mm-hmm, correct.

[00:04:03]

Tacey Ann Rosolowski, PhD

[00:04:03]

From UT Austin in 1973. Is that correct?

[00:04:07]

Lewis Foxhall, MD

[00:04:08]

Sounds good.

[00:04:09]

Tacey Ann Rosolowski, PhD

[00:04:09]

Okay. (laughter) And then with Baylor, I have that you got your MD in 1976. So tell me about your experience in medical school. How did that make you grow, and did you start thinking about underserved populations and other areas that you're working in more administratively at that time?

[00:04:31]

Lewis Foxhall, MD

[00:04:32]

Well, the program at Baylor was interesting. That was a period of time when they were trying a three-year curriculum for medical school. So it was sort of constant medical school for three years. We had no breaks, no summers off, and that was an interesting endeavor. But it worked out, and we all got through. Only a few people fell off the deep end, I think, during that time, but it was an interesting educational experience.

[00:05:08]

Tacey Ann Rosolowski, PhD

[00:05:08]

So it was very—

[00:05:09]

Lewis Foxhall, MD

[00:05:09]

Intense, yes.

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[00:05:10]

Tacey Ann Rosolowski, PhD

[00:05:10]

Yeah, very compressed.

[00:05:11]

Lewis Foxhall, MD

[00:05:12]

Instead of the usual four-year thing with the normal academic time off and these sorts of things.

[00:05:17]

Tacey Ann Rosolowski, PhD

[00:05:17]

And what was the reason for compressing the schedule, trying to get it into three years?

[00:05:21]

Lewis Foxhall, MD

[00:05:21]

I'm sure someone had a great idea how that would benefit society, but I don't recall it.

[00:05:26]

Tacey Ann Rosolowski, PhD

[00:05:27]

(laughs) I'm mean, looking back—

[00:05:27]

Lewis Foxhall, MD

[00:05:27]

I'm sure it was an attempt to increase the output of physicians and perhaps reduce cost to the state, those sorts of things. But [unclear].

[00:05:40]

Tacey Ann Rosolowski, PhD

[00:05:40]

What are your thoughts about it now?

[00:05:41]

Lewis Foxhall, MD

[00:05:41]

So it was fine. It worked fine. It was very intense and wasn't a good time to really concentrate and focus on the educational activities that [unclear], so it was a good [unclear].

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But during that time, I became more interested in clinical work and decided that I was interested in primary care, and some of that revolving around my interest in serving, you know, working in population health, working in low-access communities developed during that time. So I spent some time going back to my hometown and working with my local family physician, and really felt that was a sort of patient population that I really wanted to work with over time, so I felt a more direct connection with the patients. And the broader aspects of primary care, especially preventive care, were very interesting to me. So that's what led me down that path.

[00:07:05]

Tacey Ann Rosolowski, PhD

[00:07:05]

I was going to ask you if growing up in a fairly rural area, small town, had affected you in any way. I mean, what did you see at that time that then led you back to serve that kind of community after your medical experience?

[00:07:20]

Lewis Foxhall, MD

[00:07:20]

Well, I mean, it's a small town, so you get to know the whole spectrum of people. It's the sort of situation where if you're in a larger community, you might only interact with a subset of the population, so you really get to know them.

There was a time when schools were integrated, and that was also another factor, I think, that really kind of helped raise my awareness of the rest of the world out there and that we were really very fortunate in our living situation. My parents worked—my dad worked in farming and ranching, but we lived in a very comfortable situation, and it was, I think, a good opportunity to broaden my own personal horizons. I'm not sure I realized it as much at the time as I do now thinking back on it, that that was a formative sort of period of time and inspirational time in my life. So [unclear].

[00:08:37]

Tacey Ann Rosolowski, PhD

[00:08:38]

Did you say "inspirational"?

[00:08:41]

Lewis Foxhall, MD

[00:08:42]

I can't remember what I said now, but I'm sure it was. (laughter)

[00:08:46]

Tacey Ann Rosolowski, PhD

[00:08:46]

Yeah, I was curious because that's [unclear].

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[00:08:48]

Lewis Foxhall, MD

[00:08:48]

You know, I think it was a time when a lot of things were changing in the country, and even in our little tiny town these things were playing out and were certainly opportunities to try to learn and grow. And my parents were very supportive and open and encouraged us to participate and reach out and try to better understand everyone's situation in the community. So I think that was a good growth experience at that time.

[00:09:26]

Tacey Ann Rosolowski, PhD

[00:09:26]

Yeah, I've interviewed a number of people who recall that time as being a real, real formative period for them. I mean, you kind of couldn't avoid it. (laughs)

[00:09:37]

Lewis Foxhall, MD

[00:09:37]

That's right.

[00:09:39]

Tacey Ann Rosolowski, PhD

[00:09:39]

The sixties were a real watershed for the country.

[00:09:41]

Lewis Foxhall, MD

[00:09:41]

Yeah, it really was.

[00:09:42]

Tacey Ann Rosolowski, PhD

[00:09:42]

Yes. So tell me about either during medical school, when you began to focus on some of these interests, or afterwards, going back to your hometown, what were the types of activities you took part in that helped you develop more knowledge and skills in this area?

[00:10:01]

Lewis Foxhall, MD

[00:10:02]

Well, I think, you know, a lot of the things that happened in my career that led me to my interest in focusing on cancer prevention and on the application of that to low-income populations were during my residency training program and then during my years in private practice. So I participated in a community-based residency program in Corpus Christi, Texas, so we were working out of the county hospital and were basically the primary physicians serving a large

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patient population, most of whom were low-income and uninsured. It became very evident at that point that access to care and the lack of preventive interventions, which were being well documented by that time, were a serious detriment to that population.

So that, I think, was sort of the earliest time. But after residency, I decided to go into private practice and came back here to Houston, and went into practice with one other physician in the northern part of the county and worked at a local community hospital and was able to build up a really great patient population. It was an early time when that part of the county was growing rapidly, lots of new people moving into the community, and opportunity to grow the practice quickly. But then following those patients over time, which is one of the real joys of primary care, working with people over time, it became obvious that there were many missed opportunities, and it was despite our best efforts in our practice, it was unavoidable that we would see patients who presented with cancer often, cancers that could have been detected early and could have had a much better outcome [unclear] people who developed problems related to tobacco use, in particular, that were, sadly, related with bad outcomes.

[00:12:36]

Tacey Ann Rosolowski, PhD

[00:12:36]

Can I ask you—I'm sorry, I don't mean to interrupt you, but I wanted to make sure that I have the name of the hospital where you worked when you were [unclear].

[00:12:43]

Lewis Foxhall, MD

[00:12:43]

Houston Northwest Medical Center.

[00:12:45]

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Chapter 2

A: Professional Path

A Growing Interest in Cancer, Cancer Prevention, and First Connections with MD Anderson

Story Codes

A: The Clinician
A: Inspirations to Practice Science/Medicine
A: Influences from People and Life Experiences
A: Professional Path
C: The Professional at Work
D: Cultural/Social Influences
D: Understanding Cancer, the History of Science, Cancer Research
D: The History of Health Care, Patient Care
A: Joining MD Anderson

Tacey Ann Rosolowski, PhD

[00:12:49]

And you had mentioned specifically cancer. When did your interest in cancer and in tobacco begin?

[00:12:57]

Lewis Foxhall, MD

[00:12:58]

Well, it was during those early years in my clinical practice when I began to be very frustrated with problems that were obviously avoidable problems that were developing in my patients or that had been a result, in particular, of tobacco. There were some other primary care physicians here in Houston, actually, that were very interested in these areas as well. Dr. Allen Blom [phonetic], who was here for several years and worked at Baylor, was one who was really outspoken in his interest in addressing the tobacco problem. So that just kind of spurred me on and I became more interested in how I could help my own patients in the practice to address their use of tobacco [unclear]. At that time, there were not a lot of great opportunities to do that, so it was a frustrating sort of challenge that we faced every day.

[00:14:16]

Tacey Ann Rosolowski, PhD

[00:14:16]

Did people in Houston smoke more than in other areas of the country? What were the cancer rates here?

[00:14:22]

Lewis Foxhall, MD

[00:14:23]

No, everybody smoked more back then, so, you know, this was the time where smoking rates had begun to decline, you know. That really began in the late sixties, but still there were large proportion of the population was smoking, so that included our patients. So it was, I don't think,

Commented [T2]:

In this segment, Dr. Foxhall notes that his interest in cancer (and tobacco) began during the early years of his private practice; he mentions other professionals in Houston who were also focusing on tobacco. He lists the projects he implemented during this time: identifying and advising smokers; creating counseling services; exploring pharmacological support. He also notes his involvement in the Texas Academy of Family Physicians and its subgroups focused on prevention.

Dr. Foxhall then explains that he met and worked with Dr. Joseph Painter of MD Anderson was also interested in community outreach at the time. He describes the projects the worked on to educate physicians (part of a national movement). Dr. Foxhall also explains that it was key to demonstrate to physicians the value of collaborating with a large cancer center. He explains the previous mindset physicians held about their relationship to cancer centers.

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a unique problem to Houston, but one that I found frustrating, and when you see people suffering from disease that was totally avoidable, it's difficult to manage.

[00:15:02]

Tacey Ann Rosolowski, PhD

[00:15:03]

Yeah. So tell me about some of the first steps that you took to address that in your own practice, or what were some projects you worked on?

[00:15:12]

Lewis Foxhall, MD

[00:15:13]

Well, we implemented the processes that were promoted at the time, which were not that different from what we have now. We just didn't have all the drugs and the nicotine replacement and those sorts of things. So identifying smokers was by asking our patients if they were tobacco users, and then advising them to stop using tobacco and providing counseling services. At that time, there were not telephone quit lines, but we could provide counseling through other sources and encouraging patients to stop smoking as frequently as we could. So in time, additional resources, pharmaceutical support and online counseling and these sorts of things became available so that that was nice, helped a little bit.

But anyway, so I started working on that, and during that time I'd been involved in organized medicine through the Texas Academy of Family Physicians, and we had work groups with that organization that were focused on prevention, focused on tobacco control, education in our members' offices. And Dr. Painter at that time was interested in outreach to community physicians to help them engage in preventive activities, so we eventually met up and had a shared interest in those ideas and the resources of the Cancer Center, primarily in the educational realm, and began to work together on some projects that were related to that. So that was really what kind of led to our collaborations and eventually teasing me out of my private practice and coming over here.

[00:17:20]

Tacey Ann Rosolowski, PhD

[00:17:20]

Do you want to talk about that next? Because I'd also like to hear about some of these joint projects you worked on before actually becoming part of MD Anderson, which—you tell me what you'd like to talk about next.

[00:17:31]

Lewis Foxhall, MD

[00:17:31]

Well, they were primarily educational endeavors that we did with the Texas Academy, so lectures and conferences and things of that sort.

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[00:17:41]

Tacey Ann Rosolowski, PhD

[00:17:42]

And this was teaching physicians how to address tobacco-related issues?

[00:17:46]

Lewis Foxhall, MD

[00:17:47]

Mm-hmm, right. So the Academy provides educational programs to the members, so as part of that, we began to address those preventive opportunities with our member physicians.

[00:17:58]

Tacey Ann Rosolowski, PhD

[00:17:59]

What impact do you feel you had?

[00:18:00]

Lewis Foxhall, MD

[00:18:02]

So, well, I often think of the nice chart that shows the cancer mortality rates in the country gradually going up and up and up until the early nineties, at which time I came to MD Anderson, and then they've come down ever since. So I'm not saying I was the only cause for that, but it's an interesting correlation, you must admit. (Rosolowski laughs.)

Whatever little bit I've been able to contribute, I think is part of a big national movement to try to address some of these things, but the recognition that primary care physicians have a big role in cancer prevention and cancer screening, early detection, in that it is okay to collaborate with a large Cancer Center. To promote those concepts, I think, was one of the major things, hopefully, or messages I was able to get across.

And a lot of that I attribute to Dr. Painter's initial ideas in trying to carry forward his promotion of those concepts. But this connection between the Cancer Center and the oncology world and that of primary care, I think is one that still has opportunities to grow, but at that time was not at all well recognized that those two things kind of went together, and it was, I think, a good opportunity to kind of bring those worlds together and join forces toward a common goal.

[00:19:53]

Tacey Ann Rosolowski, PhD

[00:19:54]

What—well, I have two questions. Let me ask the first one first. Tell me about the shift in perspective. I mean, you said an important thing was to recognize the role of primary care physicians in prevention. Well, what was it like before? I mean, how did primary care physicians address the issue of prevention or intervention in something like smoking?

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[00:20:24]

Lewis Foxhall, MD

[00:20:24]

Well, some of that was going on, but the idea of connecting with the Cancer Center and working collaboratively towards those goals, so there's clearly the idea that, you know, we should address smoking, the idea that these cancer screenings were available was out there. It just wasn't at all emphasized or prioritized, for the most part.

[00:20:52]

Tacey Ann Rosolowski, PhD

[00:20:53]

What was the attitude of primary care physicians vis-à-vis big cancer centers at first? I mean, was there suspicion? Were there obstacles for establishing collaboration?

[00:21:03]

Lewis Foxhall, MD

[00:21:04]

Well, I can't speak for every primary care physician, but there was the idea that the cancer center was kind of where you went when you had cancer, and, you know, oftentimes those patients were absorbed in the cancer center sphere of influence and may or may not ever pop back up into your practice again. So this idea that maybe we should be working on this problem proactively and working on it before we had a problem was sort of a different sort of approach, that the cancer center was interested in reaching out to the community physicians to help address the

problem at that level. Rather than just waiting for something bad to happen, you did what you could.

[00:21:56]

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Chapter 3

A: Joining MD Anderson/Coming to Texas An Opportunity to Leave Private Practice for MD Anderson

Story Codes

A: Joining MD Anderson
A: Professional Path
C: Evolution of Career

Tacey Ann Rosolowski, PhD

[00:21:56]

Right. So are we at the point where you can tell me the story about Dr. Painter speaking to you about coming on to MD Anderson? How did that happen?

[00:22:05]

Lewis Foxhall, MD

[00:22:07]

Well, you know, like I say, we'd gotten to know each other through some of these educational programs that he'd put together, and we clearly had a common interest in working on the issues of addressing cancer prevention in a primary care setting. He at that time was engaged in a lot of activities in organized medicine and was president of the AMA at that point in time, so he was very busy with a lot of those things, so I think he began looking for some help, you know, some like-minded persons to bring on board to try to help continue to promote his ideas in that area.

So—

[00:23:05]

Tacey Ann Rosolowski, PhD

[00:23:06]

Can I interrupt you just for—

[00:23:07]

Lewis Foxhall, MD

[00:23:07]

Sure.

[00:23:07]

Tacey Ann Rosolowski, PhD

[00:23:08]

Can I close the door? Because I think we may have some pickup from the conversation out in the hall.

Now, when you say “organized medicine,” I’ve never heard that before. Do you mean medical organizations? What does that term refer to?

Commented [T3]: Dr. Foxhall describes the ways in which he and Dr. Joseph Painter worked together in the late 80s. He then explains why he decided to leave private practice at that time: Dr. Foxhall first took a faculty position with UT Health Science in Family Medicine in 1991. In 1993 Dr. Foxhall was hired to help Dr. Painter with outreach and educating primary care physicians.

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[00:23:23]

Lewis Foxhall, MD

[00:23:24]

It refers to the medical organizations like the American Medical Association, the Texas Medical Association, and then the specialty-based organizations like the Academy, so those kind—

[00:23:43]

Tacey Ann Rosolowski, PhD

[00:23:44]

Okay. I'd never heard the term before. (laughs)

[00:23:45]

Lewis Foxhall, MD

[00:23:45]

Sorry. As opposed to [unclear]. (Rosolowski laughs.) It's an odd term, but anyway, that's the—

[00:23:50]

Tacey Ann Rosolowski, PhD

[00:23:50]

No. Hey, learn something.

[00:23:52]

Lewis Foxhall, MD

[00:23:52]

[unclear].

[00:23:53]

Tacey Ann Rosolowski, PhD

[00:23:54]

Yeah. So what year was this when he approached you about working with him in a more formal way?

[00:24:01]

Lewis Foxhall, MD

[00:24:02]

That was in the—we began working together, I guess in the late eighties and early nineties, around through there.

[00:24:12]

Tacey Ann Rosolowski, PhD

[00:24:17]

Also, do you think that it was an advantage to you being a Texas native to do this work in the Texas context?

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[00:24:25]

Lewis Foxhall, MD

[00:24:28]

I mean, I think to the extent that I had a large network of colleagues out there that I'd developed over the years, I think was the main thing, so my association and involvement in the various organizations that I was working with, yeah.

[00:24:49]

Tacey Ann Rosolowski, PhD

[00:24:49]

I was just wondering if there was anything about more kind of understanding the culture.

[00:24:52]

Lewis Foxhall, MD

[00:24:52]

If I'd have been born in Oklahoma and moved over here, it probably wouldn't have made a lot of difference.

[00:24:56]

Tacey Ann Rosolowski, PhD

[00:24:56]

(laughs) Very well. I just thought the question needed to be asked. (laughs)

Lewis Foxhall, MD

[00:25:01]

Being around the neighborhood for an extended period is probably the major thing, just, you know, being able to develop networks and colleagues across the state was important.

[00:25:13]

Tacey Ann Rosolowski, PhD

[00:25:13]

Sure. So tell me about being recruited or being offered a position here. What was that like? What was the role you were asked to serve when you first came? You said they had trouble finding a home for you. So tell me about that whole period.

[00:25:32]

Lewis Foxhall, MD

[00:25:33]

I can't remember exactly how it became obvious to me that the position was available, but anyway, through various conversations that occurred, and then started conversations with Dr. Painter about that, and I was able to convince him that I might actually be able to do the job. So he was kind enough to hire me on, and that worked out well.

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[00:26:01]

Tacey Ann Rosolowski, PhD

[00:26:02]

Why did you decide it was time to leave private practice?

[00:26:06]

Lewis Foxhall, MD

[00:26:06]

Well, I'd been involved, like I say, in the organized medicine bit of life for a while and began to kind of look at some bigger-picture opportunities. I felt like I was contributing, I enjoyed my practice, I loved my patients, but being able to contribute on a bigger stage and to a broader audience was appealing to me. So that was, I think, probably kind of what spurred me on. I'd been in private practice about twelve, fourteen years, I guess, at that point in time, so I was just beginning to think it might be interesting to try a little something different.

So I initially took an academic position with the UT Health Science Center Medical School here in Houston in their family medicine department in teaching. So I'd always enjoyed teaching when I was a resident and I'd worked with students in my office over the years, and I decided that would be sort of a good place to start and an approach to life. So I'd been in that, I guess, about two years when Dr. Painter and I got to the stage that I decided to move over here to Anderson and focus just on the cancer prevention aspects.

[00:27:35]

Tacey Ann Rosolowski, PhD

[00:27:35]

So it was in '91 that you began teaching for—

[00:27:38]

Lewis Foxhall, MD

[00:27:39]

Yeah, about there.

[00:27:40]

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Chapter 4
B: Building the Institution
MD Anderson's Outreach Programs—the Physician Relations Programs

Story Codes

A: The Clinician
A: The Educator
B: Building/Transforming the Institution
B: MD Anderson History
B: MD Anderson Impact
B: Institutional Mission and Values
B: Beyond the Institution
B: MD Anderson and Government

Tacey Ann Rosolowski, PhD

[00:27:40]

Okay. So then in '93, you came to MD Anderson. And what was your mission at that point? What was your position and role?

[00:27:51]

Lewis Foxhall, MD

[00:27:52]

So I was hired initially to help Dr. Painter with those outreach programs, to collaborate with primary care physicians on the education side. And they had a program at that time that was funded by our ERS [phonetic], our faculty plan that was supporting outreach programs and cancer prevention largely in the Rio Grande Valley, but also other parts of the state that I was asked to support.

On the administrative side, I was asked to help set up programs that could address a growing problem in the community with physicians' attitudes toward the Cancer Center. So there were some so-called town-and-gown issues at that point in time. So, pushback from community physicians that the Cancer Center was not necessarily their friend.

[00:29:17]

Tacey Ann Rosolowski, PhD

[00:29:18]

Why was that attitude?

[00:29:20]

Lewis Foxhall, MD

[00:29:20]

Just competitive issues, so [unclear]. So anyway, so I put together what we called the Physician Relations Program, so this was a program to reach out to community physician and oncologists, as well as primary care, and help them better relate to the organization.

Commented [T4]: In this segment, Dr. Foxhall describes what was involved in the Outreach Programs, which resulted in the Physicians Relations Programs. He notes the ill will created immediately after the Texas Legislature's 1995 decision to allow patients to self-refer. He talks about the scope of the programs set up to preserve patients' connection to the primary care physician during and after cancer treatment; he also outlines the significance of the primary care physician's role in this process.

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[00:29:46]

Tacey Ann Rosolowski, PhD

[00:29:48]

And this was originally—okay. So it was first the Office of Physician Relations, and then it became Physician Relations, right? Am I getting the name right?

[00:29:59]

Lewis Foxhall, MD

[00:29:59]

Well, it was established as a program and then it was given this office designation which basically gives you a funding stream to help hire people and employ others to do your work. So that's basically what that designation is, but it just recognizes it as a formal program within the institution.

[00:30:29]

Tacey Ann Rosolowski, PhD

[00:30:30]

So tell me about the real work that you undertook as part of that program. What were the challenges?

[00:30:36]

Lewis Foxhall, MD

[00:30:38]

Well, some of this was overlap with our education programming, so we had individuals that we worked with to go out and meet with the physicians in the community and talk to them about our prevention and screening programs, and also to talk to them about any issues they might have about challenges referring patients or getting feedback on patients. So a lot of the issues related to communication or the lack thereof around their physician, around their patients' treatments when they were here. So we implemented a number of projects to help address those challenges.

[00:31:23]

Tacey Ann Rosolowski, PhD

[00:31:25]

Now, what exactly is the relationship? Because I'd never thought about this before. You know, if an individual gets a cancer diagnosis, you know, what is the relationship they sustain with their primary care physician once they go into treatment in a Cancer Center? What does that look like? I mean, what were you dealing with at the time?

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[00:31:47]

Lewis Foxhall, MD

[00:31:47]

Well, you know, at that time, it was often one in which the clinician, primary care or otherwise, really got very little feedback or information about their patient after they were referred. So that was a big issue with a lot of people. This was about the time, in 1995, when the institution was approved by the state for self-referral. So that was another issue, and a lot of physicians felt it was an unfair competitive advantage that the institution had by receiving state funding. So they felt there was more direct competition. Prior to that time, it required a physician referral to be admitted to the hospital, but now it was open, anybody could just go their own way.

So there was some feeling of disenfranchisement, I think, by the community doctors that the institution was not really respecting their relationship with the patient anymore. So that just created some ill will, and so our job was to try to help address that and help those physicians still feel part of the team, which we thought they were, but they obviously didn't, and help them address these challenges that they had with being recognized. So we worked with a number in the institution to set up databases and information systems to help connect patients with their primary care physicians and their follow-up physicians so our faculty would know that people were connecting with the information.

[00:33:41]

Tacey Ann Rosolowski, PhD

[00:33:41]

Why is it so important to sustain those connections?

[00:33:44]

Lewis Foxhall, MD

[00:33:47]

Well, the physicians, community physicians, play a significant role. Many patients are self-referred, but a few are self-diagnosed, so at some point in time there's an interaction with the physician, and that physician can facilitate access to the Cancer Center or can not. So having them feel comfortable with referrals or understanding where a patient might really benefit from coming to MD Anderson, helping them understand who our faculty are and what they do and how they're different was an important part of that work.

[00:34:30]

Tacey Ann Rosolowski, PhD

[00:34:31]

What about on the other side or during the process of treatment and then after treatment, what role does the primary care physician have in that?

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[00:34:40]

Lewis Foxhall, MD

[00:34:42]

Well, you know, it's a situation that we still are trying to work with now, as far as follow-up or what we call cancer survivorship now, is that those patients eventually do show back up in the primary care office, and, fortunately, more people survive their cancer treatment than not these days, so our ability to return patients and get them back into their home situation is much better. So it's that role in managing patients after treatment or sometimes even during treatment is one that's more clearly an opportunity for primary care than it was back in those early days.

[00:35:31]

Tacey Ann Rosolowski, PhD

[00:35:33]

As you were setting up these programs—I mean, I'm just thinking about the stories that I've heard from physicians and things I've read where physicians are sort of, "Oh, my gosh, there's so much information I have to master now in order to be an effective doctor for my patients." What has been the reaction of physicians when you present them with, "Okay, now we need to offer you a lot of information about how to support a survivor"? Or how do you manage the overload of information? Has that been a consideration or a challenge for you?

[00:36:13]

Lewis Foxhall, MD

[00:36:15]

Well, I mean, I think it's always a challenge in trying to provide physicians with educational opportunities that target the sorts of knowledge that they need at the time they need it, is really our job, and it's trying to get that packaged in a way that they can use and adapt to their own particular patient setting. So the way we work here and the way we practice here is much different from most of the rest of the world, so it's sometimes an issue of really trying to deliver that knowledge in a form that's useful to the way that they practice.

[00:36:54]

Tacey Ann Rosolowski, PhD

[00:36:56]

And what are some of the forms that you found were useful for primary care physicians?

[00:37:01]

Lewis Foxhall, MD

[00:37:03]

Well, we used the traditional educational [unclear] of lectures and seminars, and we've had more hands-on training, workshops from time to time, depending on whether we're able to find funding for those sorts of things. And it's evolved now into more online education, those sorts of things, but those are nothing too unusual.

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[00:37:33]

Tacey Ann Rosolowski, PhD

[00:37:36]

When you first began with this kind of project in 1995, how many physicians were actively involved in receiving training, and how have those numbers changed over the years?

[00:37:48]

Lewis Foxhall, MD

[00:37:48]

So you're talking about just the education program, not the Physician Relation thing?

[00:37:53]

Tacey Ann Rosolowski, PhD

[00:37:53]

Well, I mean, just the facets of this.

[00:37:56]

Lewis Foxhall, MD

[00:37:56]

Okay. I don't know how many people there were. There were several bajillion, I'm sure. But you know, we did and have done regular lecture series with community physicians, you know, I'm sure, you know, several hundred a year until now we operate our Faculty Speakers Bureau here for the institution, so that reaches, you know, a couple thousand physicians a year, utilizing various faculty members. And then the online services at that time were really nonexistent, but nowadays, that's really a big part of what we try [unclear] because it's more economical and still provides good educational information that physicians are, for the most part, interested in and enjoying using that sort of channel.

[00:39:03]

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Chapter 5
B: An Institutional Unit
The Charity Care Program

Story Codes

B: MD Anderson History
B: Institutional Mission and Values
B: The Business of MD Anderson
B: MD Anderson and Government
D: Fiscal Realities in Healthcare
B: Building/Transforming the Institution
D: The History of Health Care, Patient Care

Tacey Ann Rosolowski, PhD

[00:39:06]

So tell me how your role expanded next.

[00:39:09]

Lewis Foxhall, MD

[00:39:11]

Well, the Physician Relations operation continued for some time, and so we built that up over time and continue to operate that. The next area of responsibility that I took on was in relation to our Charity Care Program. So we had some opportunities that presented themselves in managing that challenge. We had switched back in 1995 out of the Charity Care portion of the state health laws.

[00:39:56]

Tacey Ann Rosolowski, PhD

[00:39:57]

Can you tell me a little bit about that? I'm not familiar with that background.

[00:39:59]

Lewis Foxhall, MD

[00:40:00]

So MD Anderson was founded as a charity hospital, so it was 100 percent charity care. It was 100 percent supported by the state. And over time, that gradually changed and it began to develop its own—or to attract patients who had some insurance coverage or some resources and was able to develop a more prominent side of people actually being able to pay for their care. So it wasn't limited to only charity care, but over time that ability to attract patients with other resources increased.

Commented [T5]: In this segment, Dr. Foxhall explains that, in addition to the Physician's Network Programs, he worked actively with MD Anderson's Charity Care Program.

[CLIP: The History of Charity Care at MD Anderson]
Dr. Foxhall notes that MD Anderson was founded as a charity care institution then later attracted insured and paying patients. However, he explains, the institution had a tradition and obligation to provide charity care until legislative changes occurred in 1995 relieving MD Anderson of any statutory obligation to take on charity cases.

Dr. Foxhall notes that the treatment of charity care patients was open-ended (no cap on the amount of care). During period of economic stress, which saw increases in the charity care population, MD Anderson experienced financial challenges. (In the early 2000s, 10% of the patients were charity cases.) He worked with the Charity Care Program to reduce costs while paying for care, helping to stabilize the financial situation. He notes the partnership with the Lyndon Baines Johnson Community Hospital to serve charity cases.

Dr. Foxhall observes that patients at MD Anderson in general represent the cancer levels in the general population, though MD Anderson sees insured patients and the rates of the uninsured in Houston are very high (1/3 of population). He explains why the level of uninsured is so high.

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So the changes then did not really do away or eliminate all of our charity care, so it's always been a tradition. We've always had some opportunities there, and up until '95 it was really the obligation of the institution to take patients who were unable to pay. So in '95, in addition to changing self-referral, we were switched under to the health and safety part of the regulations, at which point as a state hospital we really had no statutory responsibility to take care of funding patients.

So, however, we respected our previous tradition and respected our obligations socially and morally to care for the underserved, so that continued. Our charity program is one which is open-ended, so individuals who met the income and residency requirements came in and said [unclear] we had a certain amount of money we would spend or a certain number of people we'd take care of. So there was a period of time there largely driven by the economic climate in the region, in the state, that resulted in a large increase in our charity care population.

So we were glad to take care of all those patients, but it became clear that the trend was challenging, and we were concerned that it would adversely impact the rest of the operation. So in attempt to find a more reasonable balance of being able to care for patients and being able to pay for that care through other remedies, we implemented a number of programs at that time to try to address some of those increased costs, either by helping reduce those costs in a way that we could through finding pharmaceutical coverage for people through charity programs, from industry, or better utilization management or more careful application of our eligibility rules, we were able to stabilize that, so those huge increases stabilized and we've been able to maintain that since that time. But that took a few years to get that settled out.

[00:43:35]

Tacey Ann Rosolowski, PhD

[00:43:39]

So during this very stressful period, what was the percentage of patients?

[00:43:41]

Lewis Foxhall, MD

[00:43:41]

Yeah, it could have been up over 10 percent at that time.

[00:43:43]

Tacey Ann Rosolowski, PhD

[00:43:43]

Oh, really?

[00:43:43]

Lewis Foxhall, MD

[00:43:44]

Yeah. So it was going higher and higher every year, so we were concerned.

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[00:43:49]

Tacey Ann Rosolowski, PhD

[00:43:49]

This was in the eighties?

[00:43:50]

Lewis Foxhall, MD

[00:43:51]

No, this was back in the early 2000s.

[00:43:55]

Tacey Ann Rosolowski, PhD

[00:43:56]

Oh, okay.

[00:43:56]

Lewis Foxhall, MD

[00:43:56]

There was a big recession back in there, and a lot of this comes from, you know, the economic situation.

[00:44:03]

Tacey Ann Rosolowski, PhD

[00:44:03]

Right, right.

[00:44:04]

Lewis Foxhall, MD

[00:44:04]

Some people have a hard time when they get cancer anyway, and they need care. So we didn't turn anybody away, but we were able to try to moderate our cost and to help better manage the caseload.

It was at that point in time we developed or began to really foster our program at the LBJ Hospital.

[00:44:26]

Tacey Ann Rosolowski, PhD

[00:44:27]

Tell me about that.

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[00:44:28]

Lewis Foxhall, MD

[00:44:28]

So that was implemented in '95, during that time when the law was changed, with one physician, Dr. Valero, who's out there, and it became evident that by better supporting that program, growing that program, we'd be able to use our faculty to take care of more patients who were low-income that we could care for there as well as here. So it was really a kind of win-win situation where we were able to grow the program. We had a number of faculty that were very interested and have been very interested in working in that environment, and [unclear] help them provide care for their patients.

So we supported the salaries of all the physicians out there, and still do, and have collaborated with the hospital district to help [unclear] provide the facilities and other services, and we provide the faculty and get to take care of lots of patients that way.

[00:45:38]

Tacey Ann Rosolowski, PhD

[00:45:42]

When I was doing some of the background research for this interview, I read a little Q&A you did for one of the in-house publications that talked about the demographics issue, I mean who gets cancer in Texas, in Houston, and then who's treated at MD Anderson, who's treated at other facilities. Could you characterize that for me now, just for the record, so we can kind of get a sense of that breakdown?

[00:46:13]

Lewis Foxhall, MD

[00:46:14]

Sure. Well, you know, the patients we care for are not that dissimilar from the general cancer population, but we tend to be a little low on the percentage of Hispanic persons who are cared for here in the institution. The numbers of—you know, related to their income levels, then, you know, we see primarily patients who are insured, patients who have Medicare or Medicaid government programs, but there are still large numbers of patients who also have cancer who have no insurance. So that's a big challenge for us here in Texas, and about a fourth of the population has no insurance. That's even higher here in Houston.

[00:47:18]

Tacey Ann Rosolowski, PhD

[00:47:19]

Really? I didn't know that. Huh.

[00:47:21]

Lewis Foxhall, MD

[00:47:22]

Yeah, it's almost a third.

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[00:47:22]

Tacey Ann Rosolowski, PhD

[00:47:23]

Really? And in an urban area, that surprises me. What would be the cause of something like that?

[00:47:29]

Lewis Foxhall, MD

[00:47:30]

Well, there are a number of factors that are involved, but one big factor is the number of small businesses here in Texas, and Houston is relatively low compared to the rest of the country. Large employers, for the most part, offer all of their employees insurance coverage. Small employers do so much less frequently. So just by the economic mix that we have here in the community, that plays a big role.

So a lot of people who are uninsured are working poor. They have low incomes, but they have some member in the household who's working. It's just they often work for small companies that don't offer insurance. So as a result, none of the family members are covered. So the low-income government program, Medicaid, here in Texas is extremely limited compared to other parts of the country. So we cover pregnant women and children and we cover anyone that's disabled and

not much else in between, so adults and parents of kids in the program or single adults are not covered beyond just the very small bit of income.

[00:48:49]

Tacey Ann Rosolowski, PhD

[00:48:50]

Have the percentages of the uninsured increased dramatically over time? I'm thinking about your situation, your experience growing up in a rural area. Were there many, many uninsured people at that time when you were growing up?

[00:49:07]

Lewis Foxhall, MD

[00:49:07]

I have no clue. But uninsured has generally increased over time. In those days, insurance was generally pretty affordable, so there was things called a major medical insurance policy, so people could buy or their companies could buy, and they were relatively inexpensive. So, over time, healthcare costs have increased dramatically, insurance premiums have increased along with it, and it's become unaffordable for a lot of individuals and a lot of small companies to have that sort of coverage. So I'm sure it existed, we just didn't—I wasn't particularly aware of it at that time. So, anyway, it's still a big problem.

[00:49:57]

Tacey Ann Rosolowski, PhD

[00:49:58]

We have a few minutes left. Do you want to stop now or do you want to go until twelve-thirty?

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[00:50:04]

Lewis Foxhall, MD

[00:50:04]

Whatever is good for you. I've got to dash over to IMC [phonetic] here in a moment, so—

[00:50:10]

Tacey Ann Rosolowski, PhD

[00:50:11]

Okay. Well, maybe it would be—

[00:50:12]

Lewis Foxhall, MD

[00:50:12]

—we could pick up next time [unclear].

[00:50:13]

Tacey Ann Rosolowski, PhD

[00:50:13]

Sure. That sounds great. Well, thank you for your time.

[00:50:16]

Lewis Foxhall, MD

[00:50:16]

Sure. You bet.

[00:50:17]

Tacey Ann Rosolowski, PhD

[00:50:17]

And I'm turning off the recorder at 12:25.

[00:50:20] (end of session one)

Lewis Foxhall, MD

Session 2 — February 13, 2014

Chapter 00B

Interview Identifier

[00:00:00]

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. And the counter is moving. I'm Tacey Ann Rosolowski, and today is February 13th [2014]. The time is about twenty-five minutes after ten, and I'm in the Office of Health Policy interviewing Dr. Lewis Foxhall. This is our second session together.

So, thanks again for talking to me.

[00:00:23]

Lewis Foxhall, MD

[00:00:23]

Sure.

[00:00:24]

Interview Session: 02
Interview Date: February 13, 2014

Chapter 6
B: An Institutional Unit
The Office of Health Policy: Focusing on Outreach

Story Codes

A: The Administrator
B: MD Anderson History
B: Beyond the Institution
B: Information for Patients and the Public
B: Education

Tacey Ann Rosolowski, PhD

[00:00:24]

We talked last time about your work with the Office of Referral [?] Relations, and you talked about how the referral system got set up and what were some of the issues at stake in those early years. And I wondered if you could tell me a bit, like sketch the history, because that office was established in 1994, and obviously a lot of time has passed. So what have been some of the big markers in the development of that office and its roles?

[00:00:55]

Lewis Foxhall, MD

[00:00:56]

Sure. Well, this program was put together to address concerns of community physicians and challenges that they had in trying to get patients referred over to MD Anderson for care, and it was initially put together as a partnership with another one of our faculty members, Dr. Richard Babaian, at that time. We developed a program to begin to reach out to community physicians to better understand what their needs and issues were in relation to their interactions with the Cancer Center, and this led to the development of a program.

We hired a director at that time, Mr. Lyle Green, who is still involved with the program, and with him we put together a team of support personnel to develop surveys of the physicians, assess their interests, needs, and satisfaction with their interactions with the hospital. We worked with our internal programs to develop a system to connect physician names with patients, so that we could understand who sent the patient in and be sure we got that physician information back about the patient's treatment.

[00:02:39]

Tacey Ann Rosolowski, PhD

[00:02:39]

Now, this—I'm sorry. This all followed on the heels of the self-referral laws. That's correct?

[00:02:45]

Lewis Foxhall, MD

[00:02:46]

That's correct.

Commented [T6]: In this segment, Dr. Foxhall lays out the history of the Office of Health Policy, originating in the need to reach out to community physicians and develop their relationships with MD Anderson. He explains how a team was created to conduct surveys and also to work with programs internal to MD Anderson. Dr. Foxhall explains the issues that community physicians had in sending their patients to MD Anderson, largely in the area of need for more communication with the institution after their patients went into treatment at the institution.

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[00:02:47]

Tacey Ann Rosolowski, PhD

[00:02:47]

So that really changed MD Anderson's relationship with patients and with physicians. I think you mentioned some of the concerns last time. You said that physicians didn't quite understand how they would relate to a big cancer center. Is that correct?

[00:03:05]

Lewis Foxhall, MD

[00:03:05]

Well, not necessarily that, but they felt—or many physicians expressed concern that their patients were referred to the Cancer Center, never to be seen again, that they didn't get follow-up information. The patient's treatment and their outcomes were generally felt to be very favorable, but they just didn't know what was going on until perhaps the patient eventually returned to the practice at some point in time. So that issue of communication was a primary concern for a number of the physicians and one that we tried to address by better capturing the physician information in our system, even if the patient were self-referred, to query the patient and identify any community physician either involved with her care or intended to be involved with her care going forward so we could keep them in the loop.

Then as we developed our electronic portal at myMDAnderson, we also developed a section for physicians and their appointed medical staff support to be able to query the system and get reports and get information that they needed on their patients on a real-time basis, so that was also felt to be a real benefit.

[00:04:36]

Tacey Ann Rosolowski, PhD

[00:04:37]

And when did that happen, the electronic piece?

[00:04:39]

Lewis Foxhall, MD

[00:04:39]

Yeah. It was, I don't know, maybe ten years ago or so, something in that range. But part of that, and still we attempt to forward the information. Initially, we sent paper copies of reports to physicians just to be sure that they would get up to date on exactly what was going on with their patients.

[00:05:04]

Tacey Ann Rosolowski, PhD

[00:05:05]

Now, have some of the issues changed over the years or—you know, the patient population has obviously expanded enormously, and it seems, from what I understand, that even the complexity of treatment and duration of treatment perhaps has expanded over the years. Has that changed the way in which you interact with or have to work with interactions with community physicians?

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[00:05:33]

Lewis Foxhall, MD

[00:05:34]

Well, not that part in particular, but the major thing, I think, is our new focus on survivorship management. So we were able to set up a system so physicians could get follow-up reports. We decided we were successful when a physician finally complained that he was getting too many reports. (Rosolowski laughs.) But we did, we tracked—in a little more objective way, we tracked and developed a physician satisfaction survey and queried the physicians on a regular basis about their satisfaction with communication, and that did seem to improve.

[00:06:22]

Tacey Ann Rosolowski, PhD

[00:06:22]

And what were some of the things that were important to them in terms of communication?

[00:06:27]

Lewis Foxhall, MD

[00:06:29]

Basically what I mentioned, is getting timely reports on the treatment and recommended follow-up for their patients, better understanding what, if any, issues needed to be considered if they were still seeing the patient in their own practices. So that was really the main concern.

[00:06:51]

Interview Session: 02
Interview Date: February 13, 2014

Chapter 7
B: An Institutional Unit
The Office of Health Policy: Focusing on Survivorship

Story Codes

- A: The Administrator
- B: MD Anderson History
- B: Beyond the Institution
- C: Patients
- C: Patients, Treatment, Survivors
- B: Institutional Mission and Values
- C: Professional Practice
- C: The Professional at Work
- D: The History of Health Care, Patient Care
- B: Information for Patients and the Public
- B: Education

Tacey Ann Rosolowski, PhD

[00:06:52]

Have there been other moments when the whole sort of scope of this office or this role have expanded or shifted?

[00:07:01]

Lewis Foxhall, MD

[00:07:02]

Well, I think, you know, as far as communication issue with the physicians, this change over the years to focus on cancer survivors in particular has changed. There's been a 20 percent decline in the mortality rate from cancer over that period of time, and we have, fortunately, seen a steady growth in the number of cancer survivors in the community. So we're working with physicians now to better communicate with them in a succinct way the nature and type of treatment that the patient received, as well as recommendations for ongoing follow-up care. Many of our patients continue to come here as part of our Survivorship Program, but the majority see their community physicians exclusively or most of the time. So we're trying to better understand how we can communicate that information to them in a useful way.

[00:08:12]

Tacey Ann Rosolowski, PhD

[00:08:12]

And what are some of the media modes that you use for those communications?

Commented [T7]: In this segment, Dr. Foxhall notes the Office's focus on survivorship. He then describes some of the means developed to increase the information flow to physicians, including a survey on physician satisfaction. He then goes into more detail about how the focus of the Office has shifted to survivorship over the years and explains how MD Anderson is providing information ("Passport to Care") to community physicians so they can partner in a cancer patient's after care. Dr. Foxhall then explains some of the recommendations that MD Anderson provides to primary care physicians.

Dr. Foxhall explains why survivorship has become such an important focus at MD Anderson—resulting in a Survivorship Initiative—in the past decade or so and describes the many programs being undertaken to develop services for survivors. He talks about his role on the Survivorship Committee and the programs designed to bring survivorship care in line with recommendations made by the Institute of Medicine. He contrasts the "disorganized" approach to survivor care with the integrated approach that prevents survivors from "getting lost" after their primary treatment ends. He stresses the Office's role has been to reach out with information to community physicians. Dr. Foxhall lists some of the policy challenges that have an impact on survivors (payment for treatment plans; privacy issues; genetic testing). "We are scratching the surface of shared care," Dr. Foxhall says, and stresses that good partnerships with community physicians can free up MD Anderson specialists for acute care. He describes models of care, including shared care. He explains how MD Anderson is now applying for a grant to develop shared care. He also explains factors that have slowed the institution from moving ahead with this, despite the fact that shared care and survivorship programs can maximize a patient's ability to get benefit from the full potential of their treatment. He describes results of some studies that have confirmed the benefits of survivorship programs for patients. Dr. Foxhall also explains why the numbers of cancer survivors has been steadily increasing since the eighties, stating some of the factors that have led to lower mortality rates. Dr. Foxhall talks about the areas that need to be addressed to move survivorship care ahead. He describes the training programs across the state that builds principles of survivorship care into curricula for family physicians. He explains the larger aims for this program. Dr. Foxhall explains that survivorship is a concept that has been evolving for the past several years, beginning with work by Dr. Fitzhugh Mullins, who was a cancer patient himself. Dr. Foxhall talks about the phases in the cancer and survivorship process that Mullins identified. Dr. Foxhall lists some of the key people at MD Anderson involved in the survivorship program. He also lists some of the places he has been globally (through the GAP program—Global Academic Programs—MD Anderson's network of sister institutions) to speak about survivorship, ...

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[00:08:16]

Lewis Foxhall, MD

[00:08:17]

Well, it's similar to what we have now for other reports. We have the myMDAnderson channel, but we also have developed a summary of care we call our "Passport to Care," which is a brief summary of treatments, complications, and recommendations for ongoing follow-up as part of our Cancer Survivorship Program.

[00:08:39]

Tacey Ann Rosolowski, PhD

[00:08:40]

Now, I have to confess that I really have no idea what a follow-up care might look like, and I know it must be very individual. But could you give me an example of what a physician might need to know?

[00:08:51]

Lewis Foxhall, MD

[00:08:52]

Right. Well, it is fairly straightforward, but the survivorship management has evolved considerably over the last several years, and we have recommendations now that are actually posted on our website for physicians to use if they're interested. But it involves just a few major areas, one, the traditional test for surveillance of recurrence, and, again, that varies by disease site and stage. The second is in prevention, both primary prevention and addressing issues such as tobacco or nutrition or physical activity, as well as screening for second primary cancers. So patients who've had cancer may be at increased risk for developing another cancer, so there are recommendations for that. Then we address any issues related to complications of the patient's treatment or long-term complications from the cancer itself. And then, finally, issues of a psychosocial nature. So those are fairly common among the survivor population. So we have guidelines, recommendations. Depending on the cancer type, situation will vary from person to person, but those are available and we try to work with our community physicians to be sure they are aware of those and can apply them as they need to.

[00:10:29]

Tacey Ann Rosolowski, PhD

[00:10:36]

Now, that's the second time that you've mentioned the survivorship, and I just noticed that you, since 2006, have served as co-chair of the Cancer Survivorship Support Outreach and Policy Subcommittee. So I'm wondering what your role has been on that. What's the function of that committee in terms of supporting this kind of relationship?

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[00:10:58]

Lewis Foxhall, MD

[00:10:59]

Right. Well, it's a part of our overall survivorship initiative here at the institution, so I was involved with that from the early stages of development. We felt there was a need to focus attention on, first, support services for patients here in the Center, but also issues around education for the healthcare professionals so they could better understand this more recent approach to survivorship care that was originally espoused by the Institute of Medicine. That was the one that we've been following.

[00:11:36]

Tacey Ann Rosolowski, PhD

[00:11:36]

So what have the changes been? What was the original approach, and then how has MD Anderson changed [unclear]?

[00:11:42]

Lewis Foxhall, MD

[00:11:43]

Well, initially there was a fragmented and disorganized approach to management of cancer survivors in the community. So as I said, some patients after their treatment would continue to come back here, and come back here for years, but there was no real organized approach to that management. They just continued to be seen by their treating physician. So the Institute of Medicine did a big study and made recommendations several years ago that we needed to focus on those major areas that I just went over, and then oftentimes patients were lost to follow-up when they transition from active treatment back into the community. So that group, in particular, they felt was important for them to be brought back into the system or remain in the system so that they could get appropriate care.

So that's part of what we've been trying to do, so we've been focusing on our efforts here within the institution, but we also felt it was important to reach out to the community physician. So that was our role, provide education, provide outreach to the physician community, and also help develop our website, our public information, so that patients would better understand what services were available here to them as a cancer survivor. And then we also looked at—provided an overview of any pertinent policy issues related to survivorship management that were out there that we needed to pay attention to.

[00:13:27]

Tacey Ann Rosolowski, PhD

[00:13:27]

And what were some of the policy issues that you identified?

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[00:13:29]

Lewis Foxhall, MD

[00:13:30]

Well, there are a number of initiatives that have been proposed, but so far not moved ahead, in particular on the idea of some sort of payment for the development of these treatment summaries and care plans. So it's recommended, it's even become a standard of care for the Commission on Cancer Hospitals, but so far there's no specific way to pay for making that happen, so it just has to be done. So that's one initiative.

The other were things that related to the patient privacy issues, how patients, in particular their genetic information, which may be part of the survivorship follow-up care, was managed. There was subsequently a law passed that protected that information so that patients could feel comfortable in examining their own personal history or family history, and doing testing to see if they might have some genetic predisposition themselves or in their families for problems. So that was an important area. So those are just a couple of the main areas that were tracked along and made comments on as we moved ahead.

[00:14:54]

Tacey Ann Rosolowski, PhD

[00:14:54]

In addition to the effectiveness of follow-up, was there some way in which this kind of creating a partnership with the community in treatment helped relieve some of the work burden on MD Anderson, kind of freeing up people to see new patients? I'm trying to get a sense of that piece, too, if there was a financial component to it for the institution.

[00:15:22]

Lewis Foxhall, MD

[00:15:22]

Well, the financial component is primarily related to moving cancer patients who are stable and need no special follow-up or need nothing more than routine follow-up out of the Acute Care Clinic so that it frees up time for new patients. So that's really been the main issue. So we are just scratching the surface on trying to better develop an approach to what's sometimes called shared care; that is, interaction between the community physicians, in particular primary care physicians, and the Cancer Center, in trying to improve their capacity and comfort level while taking care of patients who are otherwise stable. So we're just beginning that journey.

[00:16:11]

Tacey Ann Rosolowski, PhD

[00:16:12]

Now, talk to me about this shared care. I've never heard that term before. How would you foresee that working, and what are the challenges to setting that up?

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[00:16:22]

Lewis Foxhall, MD

[00:16:22]

Well, there are different models of survivorship care that have been described. One is what we do here, which is subspecialty care within specialized site-specific clinics, and it's primarily by midlevel practitioners under the supervision of our faculty. The other is more community-based survivorship clinics where they may see a variety of different cancer types within the same setting, often managed by either nurses or midlevel practitioners or, at times, from other oncology professionals.

And then the idea of shared care is one in which the responsibilities for follow-up are divided in a prescribed way between either the community oncologist or the primary care physician, or in our case, the Cancer Center and the primary care physician. So this is the sort of care that often goes on, but is rarely ever done in an organized way, so there's still lack of communication, lack of interaction across the different professionals that are seeing, listening to cancer survivors. So there's opportunity for improvement there.

[00:17:42]

Tacey Ann Rosolowski, PhD

[00:17:43]

Now, what would it mean to organize that, those relationships, organize that type of care?

[00:17:48]

Lewis Foxhall, MD

[00:17:50]

Well, what we're trying to do now is to reach out to primary care practices, and, actually, this is one of the grants that we're working on right now, is to develop a program where we can work with these practices to develop the survivorship treatment summaries and care plans for each of the cancer survivors, and then to prompt an interaction between the primary care professional and the oncologist or us, if that's the case, to determine where the patient's getting each component of their survivorship follow-up, if they're getting it, and then decide who's responsible for what so we are better prepared to deliver those services in a consistent fashion.

So that's just getting started. We've communicated with physicians through various education programs, and oncologists through various education programs about the need for that, but it's been very slow to be adopted.

[00:19:04]

Tacey Ann Rosolowski, PhD

[00:19:04]

Why?

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[00:19:05]

Lewis Foxhall, MD

[00:19:05]

Nobody pays for it. It's really an unfunded mandate, and there is general fragmentation in our healthcare system anyway, so there's no real support for that to happen. So we're trying to put together an approach that we think might help that happen. So we'll see, but that's something we're working on right now.

[00:19:26]

Tacey Ann Rosolowski, PhD

[00:19:26]

Sounds pretty challenging to do. (laughs)

[00:19:29]

Lewis Foxhall, MD

[00:19:31]

It's so simple anybody could do it.

[00:19:32]

Tacey Ann Rosolowski, PhD

[00:19:32]

Yeah. I'm just thinking about that, you know—

[00:19:35]

Lewis Foxhall, MD

[00:19:36]

No, it doesn't happen spontaneously. I mean, you can't argue with the logic of that approach, but it's just, you know, there's just no incentive for anybody to do that, and the patients can't necessarily be expected to organize all that themselves. So often it just doesn't happen. So follow-up is hit or miss, and some things get done and some things don't get done, and we feel like we're not optimizing the patients' ability to really get the most out of their treatment. So there may be many patients, in particular breast cancer patients, are more likely to have a problem with something besides their cancer coming back. So if we're not addressing all these other issues, then the benefit they get from having gone through that treatment is diminished.

[00:20:29]

Tacey Ann Rosolowski, PhD

[00:20:30]

Wow.

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[00:20:30]

Lewis Foxhall, MD

[00:20:30]

So that's what we're really trying to do, so it's really part and parcel of the whole fragmentation and disorganization we have in our healthcare system in this country, and it's just another manifestation of that, in a sense.

[00:20:46]

Tacey Ann Rosolowski, PhD

[00:20:48]

Now, have there been studies done to kind of put quantitative numbers to the impact of this lack of organized follow-up on different types of cancer patients?

[00:21:01]

Lewis Foxhall, MD

[00:21:02]

To some degree, so there's a couple of studies that have looked at the impact of these care plans and whether that really prevents things, and the results have been mixed so far, but there are really not a lot of studies out there. But the things that are recommended have all been shown to work, and we know people die less often from cancer if we find it early and treat it early, so screening is important. Cancer surveillance for recurrence has been shown to be effective and efficient if done in the right way. And, of course, it's important to address the complications of treatment, so rehabilitation and the assessment of any ongoing organ damage is, of course, a thing that we would do anyway. So it just sometimes gets missed in the mix of things. So, all those things that are part of survivorship care or independently are shown to be beneficial, but there's not really been a big study that's shown that it's more effective than just usual care. But some smaller ones have shown [unclear].

[00:22:25]

Tacey Ann Rosolowski, PhD

[00:22:25]

Well, I was also wondering if there are any numbers on the effect of not having any monitoring of follow-up. Is there a sense that you could put numbers to what the impact is on patients of just having the fragmented system that now exists?

[00:22:44]

Lewis Foxhall, MD

[00:22:45]

Well, I mean, it's just the current state. I mean, we know what survivorship rates are for various cancer types and that's sort of the ultimate test of that.

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[00:22:54]

Tacey Ann Rosolowski, PhD

[00:22:55]

I mean, you know, 20 percent improvement in survivorship, that sounds like a really great number, and I'm wondering has that made people kind of, you know, casual about survivorship, like, "Oh, it's been done"?

[00:23:13]

Lewis Foxhall, MD

[00:23:13]

So the 20 percent is a reduction in mortality from cancer, so 20 percent the rate per 100,000 people who die from cancer in this country has dropped that much over that period of time. So that started in the early nineties, about the time I came to MD Anderson. That's an interesting coincidence. (Rosolowski laughs.) But that's attributable to many things, you know, so better prevention, screening, early detection, but it's also the significant improvements that we've had in treatment over those years that have made a big difference there. So that's really the main reason for that.

So our work in improving survivorship care has really been fairly recent, so that's been over the last few years that we've really been just starting to work in that area. So many of those things are really evolving, but the numbers of survivors has just steadily been increasing since really the early, mid-seventies, and now two-thirds of people live five years or longer with their diagnosis, compared to when I started practice in the late seventies, early eighties, it was barely half. So there's been a big, big change, so that means more and more people are living longer, are staying alive after being treated successfully for cancer.

So we've come to the—it's now obvious observation, but before wasn't necessarily something we spent a lot of time worrying about, was, hey, we need to be taking care of these people after their treatment's done. We're not really finished with caring for the patient, so we need to really look at what we can do, because many of these patients live many years after their cancer treatment. So what can we do to maximize the amount of time they live after treatment and to improve the quality of life that they have after their cancer treatment? So many of the things we do to patients to cure them are difficult to go through and may leave some lasting problems, so we need to better understand and apply approaches that we know work to help them deal with that and to get the most out of their time after their successful treatment.

[00:25:36]

Tacey Ann Rosolowski, PhD

[00:25:37]

So what's on your wish list for survivorship care? Obviously you've got some real hurdles to address in setting some of this up. But if the way were clear, what would you want to see accomplished?

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[00:25:52]

Lewis Foxhall, MD

[00:25:52]

I wish we would get the super grant so we could try this. Anyway. (Rosolowski laughs.) So really, you know, we're really just beginning to test this, these ideas out in the community, you know. We've done it here, we want to continue our robust survivorship programs here in the Cancer Center. And for people who are treated here and choose to or are able to come back here for follow-up, that's great, but we recognize that there is a lot of work to be done in the community to try to better understand and to facilitate the delivery of these services in a community setting. So that's really kind of where we're trying to go, and we're, like I say, just beginning to develop a small network of practices. We're actually going to focus on training programs so we can include education, and as the clinicians go through their training, they'll be better exposed to the principles of survivorship care and hopefully internalize those as part of their routine training, so when they then move out into practice, they'll be all set and ready to go and can become champions for survivorship care in whatever setting they wind up in. So over time, this hopefully would lead to a broader cadre of clinicians who are trained in survivorship management, who are comfortable with it, and hopefully would then be able to kind of pay that forward and provide care for their patients.

[00:27:33]

Tacey Ann Rosolowski, PhD

[00:27:34]

And do you mind mentioning the names of some of these programs? Where are they located?

[00:27:38]

Lewis Foxhall, MD

[00:27:39]

There's several across the state. There's one in Tyler; one in Austin; one in Baytown; one here in Houston, southwest Houston; and Galveston. So those are the first batch that we're starting to work with, and we would hope, if this is successful, we could expand it out to other programs across the state or even nationally. I mean, we want to come up with an approach that's scalable and one that can be adopted by other programs.

So we're beginning with family medicine. There's also general internal medicine. There are other primary care-related specialties that may have an interest in this. But if we can just implement these few programs as a pilot really to see if it's feasible and to really better understand how we can approach this in that setting and what that means to the patients, you know, we want to track and see if this really does help us provide a better level of service to these patients. That's really the primary goal. And then if we got some additional benefits in education and training along the way, well, great, but we really hope to focus on that issue of [unclear] do what we know needs to be done in that setting so we can reach a broader number of patients wherever they're treated. They don't have to be MD Anderson patients. So that's kind of where we're trying to go with that.

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[00:29:18]

Tacey Ann Rosolowski, PhD

[00:29:19]

I have to say this is a real eye-opener. You know, I hadn't—I think when people focus on the cancer diagnosis and then they focus on the stress of getting treatment, and, well, what happens after, it's, "Well, I'm so glad to be treated, maybe that's the endpoint." But obviously, it's not. And so this whole arena of what happens in the rest of your life, however long that might be, is maybe hazy to people who haven't gone through the process now.

[00:29:46]

Lewis Foxhall, MD

[00:29:47]

Sure. Sure. So it's a concept, I think, that's been evolving for some time, and there was actually one of the first physicians to espouse this was a person named Fitzhugh Mullins, who was actually a physician patient. So he had cancer and then observed some of these things, and then he saw that there were different phases of the process that he really kind of considered being a cancer survivor starting with day one when you're told you have cancer. And then you go through these various phases of sort of the acute phase of treatment and all the issues around that, and then sort of a medium post-treatment intermediate phase where you're still trying to kind of get back on your feet and address some of the more pressing issues around having just been wrestling with a life-threatening situation. And then the more chronic phase that, you know, [unclear] what else do you need to do, what do you need to pay attention to, what things are different when you want to get back to your life and do what do you want to do. But you still need to be aware of things that you can do to help yourself, to stay healthy to avoid having problems down the road.

[00:31:12]

Tacey Ann Rosolowski, PhD

[00:31:13]

And when did Dr. Mullins theorize these [unclear]?

[00:31:16]

Lewis Foxhall, MD

[00:31:16]

That was back in the seventies or eighties. It was quite a long time ago.

[00:31:20]

Tacey Ann Rosolowski, PhD

[00:31:21]

Wow. And so he was obviously ahead of the curve.

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[00:31:24]

Lewis Foxhall, MD

[00:31:24]

He was quite an interesting person, yes. He kind of wrote about how just being a physician but going through cancer treatment gave him a different perspective that kind of helped him highlight those perceptions.

[00:31:41]

Tacey Ann Rosolowski, PhD

[00:31:42]

Well, it's interesting the way you even phrased what he said, learning how to help yourself. I was talking to Barbara Solomon [sic; should be Barbara Summers, Ph.D. [Oral History Interview]] and she was talking about nursing, the motive of nursing is to model for the patient how they can then care for themselves, and it was a very interesting kind of approach, the importance of empowering patients, giving them control. Really neat. So that's the kind of model that people are looking at and adopting. It's a convenient way of dividing up the cancer experience, basically.

Well, is there anything else that you'd like to talk about with regards to the work in the institution on survivorship?

[00:32:28]

Lewis Foxhall, MD

[00:32:30]

Well, I think those are really kind of the highlights right now. I've been fortunate to work with some really great people: Dr. Alma Rodriguez [oral history interview], she heads up our Survivorship Program; Dr. Terry Beavers [phonetic], who's been involved with it from the Prevention Clinic point of view; and then Fran Zestra [phonetic], who's our program director, all really great champions of the effort in moving this forward and over the last several years has been a rewarding experience in seeing that partner and develop and get mature here in the Cancer Center has been great.

So we're trying to understand how we can really begin to move that forward, so, fortunately, with the support of Dr. Rodriguez, I've been able to do a good bit of educational programming, both live lectures, but also we've developed a number of education programs that we've put online, Dr. Kendra Wood [phonetic], who's been helpful in facilitating that process. We've lectured all around the state, different parts of the country, and we'll actually be going to Korea for our GAP program in May, and we'll have a section on survivorship discussions there, and I'll be talking to some of their primary care clinicians and kind of learn a little bit more about how they're doing it. They've begun to do some survivorship programming. So it's interesting that these concepts are gradually spreading across not only the U.S., but also in other countries as well.

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[00:34:20]

Tacey Ann Rosolowski, PhD

[00:34:21]

Now, you mentioned the GAP program?

[00:34:22]

Lewis Foxhall, MD

[00:34:23]

Global Academic Programs.

[00:34:25]

Tacey Ann Rosolowski, PhD

[00:34:25]

Oh, GAP.

[00:34:26]

Lewis Foxhall, MD

[00:34:26]

G-A-P, GAP.

[00:34:27]

Tacey Ann Rosolowski, PhD

[00:34:27]

Okay. And what is that?

[00:34:28]

Lewis Foxhall, MD

[00:34:30]

We have a number of what we call sister institutions around the world that work with us primarily on research efforts, but we also have a conference, annual conference that brings people together and individuals submit abstracts about their work or their interest and present those, talk about them and share information.

[00:34:53]

Tacey Ann Rosolowski, PhD

[00:34:54]

So that's the GAP program?

[00:34:54]

Lewis Foxhall, MD

[00:34:55]

Yeah. So the Global Academic Program is this organization of sister institutions that work together.

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[00:35:02]

Tacey Ann Rosolowski, PhD

[00:35:02]

I'd never heard that, never heard it referred to that as that before. So that's interesting. So other nations are dealing with this as well, and [unclear] learning experience.

[00:35:12]

Lewis Foxhall, MD

[00:35:14]

Cancer is an equal opportunity offender.

[00:35:14]

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Chapter 8
A: Character and Personal Philosophy
Work that Takes Eternal Optimism

Story Codes

A: Character, Values, Beliefs, Talents
B: Institutional Mission and Values
B: MD Anderson History
B: Beyond the Institution
C: The Institution and Finances

Tacey Ann Rosolowski, PhD

[00:35:15]

Yeah, well, sure, sure. Interesting.

You know, just this sort of off-the-wall question, but, you know, as I've interviewed surgeons, like I get sort of a sense of, you know, people talk about ways in which they get into surgery. The people who focused on administration feel they've got a certain set of skills that really suits them to that. I'm wondering do you see in yourself and among the people that you work with certain qualities or experiences that have drawn people to this kind of community work, to building networks, to outreach? Is there anything about your particular set of talents and people that you work with that really suits you to that kind of focus?

[00:35:57]

Lewis Foxhall, MD

[00:35:58]

Well, I'm not sure if there are any specific talents, but certainly a recognition of the value of care delivery in the community I think is important. We're a wonderful place and we do great things, but good things happen outside the walls too, and being able to recognize that and have comfort in collaboration, I think is important. Of course, the usual necessity of good communication skills and the ability to organize and plan strategically to move issues forward I think is something that you kind of have to have, whether that comes naturally or you figure out how to do it along the way. But those are some of the kind of the main issues.

But that [unclear] sense that our mission here at the institution is to eliminate cancer and it is a broad one and it addresses all communities, the idea that we need to have some sense of equity in how we reach out to all populations is important. That's certainly something that anybody that works in this area would tell you. So it's a challenge in our financial environment to do that. It's difficult to try to address problems when there's no funding from commercial sources or from the state, really, oftentimes. So it requires a high level of, I suppose, patience, but also persistence in trying to continue to move the issues forward, that you know what needs to be done is just a matter of trying to figure out how to do it in an under-resourced environment that makes it a little difficult sometimes.

Commented [T8]: In this segment Dr. Foxhall responds to a question about those particular gifts that suit him and others to policy work. He explains that a focus on outreach beyond the institution is key, as well as a comfort with collaboration. He also talks about the commitment to the institution and to its mission to cure cancer and a commitment to a sense of equity in reaching out to all patients. It's a challenge financially to do that in an environment of limited funding and requires a high level of patience, persistence, and optimism to move issues forward.

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[00:38:00]

Tacey Ann Rosolowski, PhD

[00:38:03]

Patience and maybe optimism too. (laughs)

[00:38:05]

Lewis Foxhall, MD

[00:38:05]

Eternally optimistic, that's very important.

[00:38:08]

Tacey Ann Rosolowski, PhD

[00:38:09]

I can imagine.

[00:38:10]

Lewis Foxhall, MD

[00:38:10]

Right. Irrational optimism, I think somebody said one time.

[00:38:13]

Tacey Ann Rosolowski, PhD

[00:38:13]

The whole bricks-from-straw thing, eternal optimism. (laughs)

[00:38:15]

Lewis Foxhall, MD

[00:38:16]

Yeah, right. So what can you do? Just keep on trying.

[00:38:19]

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Chapter 9
B: An Institutional Unit
Associate Vice President of the Office of Health Policy

Story Codes

- A: Character, Values, Beliefs, Talents
- B: Institutional Mission and Values
- B: MD Anderson History
- B: Information for Patients and the Public
- B: Beyond the Institution
- C: The Institution and Finances

Tacey Ann Rosolowski, PhD

[00:38:20]

Well, I'd like to turn now, if you are willing, to your role when you stepped into the Associate Vice President for Health Policy. That was in 1994, and I'm wondering if you could tell me how you came to serve that role, first of all.

[00:38:38]

Lewis Foxhall, MD

[00:38:38]

Well, I was hired by Dr. Joe Painter, who was VP for Health Policy at that time. He'd been focusing his career here at the institution on trying to reach out to community physicians, working with both oncologists and primary care physicians, but, in particular, working with various medical organizations and volunteer organizations, so trying to build and maintain strong collaborative relationships with those groups was a part of what he had been doing, and that was a lot of what I was hired on to do to maintain.

So this was working with what's known as organized medicine, which is folks like the American Medical Association, Texas Medical Association, specialty organizations primarily here in Texas, and then also with voluntary health groups such as the American Cancer Society, to find alignments in programs that help fulfill our mission as well as theirs and so forth. And then with public health groups, our state health department, what was then known as the Texas Cancer Council, which was a state agency targeting cancer [unclear] initiatives, and then our regional and public health entities in the Houston community.

[00:40:27]

Tacey Ann Rosolowski, PhD

[00:40:28]

Can you describe for me what is meant by health policy? It may seem like an obvious question, but, you know, I'm curious what the scope of that is.

Commented [T9]: In this segment, talks about his role as Associate VP for Health Policy (beginning in 1994). He begins with his early collaborations with Dr. Joseph Painter on outreach and education for community physicians, as well as collaboration with local institutions (organized medicine) and voluntary health groups to locate aligned interests and goals. Dr. Foxhall defines the scope of "health policy" as the zone of regulations that govern health care and can include public health, delivery of health care within and outside MD Anderson, preventative care for the community, among many other issues. Dr. Foxhall give an examples of policy issues that the Office of Health Policy has addressed in collaboration with other health organizations: how MD Anderson arranged for a patient to be reimbursed for routine care while involved in a clinical trial (when insurance companies denied any coverage). He then talks about issues in the public health arena, stressing MD Anderson's role as a resource and support for public officials who lobby for health policy in the legislature. He gives examples of the types of information that public officials tap.

Dr. Foxhall next explains the relationship between the Office of Referral relations (established first) and the Office of Health Policy, now separate entities, though first within the same administrative unit.

Dr. Foxhall next talks about the big projects he undertook as Associate Vice President: creating the network of physician referrals; a program to educate physicians about cancer screening; creating an internet based educational outreach program.

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[00:40:41]

Lewis Foxhall, MD

[00:40:41]

Sure. It's the realm of legislation and regulatory initiatives that govern, in our case, the delivery of cancer care. So it's a broad field that can include issues of a public health nature, of a financial nature, or other areas. So there are many things that touch on how we deliver services here at the Cancer Center, how they're delivered in the community, both cancer treatment as well as cancer prevention. How we value and implement those sorts of services as a society are governed by laws and regulations, and that's really kind of the area that we primarily work in.

[00:41:35]

Tacey Ann Rosolowski, PhD

[00:41:37]

So I'm curious how your work with these different voluntary organizations in organized medicine kind of fit into that. What were the issues from a policy standpoint that you were addressing?

[00:41:53]

Lewis Foxhall, MD

[00:41:54]

Well, there have been a number of issues over the years, so with the organized medical groups, oftentimes it was related to financial issues, how physicians and hospitals get paid for what they do, how we relate with insurance companies, how we relate with the federal government that provides services through Medicare, through Medicaid, or other programs. So there are all sorts of issues related to how those sorts of questions are decided and how they're implemented, that we have an opportunity to work with and collaborate with our colleagues in these other organizations that have often—or what we try to find is an alignment of our goals so that we oftentimes may differ on how we approach something, but many more times we can find common ground and work together toward a specific goal.

[00:43:03]

Tacey Ann Rosolowski, PhD

[00:43:04]

Can you give me an example of a project that you worked with?

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[00:43:08]

Lewis Foxhall, MD

[00:43:09]

Well, you know, there are things like how we get coverage for payment of individuals who are participating in clinical trials. So a person in the Medicare program, for example, might not be able to receive payment for their routine care if they're participating in that clinical trial, so the carrier may deny coverage for any of their treatment. So we worked to help establish a principle that the patient was going to get cared for anyway, the costs of the trial are separate and covered by the trial itself, but the trial shouldn't pay for what was going to happen anyway, which was the routine care, which seems like an obvious thing, but, surprisingly, it was very difficult [unclear]. (Rosolowski laughs.) And commercial entities were [unclear], you know, "This is an experiment. We're not paying for an experiment. You can take care of that yourself." So the vast majority of the costs were routine costs that occurred anyway, so the patient was in the hospital, say, getting treated, and [unclear] whether or not they were getting an experimental drug was a secondary issue.

So it took things like that, which seem very simple and obvious, often take years to eventually resolve and take collaborations across many interested parties to try to make a change, which is very important whether people can access clinical trials and the oftentimes very beneficial treatments that they get. So that's sort of an idea of the work that I did.

In the public health arena, we have been involved in a number of different issues in being sure that we have adequate funding for things like tobacco control or that we're providing immunizations that may help reduce the frequency of cancer. So there are a number of issues there that we can provide support for. We're a state institution. We can't and don't lobby per se, but we act as a resource and provide information and support for elected officials and for other groups that we work with who do direct advocacy work. So by working together, we can accomplish much more than just each of us [unclear].

[00:45:58]

Tacey Ann Rosolowski, PhD

[00:45:59]

And what sorts of initiatives would elected officials take up using MD Anderson resources?

[00:46:05]

Lewis Foxhall, MD

[00:46:07]

Well, you know, it could be things like that. We've had coverage of various preventive services addressed at the state level. We've had issues around, most recently, these regulations around tanning beds, which we worked with our colleagues in Government Relations to address. We've worked with a number of communities on their tobacco-control ordinances. So there are all sorts of areas where we try to provide resource and information and give support to those that need the knowledge of the impact of these things on their constituents. So we think that's a valuable service that we can provide there.

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[00:47:03]

Tacey Ann Rosolowski, PhD

[00:47:04]

So you became associate vice president in 1994, and you became VP of the Office of Referral Relations in the same year. Now, was the Office of Referral Relations within the Division of Health Policy or Department of Health Policy or—

[00:47:27]

Lewis Foxhall, MD

[00:47:27]

Well, first we had the Referral Relations Program established, so it was just a really [unclear]. I'm not sure where you [unclear] the VP bit, but the Health Policy bit was the VP. So I was the director, then director of the Office of Health Policy, so initially had that as sort of our administrative designation, and then eventually we split that off. We continued to have the Office of Physician Relations, which Mr. Green [phonetic] heads up today, and then we formed the Office of Health Policy as a separate area. So those are really kind of our administrative departments, if you will, so other than a title.

[00:48:19]

Tacey Ann Rosolowski, PhD

[00:48:19]

Okay. So they're separate entities.

[00:48:21]

Lewis Foxhall, MD

[00:48:21]

Today they are.

[00:48:21]

Tacey Ann Rosolowski, PhD

[00:48:21]

Yeah, today, but they were [unclear].

[00:48:23]

Lewis Foxhall, MD

[00:48:23]

That was all part of the same thing.

[00:48:25]

Tacey Ann Rosolowski, PhD

[00:48:25]

Okay. Okay. And that's right, because I have a note here that in 2001, the Office of Referral Relations became the Office of Physician Relations. It was renamed?

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[00:48:36]

Lewis Foxhall, MD

[00:48:36]

Yeah, sorta kinda. (laughter) It's had its designations over the years.

[00:48:42]

Tacey Ann Rosolowski, PhD

[00:48:42]

It's amazing the name changes at MD Anderson.

[00:48:44]

Lewis Foxhall, MD

[00:48:44]

Right. Yeah, I know. Got to be changing something.

[00:48:46]

Tacey Ann Rosolowski, PhD

[00:48:46]

Yeah. So could you tell me some more about what you felt when you became Associate VP? What were some of the big projects you worked on? Because you talked about establishing these networks, but it sounds like that was part—so was that the time when the referral relationships was folded into Health Policy so when your work on establishing the community networks was part of your role as associate vice president?

[00:49:17]

Lewis Foxhall, MD

[00:49:18]

Well, now, I mean, really, the new thing that we developed was this Referral Relations Program, so that was sort of the initial administrative task that I was assigned to do. So in addition to that, I helped manage for Dr. Painter some outreach programs that were funded by PRS at that time, outreach in the Rio Grande Valley for cervical cancer screening, and also we had one for sun protection and then had a program in collaboration with the medical schools and the primary care organizations to educate physicians on cancer screening that we initiated. So those were some kind of the things that we began to do and pursued for some time.

We also had an Internet-based education and outreach program that collected data and information around cancer statistics and cancer providers across the state and shared that out. That was initially Texas Cancer Data Center. It was funded through the state and then subsequently by [unclear] as the Texas Cancer Information website, which we still have today.

[00:50:50]

Tacey Ann Rosolowski, PhD

[00:50:50]

Right. I had it on my list to ask you about that. Yeah.

[00:50:54]

Interview Session: 02
Interview Date: February 13, 2014

Chapter 10
B: An Institutional Unit
The Texas Cancer Data Center

Story Codes

- A: Overview
- B: MD Anderson History
- B: MD Anderson Impact
- B: Education
- B: Information for Patients and the Public
- B: Institutional Mission and Values
- B: Beyond the Institution

Lewis Foxhall, MD

[00:50:55]

So that was a very longstanding program. It really had just been established when I came on board, and we continued to maintain that and expand it over the years to broaden its reach in a very successful program in a way to kind of reach out to the public and others that were interested in cancer information.

[00:51:19]

Tacey Ann Rosolowski, PhD

[00:51:20]

So tell me how that worked. I mean, how did the Data Center—because that was its first name, right?

[00:51:26]

Lewis Foxhall, MD

[00:51:26]

Mm-hmm.

[00:51:26]

Tacey Ann Rosolowski, PhD

[00:51:26]

How did it get established and then how was this data amassed?

[00:51:30]

Lewis Foxhall, MD

[00:51:31]

Well, it was a grant from the Texas Cancer Council, which was the state agency that helps support cancer initiatives, and the idea was to collect information from our state Cancer Registry, which had just recently been reestablished, and convert that into an accessible, searchable system for people to get information and have a particular [unclear] in a particular area across the state through an Internet-based, online-based program.

Commented [T10]:

In this segment, Dr. Foxhall explains that the Texas Cancer Data Center was set up in the late 80s by a grant from the Texas Cancer Council to collect information from the state cancer registry and convert it to a searchable system that includes statistics on patients, public information and information about treating centers and physicians. (Texas was one of the first states to have a formal plan to address cancer.) He explains the shifts in funding this program over the years: MD Anderson now funds and manages this system, called the Texas Cancer Information Center, which also has a website. Dr. Foxhall explains how the system evolved and the programs it includes. He explains how the Service is used and for what purposes. He notes that a related education program has reached about 500 nurses and 1000 social workers with information about programs for patients. He notes that this was one of the first data centers of this type in the country.

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[00:52:09]

Tacey Ann Rosolowski, PhD

[00:52:09]

And this is public information?

[00:52:10]

Lewis Foxhall, MD

[00:52:10]

Mm-hmm. Yeah. So this is de-identified statistical information. We also collected the names and locations of physician practices who worked in cancer, and we also tried to provide some basic public education information about cancer for cancer patients as well.

So that was launched a number of years ago and continued to be supported by the Cancer Council up until the time CPRIT came into being, at which time the Cancer Council went away and CPRIT continued to fund it for a few years. And then we switched it over to institutional funding when they decided they didn't want to be in that business anymore.

[00:52:56]

Tacey Ann Rosolowski, PhD

[00:52:56]

So it's now funded by MD Anderson?

[00:52:58]

Lewis Foxhall, MD

[00:52:58]

Mm-hmm.

[00:52:58]

Tacey Ann Rosolowski, PhD

[00:52:58]

Wow. And let's see. It was renamed. I have the most recent name as the Texas Cancer Website Information [unclear]?

[00:53:14]

Lewis Foxhall, MD

[00:53:14]

No, Texas Cancer Information [unclear].

[00:53:16]

Tacey Ann Rosolowski, PhD

[00:53:16]

Okay.

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[00:53:16]

Lewis Foxhall, MD

[00:53:20]

For better or worse.

[00:53:20]

Tacey Ann Rosolowski, PhD

[00:53:24]

And were there any changes made to it when MD Anderson took it over or CPRIT took it over [unclear]?

Lewis Foxhall, MD

[00:53:31]

It was just an evolution. The funding that we had previously was a good bit more, so we had to cut back on staff and do more with less, the usual thing. So we also obtained some grant funding from CPRIT to do some educational programming through the website, so that's still ongoing.

[00:53:56]

Tacey Ann Rosolowski, PhD

[00:53:59]

So how many people use this every year, and what is it used for?

[00:54:04]

Lewis Foxhall, MD

[00:54:06]

Well, it's a service that gets a fair amount of traffic. I think we get around a million and a half or so hits a year and several thousand unique users. So it's something that people still seem to find interesting.

So with this educational program, we've reached—well, I can't remember the exact numbers, but around five thousand nurses and a few hundred social workers, which is who we were targeting as information about access to care, how to get your patients connected, low-income uninsured patients connected with cancer care services. So that's been a good program. We're in the process of needing to update that. It's been out there almost two years now, so we're going to do a little update on it, keep it available for people.

[00:55:04]

Tacey Ann Rosolowski, PhD

[00:55:07]

When was this initiative started, the Texas Cancer Information?

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[00:55:11]

Lewis Foxhall, MD

[00:55:12]

Back in the late eighties, 1988, something like that. So it was about the time the Cancer Council came into being and the initial Texas Cancer Plan was developed modeled on the National Cancer Plan. So Texas was one of the first states to have a formal plan for addressing cancer. That was first put together then, it's been updated subsequently, and we've participated in those updates.

[00:55:44]

Tacey Ann Rosolowski, PhD

[00:55:47]

Why was Texas one of the first, you know? What was going on at the time?

[00:55:52]

Lewis Foxhall, MD

[00:55:53]

It's Texas.

[00:55:53]

Tacey Ann Rosolowski, PhD

[00:55:54]

It's Texas. (laughter) Said by a Texan.

[00:55:57]

Lewis Foxhall, MD

[00:55:58]

Well, you know, there were a number of people here in the state. You know, it was home to MD Anderson. There were a lot of people at that time that were very passionate about cancer care, and we had some unique resources that were available that really kind of raised the profile of cancer treatment and our approach to cancer here that helped move things along.

[00:56:23]

Tacey Ann Rosolowski, PhD

[00:56:27]

Well, thank you for that. We've got about five minutes left. Do you want to go until eleven-thirty? I noticed you checked your phone. Do you need to stop and—

[00:56:35]

Lewis Foxhall, MD

[00:56:35]

(laughs) Yeah. Well, whenever you're ready, yeah. I probably need to kind of move along here.

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[00:56:39]

Tacey Ann Rosolowski, PhD

[00:56:39]

Okay. Okay.

[00:56:40]

Lewis Foxhall, MD

[00:56:40]

But anyway, yeah, so lots of interesting interactions, I think, with a number of organizations. We've worked a lot with the American Cancer Society, too, over the years on collaborative programs and cancer control, promoting education, screening, prevention, public education. So they've been a real important part of our business over time, and then with our public health agencies at the state level and here in Houston partnering to try to improve the opportunities for patients to be aware of cancer risk and to address those risks.

And then the other group that we spent a good deal of time working with is this Harris County Healthcare Alliance, which is an organization we put together in collaboration with the city and county government to help provide additional support to community clinics to improve access to prevention services and to help improve the access to care for low-income populations here in the Houston region.

[00:57:54]

Tacey Ann Rosolowski, PhD

[00:57:59]

Well, great. Well, why don't we leave it there for today.

[00:58:01]

Lewis Foxhall, MD

[00:58:01]

Okie dokie.

[00:58:02]

Tacey Ann Rosolowski, PhD

[00:58:02]

So you can move on to your other important work.

[00:58:03]

Lewis Foxhall, MD

[00:58:04]

Back to work. (laughs)

[00:58:04]

Tacey Ann Rosolowski, PhD

[00:58:04]

Yes. So I'm turning off the recorder at 11:24. Thank you very much for your time this morning.

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[00:58:08]

Lewis Foxhall, MD

[00:58:08]

All right. Sure thing. You bet.

[00:58:09] (end of session two)

Lewis Foxhall, MD

Session 3 — March 11, 2014

Chapter 00C

Interview Identifier

[00:00:00]

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. We are recording and the counter is moving. This is Tacey Ann Rosolowski, and today is March 11th, 2014. The time is about 9:04. And I'm having my third session this morning with Dr. Foxhall, Vice President of Health Policy.

Thank you again for making time for me.

[00:00:25]

Lewis Foxhall, MD

[00:00:25]

You're welcome.

[00:00:26]

Interview Session: 03
Interview Date: March 11, 2014

Chapter 11

B: An Institutional Unit

Grant-Funded Projects in the Office of Health Policy: The Texas Cancer Data Center

Story Codes

A: Overview
B: MD Anderson History
B: MD Anderson Impact
B: MD Anderson and Government
B: Education
B: Information for Patients and the Public
B: Institutional Mission and Values
B: Beyond the Institution
A: Character, Values, Beliefs, Talents
A: Professional Values, Ethics, Purpose

Tacey Ann Rosolowski, PhD

[00:00:27]

And we just did our little strategizing and decided it would be a good idea to, this morning, focus on some of the grant-funded projects you've been working on and sort of the big themes. Let me rely on you to kind of prioritize which you feel are the most important ones, the ones that have had the most impact. So where would you like to start with that?

[00:00:51]

Lewis Foxhall, MD

[00:00:51]

Right. Well, I think one of the early projects that I assumed direction of was the Texas Cancer Data Center. This was funded originally through the Texas Cancer Council, which was the agency that preceded the Cancer Prevention Research Institute of Texas. And the project was initially intended to serve as a resource or clearinghouse for cancer-related information focused on Texas at that time. Actually, this was put together initially before I arrived, but it was very difficult at that point to collect information, even basic information, from our Cancer Registry. It had been defunded and put out of business a few years earlier, and they were just really trying to get back on their feet and had very limited—

[00:01:59]

Tacey Ann Rosolowski, PhD

[00:01:59]

Why was that?

[00:02:00]

Lewis Foxhall, MD

[00:02:00]

Why does government do anything that doesn't make sense?

Commented [T11]: In this segment, Dr. Foxhall talks about a number of key projects run by the Office of Health Policy. He first follows up on a discussion of the Texas Cancer Data Center (discussed in Segment 10), explaining difficulties in collecting information in the early days of the project and then sketching how services have evolved and been updated since the late eighties. He lists the kinds of information that the Center provides, its heavy use (around one million hits per year) and its impact. Dr. Foxhall notes that it is used as a platform for educational programs supported via CPRIT money. He also describes how the Center provides information for individuals with no insurance and education for nurses and social worker to help people get access to care. This need has been intensified since Texas made the decision not to participate in the Medicaid portion of the Affordable Care Act.

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[00:02:04]

Tacey Ann Rosolowski, PhD

[00:02:04]

(laughs) I always like the smile you give when you're like—oh, the cynicism [unclear].

[00:02:12]

Lewis Foxhall, MD

[00:02:12]

Right. Anyway, so for whatever reason, I wasn't there at the time, but for whatever reason, they decided not to fund it. But it did come back, but initially that time was really sort of the early days of the Internet, and connectivity as we now know it just didn't exist, so—

[00:02:33]

Tacey Ann Rosolowski, PhD

[00:02:33]

And this was around what year?

[00:02:34]

Lewis Foxhall, MD

[00:02:34]

This was in the late eighties, early nineties. The program was initially put together as basically a dial-up modem sort of operation where people could contact the service and get information, basic information around cancer incidence and mortality and cancer services that are provided in the state.

[00:03:00]

Tacey Ann Rosolowski, PhD

[00:03:01]

Now, when you took over leadership of this, what did you envision for this project? What did you want to achieve?

[00:03:08]

Lewis Foxhall, MD

[00:03:09]

Well, the program was clearly providing a useful service, and at that point, we thought it might be best to update the service and convert it over to an Internet-based operation, so we moved ahead with that and, with our staff, were able to provide a broader range of information and try to update the information more regularly. So we included community services and cancer-control information for people to access that was in addition to the basic information that [unclear]. So we also used it as an opportunity to provide access to the Texas Cancer Plan. Texas was one of the first states to have a cancer plan, and we were able to get that document posted and put online so it could be easily accessed.

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[00:04:18]

Tacey Ann Rosolowski, PhD

[00:04:19]

Oh, wow. Okay.

[00:04:20]

Lewis Foxhall, MD

[00:04:20]

So anyway, it worked out to be a very heavily used and long-lasting project. It continued in effect as it was through the funding through the Cancer Council, and then we shifted over to funding from CPRIT for a few years, and then eventually MD Anderson assumed the financial responsibility for operating it. So it still operates today.

[00:04:51]

Tacey Ann Rosolowski, PhD

[00:04:51]

It still operates?

[00:04:52]

Lewis Foxhall, MD

[00:04:52]

We've changed the name as part of our rebranding to Texas Cancer Information, so the last few years we've been operating in that sense.

[00:05:03]

Tacey Ann Rosolowski, PhD

[00:05:03]

Now, what would you say is the impact of this particular program?

[00:05:07]

Lewis Foxhall, MD

[00:05:09]

Well, it's information dissemination. The site is used. We get around a million hits a year, something in that neighborhood, so several thousand individual users each year. So it's information that the public is still interested in. Some of the capabilities of our Cancer Registry have improved, so people are able to get some of that information more readily through their website. But we've tried to continue to provide services in addition to make it user-friendly so people can access it and understand the information that they need.

[00:05:51]

Tacey Ann Rosolowski, PhD

[00:05:51]

I'm sorry. Do you have any plans to develop it further, I mean with different technologies, you know—

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[00:06:00]

Lewis Foxhall, MD

[00:06:02]

Not at this point. Basically, we're maintaining things as we go. We've used it as a platform for educational programming. We developed, with another super grant, we developed an educational program around access to care, so we developed a database that went county by county to give people information about how they could get government support if they were uninsured and needed cancer care, screening, those sorts of things, provided information on clinics and places that take patients who don't have insurance. And then we developed an education module for nurses and social workers to help them be aware of that information and how to use it. So it's been our latest. We've run that for the last couple of years, and we're in the process of doing an update on that. But that's been really sort of the most recent additional service that we've added. It seems to be something people are still very interested in.

[00:07:16]

Tacey Ann Rosolowski, PhD

[00:07:18]

Well, I can imagine, because I know last time we talked about the kind of ups and downs in the number of uninsured and how many uninsured there are, and it sounds as though with this additional project with helping people with access, that that's really key. Do you think that will continue to be a very important dimension of this particular project, the accessibility issue?

[00:07:43]

Lewis Foxhall, MD

[00:07:44]

Well, information on access, I think, will be. Texas has decided to not participate in the Medicaid part of the Affordable Care Act, so there's still a large number of low-income uninsured people that don't have insurance and don't have an obvious way to get insurance, at least for the time being.

[00:08:04]

Interview Session: 03
Interview Date: March 11, 2014

Chapter 12

B: An Institutional Unit **Grant-Funded Projects in the Office of Health Policy: Services for the Uninsured**

Story Codes

- A: Overview
- B: MD Anderson History
- B: MD Anderson Impact
- B: MD Anderson and Government
- B: Education
- B: Information for Patients and the Public
- B: Institutional Mission and Values
- B: Beyond the Institution

Tacey Ann Rosolowski, PhD

[00:08:15]

What's another grant-funded project?

[00:08:18]

Lewis Foxhall, MD

[00:08:18]

So that [unclear]. I think the one that we're working on right now is one that's funded through the—as a sharing program between the institution and the federal government, which is a waiver to the Medicaid program, which allows us to do a number of outreach programs targeting tobacco control and colorectal screening and breast screening. They will be adding some additional projects, hopefully in the near future. But this is a very significant source of funding. The outreach programs, these are things that we know work, things that we know reduce the risk of cancer, help find cancer early and reduce the risk of dying from cancer. But for low-income populations, there are very few ways to pay for that, so this has been a real positive opportunity for us to access additional federal funds that can enable us, along with our institutional funds, to reach out to low-income people around our immediate region and to be able to provide these sort of services to them.

[00:09:33]

Tacey Ann Rosolowski, PhD

[00:09:35]

What kinds of services and how exactly do these [unclear]?

[00:09:38]

Lewis Foxhall, MD

[00:09:38]

So there are three tobacco-related programs. One is we administer the funds and coordinate the programs that are done by our faculty members, in part, and we have a program of Dr. Prokhorov reaching out to the youth, adolescents and youth, on tobacco avoidance and tobacco cessation that he's implemented. It's a program project, ASPIRE, that he's had for some time, but he gives us an opportunity to get it out to the population that we couldn't otherwise reach.

Commented [T12]: In this segment, Dr. Foxhall describes initiatives supported by the institution and by federal money that are designed to reduce cancer risk among low-income individuals. He first talks about the tobacco program, mentioning the ASPIRE program designed to reach maximize tobacco avoidance/cessation in adolescents. Dr. Foxhall explained how the Office of Health Policy helped support this project. Next he talks about the project, Ask, Advise, Connect, a quit line service that services HIV patients. Dr. Foxhall notes that this is a good example of how the Office of Health Policy identifies a government program that can provide funding for initiatives relevant to the needs of at-risk individuals. He describes the individuals involved in organizing the funding mechanisms and notes where difficulties arise in the process. Dr. Foxhall explains that this is a slow and often frustrating process, but the benefits come when "you see that you help someone" and can track progress with use rates.

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[00:10:18]

Tacey Ann Rosolowski, PhD

[00:10:19]

So how does that piece work? I mean, he's doing the project. Then what do you add that expands the [unclear]?

[00:10:24]

Lewis Foxhall, MD

[00:10:24]

We write the checks.

[00:10:25]

Tacey Ann Rosolowski, PhD

[00:10:25]

Pardon me?

[00:10:26]

Lewis Foxhall, MD

[00:10:26]

We write the checks. We go to jail if he defaults. (Rosolowski laughs.)

So we're involved with negotiating the arrangement with the state and with the regional organizing entity and got the program up and running, and now we administer the funds. So the institution gives us initial startup funds, and then we use those and match them with federal funds, and eventually they come back to us with new dollars that we can use to help fund the program. These are pay-for-performance arrangements, so the programs have to meet certain milestones and expectations for us to receive additional payments. So it's a little different.

[00:11:18]

Tacey Ann Rosolowski, PhD

[00:11:19]

I'm try to visualize how it works. I mean, where are these projects actually implemented? In high schools, junior highs, churches?

[00:11:26]

Lewis Foxhall, MD

[00:11:26]

It's an Internet-based outreach program, so they work with all of the above, but they reach out to where students are, primarily in schools, and connect with them to help them reduce the risk of starting smoking, or if they already smoke, to help them quit. So it's an interesting approach.

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So that's one big project, and we have a couple of others, one with Dr. Jenny Madreen [phonetic], which is Ask, Advise, Connect Program, which is helping low-income clinics to connect their patients who smoke with the quit-line services through their electronic health records. Then the other one, Dr. [unclear] has a project he's working on in a clinic that serves a large population of HIV/AIDS patients to help them quit smoking. So they've got a very high smoking [unclear] in that population. So those are the tobacco projects we have—
[00:12:39]

Tacey Ann Rosolowski, PhD

[00:12:39]

Could I ask you, because you said it's performance-based, so how are the results, outcomes being tracked, and what does your office look for in terms of what's the threshold that says, "Yes, we go forward"?

[00:12:55]

Lewis Foxhall, MD

[00:12:55]

Right. Well, as we submitted the projects for review and approval, we had to say, "This is what we expect to accomplish, and we will measure it in this particular way," numbers of persons served or numbers of individuals who access the quit line, or number of individuals who are counseled, these sorts of things.

And then we also have a second segment, which will just be starting soon, which is more based on patient satisfaction, were they satisfied with the services they received, did it help them with whatever they're supposed to do to help them in these sorts of things, which will be a survey-type process. And then we have to report some general health-related measures from the institution as far as our clinical-type measures, which is a reporting requirement [unclear]. But—
[00:13:50]

Tacey Ann Rosolowski, PhD

[00:13:50]

I mean, I realize some of these questions sound kind of picky, but—

[00:13:52]

Lewis Foxhall, MD

[00:13:53]

No, no, no, it's fine.

[00:13:53]

Tacey Ann Rosolowski, PhD

[00:13:53]

—you know, it's like I don't know, and I think most people don't know what does health policy involve. (laughs)

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[00:13:57]

Lewis Foxhall, MD

[00:13:58]

You know, this is a good example of identifying a government program and this example that can provide funding for work that we know there's a need for, but through a mechanism that's not common or even, I think, at first comfortable for a lot of people today. So some of it is really just trying to kind of work through the technical details and address health-related needs through funding mechanisms that are organized through these sorts of mechanisms.

So a lot of it gets very technical and very, you know, arcane, but it's just part of dealing with the federal government and the state government. I mean, this involves the regional network director, which is through the Harris County Hospital District, and then the state health and human services department and then also through the centers for Medicaid, Medicare services federal folks. And we also coordinate with our colleagues through the UT system and meet periodically with the vice chancellor's team to be sure we're all sort of on the same page from a UT system point of view.

[00:15:31]

Tacey Ann Rosolowski, PhD

[00:15:31]

So what are the kinds of things that can get you off page? You know, where—

[00:15:35]

Lewis Foxhall, MD

[00:15:37]

People not doing what they said they were going to do. You know, we have to rely on our colleagues to provide the services that they said they were going to provide. So that's one issue. The other is just the difficulty of working in low-income settings with limited resources. You know, it's always a lot harder than you think to do these things.

[00:16:00]

Tacey Ann Rosolowski, PhD

[00:16:01]

What keeps you doing this? I mean, it sounds like really frustrating and just like climbing through a constant jungle of junk. And why do you keep doing it?

[00:16:11]

Lewis Foxhall, MD

[00:16:11]

Well, every now and then you figure out you can actually help somebody, so that's a good thing. So I think you do have to sort of take the long view and it can be frustrating, but it's clear eventually that you're making some difference and contributing to the improvements.

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[00:16:29]

Tacey Ann Rosolowski, PhD

[00:16:30]

What's an improvement that really gratified you?

[00:16:33]

Lewis Foxhall, MD

[00:16:34]

Well, you know, the mortality from cancer in this country has dropped 20 percent since I started working in this area. So it's just a coincidence, I'm sure. It had gone up every year before that. But seriously, we track and monitor screening rates, we track usage rates for tobacco, for example, and really try to get some idea that the projects and efforts, education efforts, and other interventions that we've been working on are making some difference.

[00:17:13]

Tacey Ann Rosolowski, PhD

[00:17:14]

And you find they do.

[00:17:15]

Lewis Foxhall, MD

[00:17:15]

Yeah. So, you know, things are moving in the right direction, so that's good. So it's not the same as in clinical practice where you have one patient you're working with at a time, you can see the benefits of your labors more directly, but working with populations, you've got a broader reach, but it's a longer timeline to really see results.

[00:17:40]

Tacey Ann Rosolowski, PhD

[00:17:41]

Well, that's the beauty of having very different individuals involved in the process, because everybody brings their own gift and passion and where they want to focus.

[00:17:50]

Lewis Foxhall, MD

[00:17:50]

Right. Exactly. So all that stuff is good.

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Chapter 13
B: An Institutional Unit
Grant-Funded Projects in the Office of Health Policy: Screening for Colorectal Cancer and Breast Cancer

Story Codes

- A: Overview
- B: MD Anderson History
- B: MD Anderson Impact
- B: MD Anderson and Government
- B: Education
- B: Information for Patients and the Public
- B: Institutional Mission and Values
- B: Beyond the Institution

Lewis Foxhall, MD

[00:17:50]+

The other couple projects we're working with are actually directed from our office. One is going to be for screening women for breast cancer with mobile mammography, so we've purchased a new mobile van, and we'll be able to deploy that out across the region here in the next few months. And we've started a colorectal cancer screening program which we've also just started in the rural counties all around Houston, and we'll be moving into the Harris County region this summer. So that will get us kind of plugged in there. So that's been, I think, a positive thing.

We see a lot of the partner—you know, we work with partners and clinics that actually arrange for and provide the services. We're really providing the infrastructure and paying for getting the tests done. So that's been very gratifying to see their interest, and I think that's a positive thing.
[00:18:59]

Tacey Ann Rosolowski, PhD

[00:18:59]

I'm trying to—you know, I'm putting together that statement with what you said even in our first session, where you said that it was a process of figuring out how primary care people could be involved in cancer care.

[00:19:17]

Lewis Foxhall, MD

[00:19:18]

Right.

Commented [T13]: In this segment, Dr. Foxhall talks about projects that support screening for colorectal cancer and for breast cancer (via a mobile unit). The Office of Health Policy "provides the infrastructure," identifying an opportunity and partners who can help accomplish goals that fit with MD Anderson's mission. He provides additional information about both of these screening programs.

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[00:19:18]

Tacey Ann Rosolowski, PhD

[00:19:18]

And that just seems like a really interesting shift, maybe even in MD Anderson's understanding of the role, providing infrastructure and support rather than directly providing physicians who would do the work. Is that true? I mean, am I hitting it, or was there some other change that had to take place in order for MD Anderson to begin doing this?

[00:19:42]

Lewis Foxhall, MD

[00:19:43]

Well, I mean, that's, you know, an opportunity for us, and I think that's part of the broader policy analysis is to say, "Here's the work that needs to be done. Who else can help us in this?" And to try to understand who those entities might be, whether they're clinicians in the community or they're state agencies or funding partners or others that can help us accomplish our goals. So we've got a pretty broad mission of eliminating cancer, and we do a pretty darn good job of treating patients and doing research about how to cure cancer, but there's a lot of community work that we're not necessarily all that well suited for, and finding partners and helping with our expertise and knowledge and ability to attract funding is a way to achieve those goals. Collaboration with others, that really makes a big difference.

[00:20:42]

Tacey Ann Rosolowski, PhD

[00:20:43]

Now, am I correct in assuming that this look outside the institution really began with Joseph Painter and with you coming on and kind of saying, "Okay—"?

[00:20:55]

Lewis Foxhall, MD

[00:20:55]

Dr. Painter was an advocate of that approach and that's how he got in touch with me, was reaching out to primary care physicians with educational programming and got me interested in this stuff. So it's all his fault. (Rosolowski laughs.)

And Dr. LeMaistre, who was president at the time, was very supportive of prevention interventions, and they'd been involved in the tobacco program and worked for many years and was part of the initial Surgeon General's team that really provided our first knowledge about the link with lung cancer and tobacco. So there's sort of a lineage of folks that are interested in prevention and interested in connecting with the community beyond the hallowed halls to really figure out how we can make all this stuff happen in the real world.

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[00:22:00]

Tacey Ann Rosolowski, PhD

[00:22:01]

And, you know, they had an effect not only on what MD Anderson does, but also what it looks like as an institution, in terms of organization and the complexity of it. I'm sort of getting the feel for that.

Is there more you'd like to tell me about the breast cancer and colorectal cancer screening programs? I mean, why is that suddenly possible now? Because it seems like those would be needs that had existed for a long time. What happened to make it possible to address this now?

[00:22:39]

Lewis Foxhall, MD

[00:22:39]

Well, it's federal funding. This is federal funding. Yes, there's been a need for a long time, but there's very little opportunity to get funding for these sorts of projects. So for the mammography, we really needed another van. We have one, but it's already used all the time, so we had to buy another van, which is close to a million dollars. So to do that, we have to have some sort of way to pay for it besides the institution writing a check for it. So that was very important.

And then the colon screening involves colonoscopies and some fairly expensive procedures that when people don't have insurance, they just can't pay for them, so it doesn't happen. But it's an almost totally avoidable condition if we can get people screened on a regular basis, so that's the opportunity here. There's a chance to really reach out to clinics that serve those populations and help them do what they need to do to get them screened.

[00:23:54]

Tacey Ann Rosolowski, PhD

[00:23:57]

What are the numbers you expect to use, or have you started getting the numbers at this point?

[00:24:01]

Lewis Foxhall, MD

[00:24:02]

We're just barely getting started, but we've had good results. Some of the clinics have been very, very active. They're screening at fairly high rates, almost 80, 90 percent screening. In general, most of these clinics have been screening at 25, 30 percent for eligible people, so it's a big jump. Some are having a little more challenge getting organized, getting started, but this is really just our first pass at it, and I think over time more of them will be screening at higher rates. But the financial barrier is a big one. I mean, they know what to do, they want to do it, but if your patients can't afford the test, then they can't afford the test. So there's not much you can do about that. So it's been exciting to see them get engaged, and really just helping them along a little bit has been very, very rewarding. So that's good.

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[00:25:00]

Tacey Ann Rosolowski, PhD

[00:25:00]

Yeah. I mean, that's a huge jump in numbers when you think about how that translates to the number of individuals who've had potential problems identified. Yeah, that's pretty amazing.

[00:25:12]

Lewis Foxhall, MD

[00:25:12]

Sure.

[00:25:12]

Tacey Ann Rosolowski, PhD

[00:25:13]

Wow. So the investment in this van is sort of a one-time investment, and then you expect that project to run for how long on these funds?

[00:25:26]

Lewis Foxhall, MD

[00:25:26]

Well, we have about two and a half more years of the project at this point. It's possible it might be renewed, but we don't know for sure. But we at least have that period of time to see what we can do [unclear].

[00:25:41]

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Chapter 14

B: An Institutional Unit

Grant-Funded Projects in the Office of Health Policy: Cancer Survivor Management

Story Codes

A: Overview
B: MD Anderson History
B: MD Anderson Impact
B: MD Anderson and Government
B: Education
B: Information for Patients and the Public
B: Institutional Mission and Values
B: Beyond the Institution
A: Character, Values, Beliefs, Talents
A: Professional Values, Ethics, Purpose

Tacey Ann Rosolowski, PhD

[00:25:43]

What about some of the other projects? What's sort of next on your list of things that you'd like to talk about?

[00:25:52]

Lewis Foxhall, MD

[00:25:53]

Well, keeping these things going does take a lot of time and effort, so we're concentrating on that. We're working on a grant for a new project for cancer survivor management, so we're going to be applying for funds to increase cancer survivor services and primary care residency training program clinics. So we're focusing on family medicine, and there are several clinics around the state that are interested in working with us to see what we can do together to help increase the services that are provided for people who've been treated and completed their treatment for cancer. So that'll be an interesting, if they fund us.

[00:26:46]

Tacey Ann Rosolowski, PhD

[00:26:47]

(laughs) Now, as you're working on this, are you just working on the mechanisms of getting money, and then someone else will develop the curriculum, or is MD Anderson kind of

[unclear]?

[00:26:58]

Lewis Foxhall, MD

[00:26:58]

Yeah, we'll do the whole thing.

Commented [T14]: In this segment, Dr. Foxhall talks about a grant that the Office is now preparing for Cancer Survivor Management—a training program that will be instituted in clinical around the state. Dr. Foxhall explains that his “love in life is education,” and that such projects are very significant for him. He explains the elements of the training program: identify survivors; create care plans to maximize the effectiveness of aftercare following MD Anderson guidelines; follow up with providers to help them adhere to best practices; monitor patients receiving services. He discusses a tele-mentoring system that will be used to provide support for health care personnel.

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[00:27:00]

Tacey Ann Rosolowski, PhD

[00:27:00]

You'll do the whole thing.

[00:27:00]

Lewis Foxhall, MD

[00:27:01]

Yeah, that'll be our project.

[00:27:02]

Tacey Ann Rosolowski, PhD

[00:27:02]

So what is that going to look like? I mean, what is the educational product that you're going to be providing?

[00:27:09]

Lewis Foxhall, MD

[00:27:09]

So this is targeting services, so my real joy in life is doing education, so I'm having to approach it within that framework. But the goal is to increase services for cancer survivors. There have been a number of studies that show survivors don't receive all the recommended care that they should, and they tend to fall through the cracks and don't always get the proper follow-up or preventive services that have been shown to be helpful for them.

So what we're going to do is go into these practices, and we know many cancer survivors are in primary care practices, they continue to see their primary care doctor, although they may not be known as cancer survivors or followed specifically for that, so we'll identify them, develop care plans, work with their treating oncologist, whether that's us or someone else, to find out exactly what treatments they had and what potential complications they might be facing down the road, and then use guidelines that have been developed through MD Anderson to provide care for surveillance and prevention and dealing with psychosocial issues and complications of treatment.

So we'll do this through their faculty and, more importantly, through their trainees, so they have clinics that they operate as part of their education, so we'll help them learn the best approaches to follow-up for cancers patients. So we have an online education program we developed through our previous super grant which will put them through, and we will provide additional education opportunities for them, depending on what other areas they feel are important. And then we'll track and monitor how the patients do over time as far as whether they're getting the services we think they ought to be getting to see how it's working.

So we're going to provide additionally some support through a telementoring program. This is an Internet-based web conferencing approach that's been shown to be helpful for [unclear] experts here in the Cancer Center what the practice is, do case presentations, brief educational

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interventions as we go along to help be sure they're comfortable and have everything they need to take care of the patients.

[00:29:57]

Tacey Ann Rosolowski, PhD

[00:29:59]

Now, you said your great love is education. You hadn't said that before. (laughs)

[00:30:07]

Lewis Foxhall, MD

[00:30:07]

Oh, no?

[00:30:08]

Tacey Ann Rosolowski, PhD

[00:30:08]

No. So tell me about that. How did that start and what's that about?

[00:30:11]

Lewis Foxhall, MD

[00:30:11]

Well, I've always enjoyed education. So I've been involved in providing or supporting our education program for community physicians through our Faculty Speakers Bureau, coordinating that, getting our faculty members out and doing presentations myself. I enjoy doing education programs and have done those pretty regularly over the years. I've been involved most recently with our Cancer Survivorship Program in coordinating the educational offerings that we have in that area, so that involved getting that super grant and putting together, with Dr. Kinderwoods [phonetic] and others in Dr. Butler's [phonetic] area, the education materials. Then we did the program I mentioned on access to care. That was another education program for a different audience. And we're putting together a textbook on cancer survivorship management, working with Dr. Rodriguez and [unclear] that's off at the publisher's right now.

[00:31:25]

Tacey Ann Rosolowski, PhD

[00:31:26]

Wow, that's exciting.

[00:31:27]

Lewis Foxhall, MD

[00:31:27]

So I'm looking forward to getting that done. So those sorts of things are fun. I mean, it's an enjoyable sort of thing.

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[00:31:35]

Tacey Ann Rosolowski, PhD

[00:31:35]

When will the cancer survivorship manual come out?

[00:31:38]

Lewis Foxhall, MD

[00:31:39]

Sometime this summer, they say. We'll see.

[00:31:42]

Tacey Ann Rosolowski, PhD

[00:31:42]

Wow, that's exciting.

[00:31:43]

Lewis Foxhall, MD

[00:31:44]

Yeah. So we're looking forward to getting that out [unclear].

[00:31:47]

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Chapter 15
B: An Institutional Unit
Educational Projects with Physicians and Medical Students

Story Codes

A: The Administrator
B: MD Anderson Impact
B: Information for Patients and the Public
B: Education
B: Institutional Mission and Values
B: Beyond the Institution
A: Overview

Tacey Ann Rosolowski, PhD

[00:31:49]

Now, education is certainly one of the cornerstone mission areas for MD Anderson. What would say the real impact of education is and can be for working against cancer?

[00:32:04]

Lewis Foxhall, MD

[00:32:05]

Well, you know, from my point of view, it's this idea of trying to help support the community physicians we work with in being able to provide the prevention, screening, early detection sort of interventions that we've been promoting. So it's fine for us to just say, you know, "Go out and do that," but giving them the knowledge and building their self-efficacy, their confidence, and being able to deliver those has been an important thing, I think, for us to do. I mean, it's really [unclear]. We have experts here, you know, people that are knowledgeable in the area, and get them in front of the community physicians, whether they're primary care or oncologists or others that can benefit from the knowledge that we have.

So we create knowledge through research, but we also need to disseminate that knowledge and help improve practice across the board so everybody can benefit from these sorts of new findings and new information that we have, or just helping a new crop of physicians understand what we know and what they can do that works. So a lot of that's just part and parcel of what we do.

[00:33:25]

Tacey Ann Rosolowski, PhD

[00:33:26]

Well, it also sounds, too, like you are, you know, making a change in the culture of education in the physicians, getting physicians that may have never thought about survivorship or putting that on the list of what they need to think about with a patient. I mean, that's changing their mindset, how to deal with this person sitting in front of me in the examination room. And that's huge.

Commented [T15]: In this segment, Dr. Foxhall talks about the importance of educational outreach to the mission of the institution. He lists the impact that educational initiatives have: support for community physicians; building self-efficiency and confidence; creating and disseminating knowledge to a new crop of physicians; changing physician behavior. The main challenge, he notes, is communicating effectively with community physicians so they successfully change their behavior.

Next Dr. Foxhall describes the Preceptorship program initiated in the eighties at the UT Medical School in Houston. The challenge, he explains, was (and is) that "we need more primary care physicians" and medical students need to know that family medicine can be a viable career path. Dr. Foxhall explains that the Preceptorship enables medical students to spend a month with a family physician. He talks about the importance of targeting students early. He notes that in a national ranking of states and the availability of primary care physicians, Texas ranks #42. The grant supporting the Preceptorship was renewed several times and the program has been successful at convincing medical students to enter family medicine. Recently funding was cut and then transferred to the Texas Council of Family Physicians.

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[00:33:53]

Lewis Foxhall, MD

[00:33:54]

It takes that, and to change physician behavior as far as how they work with patients is a challenge at times and often goes beyond just the knowledge base. So that's part of this grant is about how do they change their practice and what sort of system changes do they need to implement for making sure this works, and how do we foster communication across the specialties between primary care and oncologists, to be sure everybody understands who's responsible for what and the patient doesn't fall through the cracks anymore.

So all that's been written about, and the Institute of Medicine has recommended that all these things happen. It's just they're not happening, so this is an opportunity for us to really try to say how and what do we need to do to really make those connections and make those changes in practice so, (a), physicians are aware of the needs of survivors that are different from the usual population, and, (b), what do we need to do within the local practices to make that happen. By doing it through an education training program, then hopefully we'll be able to share that information with people that are going through training, so when they go out and set up their practices or join another practice, they can carry that with them and disseminate it further. So that's sort of the vague idea of what [unclear]. But anyway, you know, it's a dissemination attempt to both improve knowledge, change behavior, and change practice that really takes all those things to do something different at the end of the day so that the patients can benefit.

[00:35:47]

Tacey Ann Rosolowski, PhD

[00:35:48]

Absolutely, absolutely. I notice that there was some—oh, I was just looking at my notes about some other themes that were coming up in these projects, and there was preceptorships. And I wasn't sure if what you were just describing is part of that or the preceptorships were part of it.

[00:36:14]

Lewis Foxhall, MD

[00:36:14]

Well, that was an initiative I started working on when I was first at the University of Texas Medical School here in town and began working with the then director of that program, which was also initiated back in the eighties. There was this idea that then, like now, we need more primary care physicians and that students of medicine are much more likely to pursue a career in family medicine if they have some idea of what family medicine is like in the community. So unlike other subspecialty fields, there's often not a good representation of family medicine within the medical school environment, and especially in an urban center like Houston.

[00:37:18]

Tacey Ann Rosolowski, PhD

[00:37:18]

Meaning that there's more focus placed on or pressure placed on choosing a more focused specialty?

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[00:37:26]

Lewis Foxhall, MD

[00:37:27]

Well, it's just the role models are not there.

[00:37:29]

Tacey Ann Rosolowski, PhD

[00:37:29]

Oh, okay, gotcha.

[00:37:30]

Lewis Foxhall, MD

[00:37:30]

So it's an outpatient specialty, they're not in the hospital, so the chances of actually encountering a family physician during medical school tenure, especially early when you're trying to figure out what to do, is limited. So this provided an opportunity for students who have some interest to go and spend a month with a family physician, and we have physicians all around the state who work with us as volunteers to host students during their summer breaks so that they could go out after their first year and have an opportunity to see what clinical practice is like. They're mostly in the classroom their first year.

[00:38:11]

Tacey Ann Rosolowski, PhD

[00:38:12]

Am I remembering correctly that you did that? (laughs)

[00:38:13]

Lewis Foxhall, MD

[00:38:15]

I did. I did. So I spent some time with a physician in my hometown.

[00:38:20]

Tacey Ann Rosolowski, PhD

[00:38:20]

Yeah, [unclear].

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[00:38:22]

Lewis Foxhall, MD

[00:38:22]

Yeah. So it was a little different, but it was the same basic idea. But, yeah, so this idea that, you know, well, it really would help if you're just not sure what you want to do or you think that's what you want to do but you're not totally sure, then that gives you a chance to really get out and see what it's like, and especially if we target it early, then for those students who have at least some interest in primary care, that they can see how it really works in the community, that it is a valuable and much appreciated service, and it's a rewarding career that they may not realize just from what happens in a tertiary care hospital setting.

[00:39:09]

Tacey Ann Rosolowski, PhD

[00:39:11]

What are the shortages of primary—I mean, what do the statistics look like for shortages of primary care physicians?

[00:39:16]

Lewis Foxhall, MD

[00:39:16]

Well, it's still bad. I mean, I think we're forty-second or something in the nation as far as primary care physician supply.

[00:39:22]

Tacey Ann Rosolowski, PhD

[00:39:22]

Really? And what does that mean in terms of doctors to—

[00:39:26]

Lewis Foxhall, MD

[00:39:27]

I don't remember the exact numbers, but it's not enough to go around. So the challenge is one that is national. I mean, our ranking's bad, but it's not good anywhere, so [unclear].

[00:39:44]

Tacey Ann Rosolowski, PhD

[00:39:44]

And you said Texas is forty-second in the nation in terms of shortages. Yikes.

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[00:39:48]

Lewis Foxhall, MD

[00:39:48]

Mm-hmm, mm-hmm, yeah. So we have, I think, compared internationally, comparisons also are not good with countries that have a lot higher rates of primary care service, have good quality care but lower costs and things like that. So there are lots of reasons to do it, but it's an opportunity to try to help students at least level the playing field a little bit for students who are trying to figure out what to do with their careers and can understand better what they want to do in life.

[00:40:27]

Tacey Ann Rosolowski, PhD

[00:40:27]

So this preceptorship program—because I notice it appears several times in the course of the years—

[00:40:33]

Lewis Foxhall, MD

[00:40:33]

Yeah, this is a grant that got renewed and renewed and renewed.

[00:40:35]

Tacey Ann Rosolowski, PhD

[00:40:35]

Yeah. So what kind of impact have you seen it having?

[00:40:37]

Lewis Foxhall, MD

[00:40:38]

Well, we actually did an analysis that it showed that students who participated had significantly higher rates of adoption of family medicine careers. So tracking students through training and then eventually into their careers, we were able to demonstrate that beyond the idea that it has some face validity but we were able to demonstrate the positive impact of it.

[00:41:06]

Tacey Ann Rosolowski, PhD

[00:41:06]

I don't know why I want to ask this question, but I kind of have to ask it. Do you find that more women than men go into the field of family medicine?

[00:41:12]

Lewis Foxhall, MD

[00:41:13]

It's about half and half now.

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[00:41:14]

Tacey Ann Rosolowski, PhD

[00:41:14]

Oh, it is? Interesting.

[00:41:15]

Lewis Foxhall, MD

[00:41:15]

Yeah. That's just, you know, a reflection of the general trend in medical education, that there is a growing proportion of women over time. So, yeah.

[00:41:28]

Tacey Ann Rosolowski, PhD

[00:41:29]

How interesting.

[00:41:29]

Lewis Foxhall, MD

[00:41:30]

So that program continued for a number of years and was administered through our Education Coordinating Board and continued to do well until the funding was cut a couple sessions ago. So, anyway, so we transferred it over to the Texas Academy of Family Physicians. So the state funding was to help provide some stipends for the students to help cover their expenses and things of that sort, but that's not available anymore. But still students do it just because they want to go do it, but we administer it through the Academy at this point.

[00:42:14]

Tacey Ann Rosolowski, PhD

[00:42:15]

So what's your take on why the funding was cut?

[00:42:17]

Lewis Foxhall, MD

[00:42:21]

The funding was cut [unclear].

[00:42:23]

Tacey Ann Rosolowski, PhD

[00:42:23]

The funding, who knows? Yeah. (laughs) The gods, the planets misaligned.

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[00:42:25]

Lewis Foxhall, MD

[00:42:26]

It's a tiny little bit of money in the overall budget, but whatever. This was back a couple sessions ago when there was a major budget crisis, so they were just cutting everything.

[00:42:36]

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Chapter 16
B: An Institutional Unit
Projects in Cancer Prevention; the Lung Cancer Moonshot; CYCORE

Story Codes

A: The Administrator
B: MD Anderson Impact
B: Information for Patients and the Public
B: Education
B: Institutional Mission and Values
B: Beyond the Institution
A: Overview
D: Technology and R&D

Tacey Ann Rosolowski, PhD

[00:42:37]

What are some of the other projects? I notice that you had a couple of grants for study of selenium and vitamins. It was just only a couple, but—

[00:42:51]

Lewis Foxhall, MD

[00:42:52]

I helped out with a couple of projects that were run through the Cancer Prevention Center, so I helped support recruitment for those projects. Dr. Cook [phonetic] was the one that was working on that. So, anyway, just kind of pitching in to help out.

[00:43:15]

Tacey Ann Rosolowski, PhD

[00:43:16]

Mm-hmm, mm-hmm. Just scanning here. Have we covered this? Is this good? Is there something—

[00:43:26]

Lewis Foxhall, MD

[00:43:27]

Those are the biggies. I mean, you know. I tried to help with other projects over the years that Dr. Beavers and her Star [phonetic] program, she had a role in that, and then the national [unclear] screening trial, trying to help recruit patients for that. And right now I'm helping with Dr. Hanash [phonetic] and the Moon Shot lung cancer screening trial, so trying to get the hospital district and the community clinics involved in recruiting patients for that and taking care of patients that don't have any insurance if they having something wrong with their scans. So that's an interesting new angle.

Commented [T16]: In this segment, Dr. Foxhall talks a cancer prevention programs and the place of the lung cancer screening trial in the Lung Cancer Moon Shot. He then talks about CYCORE, a program that uses electronic devices to address patient needs and treatments. This project was funded by stimulus money and uses a tele-monitoring device created by Time Warner. He describes some of the benefits and also mentions the video conferencing systems that can support patients. Dr. Foxhall notes that the Office tries to keep up with the latest electronic advances that can help patients.

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[00:44:16]

Tacey Ann Rosolowski, PhD

[00:44:17]

The Moon Shots have a very different financial organization and structure. What's your view of that? How is that different to work with that kind of structure? Maybe talk about what it is first.

[00:44:35]

Lewis Foxhall, MD

[00:44:36]

Well, it's primarily philanthropic support, so the institution's identifying philanthropic dollars that they can channel into the Moon Shot Program. So they're supporting these research initiatives. They also get some support for our cancer prevention and control platform that we're using to help address tobacco and the skin cancers and potentially a risk of breast and ovarian cancer [unclear]. So we put that together with Dr. Hawk [phonetic] and Dr. Moreno [phonetic], are kind of the lead players in that. That was kind of an outgrowth of our cancer control initiative that we started a number of years ago. So we have the opportunity to really kind of use those cancer control sort of interventions to help facilitate the success of the Moon Shot Program. So while they're trying to figure out how to cure things, we're trying to help do what we know works to reduce the impact on those cancers.

[00:45:48]

Tacey Ann Rosolowski, PhD

[00:45:49]

Interesting. There was one item here I just didn't understand at all. (laughter)

[00:45:54]

Lewis Foxhall, MD

[00:45:55]

Yeah?

[00:45:57]

Tacey Ann Rosolowski, PhD

[00:45:57]

CYCORE, Cyber Infrastructure for Comparative Effectiveness Research.

[00:46:03]

Lewis Foxhall, MD

[00:46:03]

Yeah. So this was a program that was funded through some of the stimulus monies that came after the financial crisis. They had this financial stimulus package.

[00:46:16]

Tacey Ann Rosolowski, PhD

[00:46:17]

I didn't know that.

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[00:46:17]

Lewis Foxhall, MD

[00:46:18]

Some of that went to research. So this was trying to look at how we could better utilize the technology in patient care, so that might be monitoring for physical activity or helping address patient needs through Internet-based interactions. So they had that.

Actually, I was just—the email I was working on was with some of the folks from Time Warner who have a new home-based telemedicine gadget that they're trying to promote, so our CYCORE people are interested in how they might use that.

[00:47:10]

Tacey Ann Rosolowski, PhD

[00:47:11]

Could you give me an example of some of these kinds of things that are being [unclear]?

[00:47:15]

Lewis Foxhall, MD

[00:47:16]

These are like, you know, trying to increase physical activity in cancer patients or cancer survivors potentially to see if that helps improve their situation. So you can monitor that remotely with these little accelerometers that people wear around, and they feed data into a modem and they can analyze how much people are walking.

[00:47:41]

Tacey Ann Rosolowski, PhD

[00:47:41]

So this is sort of like a GPS kind of thing that you—

[00:47:43]

Lewis Foxhall, MD

[00:47:44]

Well, it's not really where they're walking, it's just how much they're walking and how much activity they have. And then, you know, you can do—there's little scales and other gadgets you can use that will kind of remotely report to you about various physical attributes of a patient. So, yeah, that's interesting.

[00:48:03]

Tacey Ann Rosolowski, PhD

[00:48:04]

Yeah, yeah. I'm just—what are patients' reactions to that? I mean, does it feel like surveillance? Are they glad about it?

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[00:48:11]

Lewis Foxhall, MD

[00:48:12]

I don't know. I mean, it's like these little Fit Bit [phonetic] things that people wear around. It's very similar to that. You know, you're sharing it with your clinical team. It's not like you're broadcasting it out on Facebook or—

[00:48:26]

Tacey Ann Rosolowski, PhD

[00:48:26]

Right. Putting it on Facebook. "I've been a real slug today." (laughs)

[00:48:29]

Lewis Foxhall, MD

[00:48:29]

Ten thousand steps [unclear]. So it's a way to just kind of keep track of what people are doing. They did a lot of studies that try to intervene with people getting exercise more or whatever, that people's self-reports tend to be somewhat less than accurate, so having a way to really kind of objectively measure those sorts of things is helpful in trying to figure out if this is really useful or not, or if the people are adhering to the program or not, report—everybody wants to tell the clinician they're doing what they're doing, but sometimes it's not quite exactly right. So, just another way to kind of get information about what's really going on with a person.

[00:49:25]

Tacey Ann Rosolowski, PhD

[00:49:25]

So it's, again, simultaneously you're doing something to help, you know, effect patient behavior or care in a certain way, but also collecting information too.

[00:49:35]

Lewis Foxhall, MD

[00:49:35]

Right, right, right. So there's [unclear] studies, and this gadgetry has a little camera, you know, you stick it next to your TV, and you can do two-way videoconferencing with an individual. So that might be helpful in, like, smoking cessation counseling or things like that, or monitoring patients after surgery, things of this sort. So there may be some applications for it. But the technology is gradually improving and getting a little less expensive over time, so it's something that I think we'll probably do more of down the road.

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[00:50:11]

Tacey Ann Rosolowski, PhD

[00:50:12]

It's interesting, I do a chat room, and it really is kind of incredible how much interaction you can feel in those environments. And, in fact, in one of these chat rooms, there was a woman who is a cancer survivor, and she was talking about how she had a bone sarcoma a number of years ago. She was quite young; she was nineteen when she had it. And she has to have very regular screenings, and she says she feels like she lives her life in three-month increments. And I said, "Can you check out and see if there are some survivorship support things in your Cancer Center?" And I don't know what happened with that. She kind of came and went. But I can really see that something like that videoconferencing or even an online where someone could go on and, you know, talk to a peer group about these kinds of issues being enormously helpful, enormously helpful. Yeah.

[00:51:07]

Lewis Foxhall, MD

[00:51:07]

So we'll see, but anyway, that's some kind of interesting technology just kind of coming up.

[00:51:11]

Tacey Ann Rosolowski, PhD

[00:51:12]

Yeah. So how do you keep track of all that? I mean, what's—you know, obviously you've always got feelers out, you know, like what's new, what's possible, how do we leverage this, to make what MD Anderson does better.

[00:51:26]

Lewis Foxhall, MD

[00:51:26]

Right, sure.

[00:51:26]

Tacey Ann Rosolowski, PhD

[00:51:26]

So what's that process like?

[00:51:28]

Lewis Foxhall, MD

[00:51:28]

Well, I mean, there's just, you know, the usual reading of journals and other publications and staying up on Internet news services, and participate in a number of groups that also try to acquire information and share [unclear] so the medical society or the health department or the cancer society, all those groups are kind of doing the same thing and feeding information to us to kind of help us stay abreast of what's happening and what the new opportunities are. So, yeah, that's kind of the fun part.

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[00:52:06]

Tacey Ann Rosolowski, PhD

[00:52:06]

Yeah, sounds like it.

[00:52:06]

Lewis Foxhall, MD

[00:52:07]

Seeing what's popping up, what might fit, what might be useful.

[00:52:11]

Tacey Ann Rosolowski, PhD

[00:52:11]

Yeah. And kind of creative too.

[00:52:13]

Lewis Foxhall, MD

[00:52:13]

Sure.

[00:52:13]

Tacey Ann Rosolowski, PhD

[00:52:13]

Like think outside the box here. Yeah.

[00:52:15]

Lewis Foxhall, MD

[00:52:15]

Mm-hmm, exactly.

[00:52:15]

Tacey Ann Rosolowski, PhD

[00:52:16]

Very fun. Very fun. Anything else from this section, grants and projects that you've worked on you want to share?

[00:52:25]

Lewis Foxhall, MD

[00:52:25]

No, I think those are sort of the highlights, and I think we're just hopefully going to see a lot more impact from these waiver projects that we have going on right now. So that's really kind of the exciting thing, is to see how they all work out. So it'll either be really great or a lot of people will be really irritated. (laughter) See what happens.

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[00:52:52]

Tacey Ann Rosolowski, PhD

[00:52:57]

Well, shall we leave it here for today since it's almost ten?

[00:53:00]

Lewis Foxhall, MD

[00:53:01]

Yeah, that's probably good.

[00:53:02]

Tacey Ann Rosolowski, PhD

[00:53:02]

Good stopping place. And then I can talk to Robbie [phonetic] about another time.

[00:53:06]

Lewis Foxhall, MD

[00:53:06]

[unclear] the next time, sure.

[00:53:07]

Tacey Ann Rosolowski, PhD

[00:53:08]

Thank you very much for your time this morning.

[00:53:09]

Lewis Foxhall, MD

[00:53:09]

Oh, you bet. Thanks.

[00:53:10]

Tacey Ann Rosolowski, PhD

[00:53:10]

This has been really interesting.

[00:53:10]

Lewis Foxhall, MD

[00:53:10]

All right. Very good.

[00:53:11]

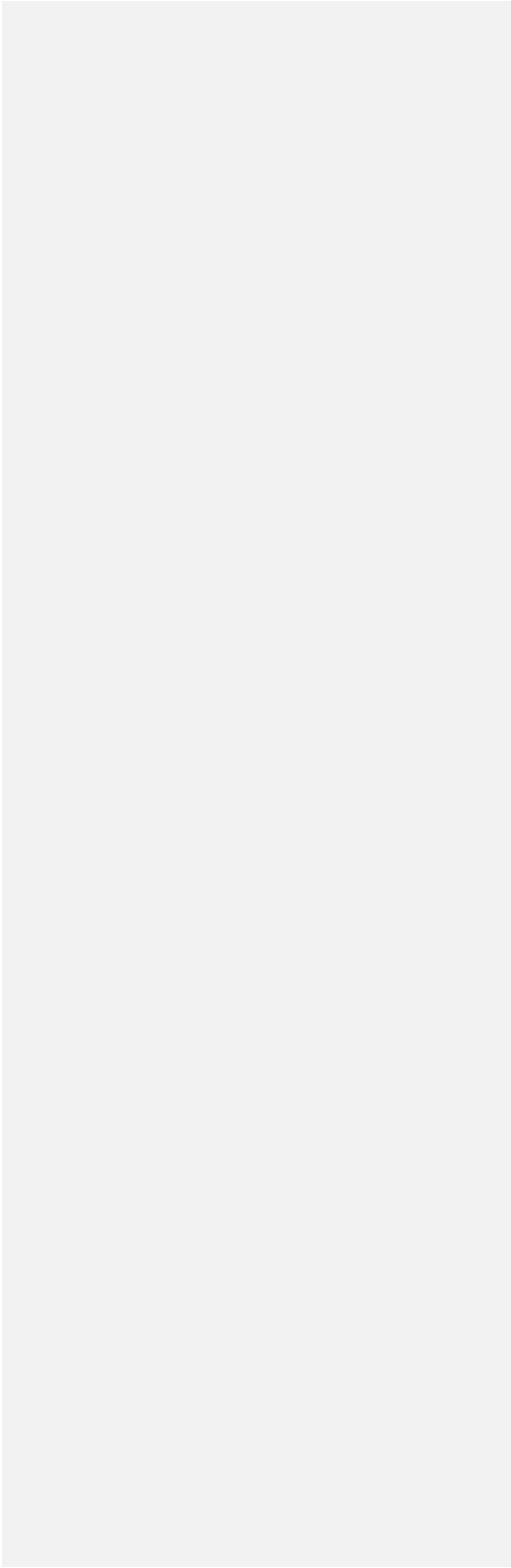
Tacey Ann Rosolowski, PhD

[00:53:11]

And I'm turning off the recorder at—boy, I'm glitching out on time here—9:56. (laughs)

Thanks.

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[00:53:22] (end of session three)



Lewis Foxhall, M.D.

Session 4 — April 9, 2014

Chapter 00D

Interview Identifier

[00:00:00]

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. Okay. Today is April 9th, 2014, and my name is Tacey Ann Rosolowski. And I am on the nineteenth floor of Pickens Tower today, interviewing Dr. Foxhall. This is our fourth session together.

Thank you very much again for making the time—

[00:00:25]

Lewis Foxhall, MD

[00:00:25]

Sure.

[00:00:25]

Tacey Ann Rosolowski, PhD

[00:00:25]

—Vice President of Health Policy. And the time is about 12:58.

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Chapter 17

B: Institutional Change

A Major Challenge: Serving the Uninsured as Health Care Changes

Story Codes

A: Overview

A: Definitions, Explanations, Translations

B: Growth and/or Change

B: Controversy

B: Institutional Mission and Values

B: Beyond the Institution

B: MD Anderson in the Future

Tacey Ann Rosolowski, PhD

[00:00:25]+

And we've covered a lot of ground in three sessions. We really have. But I wanted to give you the opportunity, because last time we talked a lot about your role as vice president for health policy, and I wanted to find out what do you feel right now are some of the most pressing issues to address. We've talked about a whole variety of roles that you serve under the umbrella of health policy, but what's really, really important and pressing for the institution and perhaps also for Texas?

[00:01:10]

Lewis Foxhall, MD

[00:01:12]

The institution really is challenged in the area of access to care. This is not unique for MD Anderson or any large health center, but we continue to struggle in this country, and particularly in this state, to provide access to certain segments of the population, in particular those who lack healthcare insurance, who are low-income and can't otherwise afford the wonderful care that we have here. So we have wonderful opportunities in treatment and prevention and participation in research trials that are provided through the institution, but not everyone can access it. So Texas is still the leader in the nation in the proportion of uninsured people, and that's a problem, so we continue to work to find opportunities to collaborate with our elected officials and with other components of the healthcare system to try to address that problem.

So we're just beginning to see the initial effects of the Affordable Care Act, and it's not totally clear how that's going to impact things, but at least the early signals indicate that there may be some at least modest decline in the number of uninsured. So we're hopeful for that. So it's still a very politicized issue, and regardless of your political persuasion, it's clearly important for us to get more opportunities for people to get the kind of care they need if they have cancer and apply those things that we know work out in the community to help reduce the incidence of cancer. So I'd say that's really still our biggest challenge right now.

Commented [T17]: In this segment, Dr. Foxhall explains that the most immediate challenge that MD Anderson (and the nation) must face is expanding access to care. He notes that there are many opportunities for excellent care, prevention services, and clinical trials, but not everyone can get access. Texas ranks number one in numbers of uninsured individuals. Dr. Foxhall notes that there are early signals that the Affordable Care Act is reducing those numbers, but this is a very polarized issue, complicated by the decision Texas made not to participate in the Act. The Office of Health Policy, Dr. Foxhall explains, works with colleagues in Harris County and LBJ Hospital to provide access.

Next Dr. Foxhall talks about his role as a governor-appointed member of the Texas State Health Services Advisory Council (2009 – present). He describes the broad scope of the Council's services and what the Advisory group does. He gives an example of the Council's role in setting up tobacco control initiatives and breast and cervical cancer screening services. He comments on the perspective he has gained from service and the value of learning about approaches to chronic disease.

Dr. Foxhall next explains that the main challenge MD Anderson will face is the transition from a fee for service system to a value-based care system. [CLIP A: Overview, A: Definitions, Explanations, Translations Dr. Foxhall defines value-based care, founded on careful documentation of care provided and outcomes. He explains the related concept of "the triple aim": to improve quality of care, to reduce cost, to increase levels of patient satisfaction, noting that some policy makers include a fourth aim, insuring equal access to care.] He explains why the status quo cannot continue.

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[00:03:18]

Tacey Ann Rosolowski, PhD

[00:03:19]

And what would you like to see undertaken in the near future to help move ahead with that or with other issues that you find very pressing? I mean things that you're not already doing.

[00:03:32]

Lewis Foxhall, MD

[00:03:33]

Sure. Well, I think everyone's doing everything they can. It's a big problem and it's going to take a lot of work to find a solution, but we have been hopeful that the changes with the Affordable Care Act could lead the way, and it's just not clear right now if that's going to happen here in Texas, because a large component of it has not been adopted with the use of the Medicaid program to provide care to more very-low-income individuals.

So it's still going to be a challenge, and we'll continue to work with all of our partners and colleagues in the community and other [unclear] providers to do everything we can to be sure people are taken care of. So we'll continue to work very closely with our colleagues and through the Harris County Hospital District and partner with the LBJ Hospital to care for people here in the immediate region and to provide access to low-income Texas residents to facilities through our Patient Assistance Program.

[00:04:55]

Tacey Ann Rosolowski, PhD

[00:04:58]

Now maybe is the time to ask you about your role on the Texas Department of State Health Services Advisory Council, because I imagine that through that you really have a detailed look at what the situation is. When did you start in that role?

[00:05:13]

Lewis Foxhall, MD

[00:05:14]

So it's been about eight years now, I believe, I've been working with that agency and was appointed by the governor to serve on the council. This is the agency that includes what was formerly the state health department and also includes some of the agency functions that oversee behavioral health services for the state. So it has been a very interesting area to work in. That agency is a very large agency that addresses the public health needs of the state in terms of traditional public health surveillance, and that incorporates our Texas Cancer Registry as well as a number of programmatic areas that help to address public health risks, including problems such as tobacco and nutrition and physical activity across the state, and also includes work in the area of preparedness in emergency response that we certainly saw used during our major hurricane events here in the state.

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So it's a very broad, wide-ranging agency, and our group is an advisory group. We get presentations on a regular basis related to any new rules or changes in procedures that the agency is considering, and provide input and take input from the public and then move those issues along to the Health and Human Services Commission, which has ultimate review authority in the state.

[00:07:21]

Tacey Ann Rosolowski, PhD

[00:07:21]

Can you give me an example of a particularly intriguing or significant policy that you worked on through that committee?

[00:07:29]

Lewis Foxhall, MD

[00:07:30]

Well, there are a number of important areas, so this includes policies related to tobacco control, which is an area I'm very interested in, and the agency receives funding for that program. So we get input on the strategic plan about how they intend to use the funding that they get and work with them as they develop their legislative appropriation requests when the legislature comes into session to see how much they're going to ask for to fund the work that the agency does in that area.

They also support programs on breast and cervical cancer screening, on nutrition and physical activity that are important risk factors related to cancer. So those areas are very interesting. It's a very wide-ranging field of policies that they consider, so all the way from rabies control to emergency center operations and things like that.

[00:08:41]

Tacey Ann Rosolowski, PhD

[00:08:42]

Have you learned anything unexpected from serving on that committee? Because I think you've been on it since 2009?

[00:08:48]

Lewis Foxhall, MD

[00:08:49]

Yeah.

[00:08:49]

Tacey Ann Rosolowski, PhD

[00:08:49]

Yeah. I mean, how has that broadened your perspective?

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[00:08:52]

Lewis Foxhall, MD

[00:08:53]

Well, it's a good overview of the public health initiatives that the state's engaged in. So to that extent, my focus has been primarily in the cancer arena, so it's good to learn about the initiatives that are ongoing related to control of other big public health issues. And chronic diseases in the state have become more and more of a challenge, so things like cardiovascular disease and diabetes and other issues that are somewhat related to our cancer issues but a little different are interesting to hear about. So those are good. Other areas are childhood immunizations and things of that sort that they help work on. So it's a very broad set of responsibilities that are required.

The responses to these big challenges such as Hurricane Ike and Hurricanes Katrina and Rita that occurred were also very interesting areas that I'd not been involved in over the years, but they gave us input on how to get ready for those sorts of things and then how the response went when they had to deal with those sorts of occurrences. So, interesting stuff.

[00:10:21]

Tacey Ann Rosolowski, PhD

[00:10:22]

Yeah, very interesting. Was there anything that you felt you learned that you could bring back to your work on health policy that's focused on cancer? I'm just curious about those lateral moves.

[00:10:35]

Lewis Foxhall, MD

[00:10:35]

Yeah, well, cross-platform issues, I think, is really more the general approach to the administration of public health-related laws. I think that's interesting. So the agency is really charged with implementing legislation that is passed by our elected officials during the legislative sessions, so they don't necessarily come up independently with their own agenda, but they tend to interpret the laws that are provided to them by the legislature and try to apply them to get the most effect for the citizens here in the Lone Star State. So that's kind of the way it works, but, anyway, it's an interesting process.

[00:11:33]

Tacey Ann Rosolowski, PhD

[00:11:33]

Kind of back to more general issues but more related to cancer, are there particular challenges that you see coming with changes in healthcare, anything that you feel this office is preparing itself for?

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[00:11:52]

Lewis Foxhall, MD

[00:11:53]

Well, a number of the issues are things that are really extensions of the challenges that we see now, so in trying to think ahead to how we can best provide treatment and preventive services, a lot of the issues revolve around funding, and this is an evolving process right now. So as the payment system is slowly being changed from the traditional fee-for-service arrangement where clinicians and institutions like ours are paid for doing things, no matter how many things we do, to one in which it's based on value, quality of care, and outcomes of care is a big change, and trying to understand how to best position the institution and our clinicians to deal with that is a big challenge. But that whole area is going to change and it has to change, and we're just trying to best understand how we can connect with these new sorts of payment arrangements and different ways to manage the cost of not only care, but also provision of preventive services is a big challenge.

[00:13:23]

Tacey Ann Rosolowski, PhD

[00:13:24]

Are there some specific solutions within that arena that you're beginning to think about now?

[00:13:30]

Lewis Foxhall, MD

[00:13:30]

Got it all figured out.

[00:13:31]

Tacey Ann Rosolowski, PhD

[00:13:31]

You got it all figured out. Well, share. (laughter)

[00:13:33]

Lewis Foxhall, MD

[00:13:36]

There are many possibilities. I think we're trying to look at different approaches, and other people in the institution, of course, are really heavily involved in this as well. So, trying to think through what value-based care means and how we can apply it, what we can do here in the institution to help reduce the cost of the care that we provide, while maintaining or even improving quality in patient satisfaction are very complex and challenging issues.

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So we have a very large and complicated delivery process here that's not all that easy to really change the way we do things, and it's not exactly clear when we should make a change either. There's still, you know, the vast majority of payments are still on a fee-for-service sort of basis. But as that changes, as more organizations that are driven by value-based payments, like accountable care organizations and different value-based payment demonstrations [unclear] are allowed, then we have to be able to position ourselves to try to take advantage of those situations, or at least not be harmed by them in a financial way.

[00:14:59]

Tacey Ann Rosolowski, PhD

[00:15:00]

Now, as I understand it, there's actually been a lot of discussion about what exactly value-based care means. I mean, how do you establish, quantify that? And can you enlighten me a bit now? What is your understanding of what that phrase means, maybe in the abstract but also to MD Anderson?

[00:15:21]

Lewis Foxhall, MD

[00:15:22]

Well, I think in general it's the idea that the public and the federal government or the entity that's paying for care wants to have some assurance that it's getting its money's worth. So the idea that we need to be able to measure and document the outcomes of care and the processes of care more than just the volume of care, and the payment based on that is really the big change [unclear]. So this has been under development for a long time, and things are slowly beginning to change as we think about how things move forward.

But the big overriding principle of this is really what's sometimes called the triple aim of improvement, and that's to improve the quality of care while reducing the cost of care and increasing the level of satisfaction of the course of care by the patient. So some people say there's a fourth thing which ought to be one related to equity, that everyone in the population should be able to access that value generated by that change.

So it's rather than just continue to do business as usual, continuing to do today what we did yesterday, is not going to work as we look at the continually rising costs of our expenditures on healthcare, and the growing proportion that healthcare absorbs of the total budget of the country is continuing to increase year over year, and that just can't be maintained. Meanwhile, other concern that at least by the measure of how long we live, the country is not at the top of the heap. So our numbers are middling at best. So people have begun to ask about that. The federal government has driven a lot of this. They've seen their costs related to the Medicare program, in particular, rise over time. The vast majority of healthcare expenditures is related to the relatively small number of chronic diseases that people do suffer from them, so that we are dealing today primarily with these noncommunicable diseases rather than infectious diseases that have traditionally been the big problem in decades past.

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[00:18:29]

Tacey Ann Rosolowski, PhD

[00:18:29]

Interesting.

[00:18:30]

Lewis Foxhall, MD

[00:18:30]

So these are all things we can manage. They are things, however, that tend to cost a lot of money to fix or to maintain, and it's a big challenge. So we see great progress in the research that we're doing, particularly in cancer, has yielded wonderful new treatments, targeted treatments that are able to treat disease very effectively with relatively lower side effects, but all these new treatments are very expensive, so we're trying to understand how we can pay for those and get them to everybody who can benefit from them is difficult. So there's a lot of thought going on into how we can go about approaching that.

[00:19:17]

Tacey Ann Rosolowski, PhD

[00:19:19]

I just wanted to ask you for a clarification. When you were going through the triple aims, I was kind of surprised at number three, which was increase the level of satisfaction, and I thought, wow, why isn't it increase the effective outcome? So what was the choice there, talking about satisfaction as opposed to outcome?

[00:19:39]

Lewis Foxhall, MD

[00:19:39]

Well, outcomes is one [unclear].

[00:19:41]

Tacey Ann Rosolowski, PhD

[00:19:41]

Outcomes, okay, okay.

[00:19:42]

Lewis Foxhall, MD

[00:19:42]

So improved outcomes, reduced cost, and improved patient satisfaction with the experience of care. So it's not intended to, you know, be better and cheaper, but [unclear]. (Rosolowski laughs.) So it's trying to find a balance there between the clinical outcomes and the patient's perceptions of getting there. So that's really sort of the discussion that's gone on for some time, and Don Burwick [phonetic] and folks of that sort have been talking about this for some time and have gradually been incorporating that into some of the policies, primarily with the Medicare program, over time to help sort of change the way we think about things.

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[00:19:42]

Tacey Ann Rosolowski, PhD

[00:20:34]

Very complicated situation.

[00:20:35]

Lewis Foxhall, MD

[00:20:36]

It can be.

[00:20:39]

Tacey Ann Rosolowski, PhD

[00:20:39]

Yeah. I'm just thinking, wow, lots of sleepless nights.

[00:20:41]

Lewis Foxhall, MD

[00:20:41]

The principles are fairly straightforward, but how you get there is kind of tough.

[00:20:44]

Tacey Ann Rosolowski, PhD

[00:20:44]

How you get there, yeah. How you get there.

Chapter 18

B: Institutional Change

Impact of Institutional Growth on the Office of Health Policy

Story Codes

B: Growth and/or Change

B: Institutional Mission and Values

B: Beyond the Institution

A: The Administrator

B: MD Anderson Culture

Tacey Ann Rosolowski, PhD

[00:20:44]+

I wanted to ask you, too, since you came to the institution, it's changed enormously in terms of size, patient numbers, that. What are some of the ways that you would identify? What are some of the ways in which the institution has changed very dramatically, and how has that had an impact on your role with head of health policy?

Commented [T18]: In this segment, Dr. Foxhall comments on how the MD Anderson's growth since the nineties has had an impact on the activities of the Office of Health Policy. He first notes that the growth has necessitated a huge expansion of the institution's external connections with network affiliates and also with international connections. He notes over the past few years, the institution has begun to adopt the CDC's Comprehensive Cancer Control Program to organize information provided to the external connections. Dr. Foxhall gives a brief history of that program, noting that the Lung Cancer Moon Shot is part of the institution's Cancer Prevention and Control Platform, which Dr. Foxhall serves on. He next talks about the expansion of these activities through tobacco control programs in Colombia, Mexico, and Korea.

Next, Dr. Foxhall talks about how the institution's financial structure has changed: healthcare delivery has changed and it is increasingly difficult to secure funding for research and also raise income from patient care. He then moves on to note what has not changed: the institution's ability to provide personalized and compassionate care for patients. This has not changed, he observes, because it is imbedded in the culture and tradition of MD Anderson.

He ends this segment with comments on how MD Anderson is seen by the community.

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[00:21:16]

Lewis Foxhall, MD

[00:21:19]

I think the most obvious change has been the size of the organization. It's certainly grown dramatically. The number of faculty we have has increased significantly, and just the physical presence of the organization has changed markedly since I started here. So it's been also, I think, fascinating to see the growth of our external connections with our network affiliations, and in particular our regional care centers and the amount of work that we're able to do outside the main campus has really been fascinating as well.

[00:22:16]

Tacey Ann Rosolowski, PhD

[00:22:16]

Well, you mentioned to me the last time, actually, this was after the recorder was off, that you'd recently been to Colombia and you were going to be going to Korea. Can you tell me a little bit more? I mean, I don't mean to derail you, but since we're on the topic—

[00:22:31]

Lewis Foxhall, MD

[00:22:31]

Oh, sure. That's—

[00:22:31]

Tacey Ann Rosolowski, PhD

[00:22:31]

—you know, a bit about these international connections.

[00:22:33]

Lewis Foxhall, MD

[00:22:33]

Yeah, it's certainly in the same vein. Another big change, I think, has been our gradual adoption of the Comprehensive Cancer Control Program. So this has gradually grown from a really disorganized effort and well-intended efforts of several of our faculty members to provide services usually related to research projects to the community, to one in which we have several organized work groups that address different aspects of cancer control primarily around prevention, screening, early detection work.

[00:23:21]

Tacey Ann Rosolowski, PhD

[00:23:22]

Now, this phrase "Comprehensive Cancer Control Program," is that an MD Anderson phrase, or is that adopted from the NCI?

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[00:23:28]

Lewis Foxhall, MD

[00:23:28]

Yeah, it's from the CDC, NCI. So there's been a national cancer control program for some time, mostly at the state level, but we're just really beginning over the last few years to adopt that to the Cancer Center. So it's really been intended to focus more on our efforts out in the community to provide these sorts of services, in particular to our low-income populations.

So more recently, we've had the Moon Shot initiative, and part of that has been the adoption of a cancer control prevention and control platform. So this is a workgroup that's been put together that I serve on, and led by Dr. Hawk and Mark Moreno, that is focused on these same efforts, although primarily prioritizing work related to the Moon Shots, which is lung cancer and skin cancer.

So it was through that initiative that we developed our international, these more recent international connections, and they have really come from Dr. DePinho's discussions with state leaders in Mexico and then subsequently in Colombia to reach out to us with interest to collaboration on these cancer control efforts, mostly on tobacco. So those are really just getting started. I think it's interesting to see where those might go. We've had at least some initial exchange of ideas with both groups. So with Mexico it's the entire country and some of the national-level leaders involved there, and with Colombia it's a city [unclear], which is a very large metropolitan area about the size of Houston that is very forward-thinking in their public health efforts—

[00:25:39]

Tacey Ann Rosolowski, PhD

[00:25:39]

Oh, interesting.

[00:25:39]

Lewis Foxhall, MD

[00:25:40]

—that seems to be interested in working with us.

[00:25:45]

Tacey Ann Rosolowski, PhD

[00:25:45]

And is the Korea connection also tobacco-related?

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[00:25:47]

Lewis Foxhall, MD

[00:25:48]

Korea is a conference. This is our Global Academic Program Conference, so every year we get together with our sister institutions around the globe and share information and ideas, present abstracts, and talk about research primarily that's going on. We have a section on cancer control. We have a section on cancer survivorship, which is the one I'm going to be participating in. So we'll be sharing with our colleagues in other institutions our ideas around how we approach things. So every year we have a conference that alternates between here and Houston, being hosted by us here in Houston and one of the global partners. So this year it happens to be Korea.
[00:26:36]

Tacey Ann Rosolowski, PhD

[00:26:37]

And the institution in Korea that you're connected with?

[00:26:39]

Lewis Foxhall, MD

[00:26:39]

It's the Goyang-si Cancer Center. So it'll be interesting. So we'll be presenting abstracts and have several presentations on survivorships. So I'm co-chairing on that group. And while I'm there, it turned out I had the opportunity to go to a symposium and present a couple of lectures to the other cancer center in town, which is the Seoul National University Cancer Center, so I'll be meeting with them the day prior to our [unclear] conference, and then on the last day I'll spend a little time with the Korean National Cancer Center in their Department of Health Policy. So we're going to talk a bit about policy-related issues in that country. So that should be interesting.

So it's an interesting area to work in and get a little different perspective with the different countries that are involved. And Korea has a very similar incidence in mortality of cancer, although the types of cancer are a little bit different, but overall are fairly similar. You know, it's now a very developed medical system. They do a great job of finding cancer and treating cancer. So I guess I shouldn't be surprised [unclear]. It'll be interesting to see. I think everybody approaches things a little differently in each country. Depending on what part of the world you're in, has a slightly different balance of the types of cancers that are a problem and how they're dealing with them.
[00:28:31]

Tacey Ann Rosolowski, PhD

[00:28:32]

Very interesting opportunity for cross-fertilization.

[00:28:37]

Lewis Foxhall, MD

[00:28:37]

Mm-hmm.

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[00:28:37]

Tacey Ann Rosolowski, PhD

[00:28:38]

Are there situations in the past when you've gone to these cancer centers overseas where you feel that learning about these other approaches and perspectives has changed the way you see something here in the States?

[00:28:53]

Lewis Foxhall, MD

[00:28:54]

Well, I'm fairly new to this international stuff, but the interactions that I've had with different cancer researchers and cancer control professionals has, I think, mostly been impacted by the particular country's social and economic development status and the types of risk factors that their population's exposed to. So we are fortunate here that most of our population is able to access care, but our low-income populations and low-access populations really are not a whole lot different from those in less developed countries.

[00:29:52]

Tacey Ann Rosolowski, PhD

[00:29:53]

Wow.

[00:29:53]

Lewis Foxhall, MD

[00:29:53]

So there's certainly things to learn from [unclear].

[00:29:55]

Tacey Ann Rosolowski, PhD

[00:29:55]

That's sobering, isn't it?

[00:29:56]

Lewis Foxhall, MD

[00:29:56]

Yeah. So we have a real difference here in the levels of care that are provided to certain groups in our country. We certainly see differences in mortality and challenges with the cancer burden depending on where you live and what sort of income you make and those sorts of things.

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[00:30:23]

Tacey Ann Rosolowski, PhD

[00:30:25]

We were talking about changes that you've seen in the institution, and you mentioned growth and kind of got on the subject of your international connections. What are some of the other areas in which you've seen the institution change since your arrival and how that's affected your work with policy?

[00:30:47]

Lewis Foxhall, MD

[00:30:48]

You know, the other area, I think, has been the gradual change in the financial structure of the economy and how that impacts healthcare delivery, so our ability to generate revenues from patient care has certainly changed over time. The funding for cancer research has changed very significantly over the last several years, so those are major alterations in the firmament, and we just have to learn how to deal with that.

[00:31:25]

Tacey Ann Rosolowski, PhD

[00:31:25]

And from the look on your face, I assume that the conclusion is that the amount of money generated is going down. (laughs)

[00:31:30]

Lewis Foxhall, MD

[00:31:31]

Exactly. Exactly. So they're not bringing in buckets of money. So, yeah, so it's been more challenging, and our colleagues who focus on research have a much harder time of getting research funded, and it's difficult, especially for young researchers to get started and start building a career. So those are big, big differences.

Important, I think, is what hasn't changed. I think the ability of the institution, everybody that works here, to really continue to provide personalized and compassionate care to our patients has really been preserved at a very high level. So you'd think that might be something that might get lost over time, but it really hadn't. And this idea that we only take care of cancer patients and special needs of cancer patients, I think, is very upfront in everybody's mind, and people try really hard and have been, as partners, successful in being able to maintain that. So that's really a big differentiator for what we do here.

[00:32:47]

Tacey Ann Rosolowski, PhD

[00:32:48]

Why do you think that hasn't changed, despite the increase in size and kind of maybe even chaos in delivery system?

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[00:32:57]

Lewis Foxhall, MD

[00:32:58]

Well, I think, you know, there's been such a long tradition here of doing that, it's really embedded in the culture of the place and the people who work here and who've been able to pass that along to new employees who come on board and professionals who start working with our patients, and they can see the way people have been here for a while do this. And it's really been a positive thing and a learn-by-seeing sort of approach. There's a lot of effort, I think, in, you know, as we on-board new employees and as we continue to work to support the efforts of the institution, that training programs have been implemented and support programs to help people keep that upfront and do a better job of it.

But, you know, I think just this idea that we're not a general hospital, we don't see lots of people with sort of issues that you would expect them to get over pretty easily and not require a lot of counseling and support for it, the cancer center only treats people with life-threatening illnesses, and, you know, the emotional support and the emotional connections that our team has with patients I think is really different and special. And somehow we've been able to keep that going, and I think that's what a lot of people are proud of. So patients recognize it.

[00:34:46]

Tacey Ann Rosolowski, PhD

[00:34:47]

How does the community see MD Anderson? I mean, what are the variety of images that the community has of this institution?

[00:34:58]

Lewis Foxhall, MD

[00:35:00]

Well, I don't know if I can speak for the community, but my perception from people who talk to me about their experiences here and health professionals who work with us are, I think, generally very positive. The institution has had a very good reputation as far as its ability to do a good job and to successfully take care of patients or do the best we can for people, and rightfully so. And I think our relationship with our professional colleagues in the community has, I think, been good of late.

We have had our ups and downs. One of my first jobs here, I think as I mentioned, was to try to kind of patch up some rocky relations we had bumped into with community physicians, and I think we've continued to focus on maintaining a good relationship with those clinicians in the community who are both our collaborators as well as competitors at times, and have tried to do a good job of maintaining a professional relationship that's respectful and providing each other with the information we need to take care of patients and get good outcomes.

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So, you know, that's generally good. I think, you know, we are still are challenged the farther you get away from Houston with people not really knowing who we are and figuring that out, but we've got a great team of people in our Communications Office, and we're working on that. But I think the reputation and the awareness of the institution has grown dramatically over the last couple of decades I've been here and is one that will continue to [unclear].
[00:36:59]

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Chapter 19

A: View on Career and Accomplishments The MD Anderson Presidents; No Plans for Retirement

Story Codes

C: Portraits

A: Personal Background

Tacey Ann Rosolowski, PhD

[00:37:01]

I wanted to ask you kind of as part of that general question about changes to the institution, about your impressions of the executive leadership, because you've worked now with a number of different presidents. I'd be interested in your impressions on their leadership styles and the mark you feel that each of them as left on the institution.

[00:37:25]

Lewis Foxhall, MD

[00:37:26]

Sure. Well, I haven't been here that long. I've only worked with three of the four presidents. (laughs)

[00:37:31]

Tacey Ann Rosolowski, PhD

[00:37:33]

That's still three-quarters of them. (laughs)

[00:37:34]

Lewis Foxhall, MD

[00:37:34]

But, no, it's been interesting, and, you know, we've been fortunate to have really great leaders. Dr. LeMaistre was president when I first came on board, certainly a remarkable individual that had a strong career in leadership with the University of Texas before he took the reins here and did a masterful job, really had a good focus on prevention and helped us get the prevention area built up and was able to initiate some of the changes that then led to further growth in the institution.

Dr. Mendelsohn was such a strong leader in the research world and brought his skills and vision to help us build the research side while also growing the clinical side dramatically. The continued expansion of the institution under his leadership I think is really phenomenal. So he was a real leader during his tenure. Now he continues his leadership in the research arena as he's continued his efforts there.

Commented [T19]: Dr. Foxhall begins this segment with comments on MD Anderson presidents, Dr. Charles LeMaistre, Dr. John Mendelsohn, and Dr. Ronald DePinho. He then notes that he has no immediate plans for retirement (he is "having too much fun"), and explains that intends to further the tobacco agenda and to develop survivorship management, positioning the institution to work within more effective shared care models for survivorship.

Dr. Foxhall comments on the legacy he will leave: a network of collaborative connections designed for cancer control and management. He comments briefly on his love of travel, the enjoyable time he spends with his children, and his hobby, landscape photography.

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And Dr. DePinho is a fascinating person with just a tremendous amount of energy and huge vision, I think, to really bring us forward and to continue to help us use the resources of the institution to make a difference in the cancer problem, not just here in Houston and in Texas, but clearly across the country and even out in the world. He really has a broad focus and senses the great opportunities that we have here at the institution, with our wonderful faculty and assets, to really make a difference in the cancer problem. This whole initiative around the Moon Shots I think has been a very bold change that he's brought forward to see if we can't move the meter on some of these problems that have been very, very difficult to address. So, always moving forward. It's interesting to see what's happened over the years.
[00:40:11]

Tacey Ann Rosolowski, PhD

[00:40:13]
Now, Dr. Foxhall, you're so involved with so many projects, I shudder to ask you, but have to, do you have plans for retirement? (laughter) So I can't imagine that you do.
[00:40:25]

Lewis Foxhall, MD

[00:40:26]
Well, not immediately. As soon as I get this cancer problem taken care. (Rosolowski laughs.) When I first came here, I mentioned to you I thought I'd come here and work two or three years and then go off and do something else, but two turns into twenty pretty quickly, so it is amazing how quickly times go by. But there's still, you know, a lot of really fascinating programs to work on and opportunities, I think, to try to address some of these issues that I've been interested in for some time.
[00:41:00]

Tacey Ann Rosolowski, PhD

[00:41:01]
What are some key ones that you really want to address hard before you leave the institution?
[00:41:06]

Lewis Foxhall, MD

[00:41:06]
Well, I think the issues around survivorship management and trying to better understand how we position the institution and build collaborations with our community physicians to manage that growing population is one that I think is ripe for improvement, so I'll continue to work there. We're trying to get a grant in, actually, over the next couple of weeks to help us reach out to sort of primary care training programs and work with them to implement some changes that will help us with the shared care model.

So then just promoting the prevention agenda, particularly around tobacco as we focus on the agenda to help, again, eliminate this number-one preventable cause of cancer and other illnesses here in this country. I think there's still work yet to be done there. We've made a lot of progress over the years, but still not where we need to be.

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And this place is just a fascinating place to work and wonderful people to work with, and I think as long as they'll put up with me, I'll keep plugging away here for a while yet. So, lots of good opportunities out there still.
[00:42:27]

Tacey Ann Rosolowski, PhD

[00:42:28]
What legacy do you feel you will leave when you decide to depart the institution?
[00:42:33]

Lewis Foxhall, MD

[00:42:34]
Well, I hope this work that we've done around building and improving relationships with our community physicians, building better collaborative practice initiatives is one. The other is the work around cancer control programs, trying to get those started and building them into a more sustainable program over time. And then the programs around survivorship, how we deal with that, dealing with the success of our wonderful treatment programs and better understanding how we can help people get the most out of their treatment that they went through and maintain a good quality of life after they have completed their treatments, I think is good work to be done. So, no shortages there.
[00:43:29]

Tacey Ann Rosolowski, PhD

[00:43:31]
What are your plans for retirement? Have you thought those out at all?
[00:43:34]

Lewis Foxhall, MD

[00:43:34]
No. (laughter) I really enjoy what I'm doing, and I don't really have a burning interest in playing golf all day, so I get to do the fun things I do. I enjoy traveling and being with my now-grown kids and enjoying that aspect of life. So when I have opportunities to do that, it's great. But I still get a kick out of doing what I'm doing, so it's hard to really kind of think of a real reason to quit unless you really want to kind of go do something else.
[00:44:19]

Tacey Ann Rosolowski, PhD

[00:44:19]
That's right. Yeah. Is there a talent or ability that no one knows about that you'd like to share? (laughter) You know, are you a secret portrait painter or— (laughs)
[00:44:34]

Lewis Foxhall, MD

[00:44:35]
No, no, I don't think there's any great missed opportunities on that part.

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[00:44:41]

Tacey Ann Rosolowski, PhD

[00:44:41]

I wasn't thinking that, but—

[00:44:42]

Lewis Foxhall, MD

[00:44:42]

I don't know. I mean, I enjoy photography and—

[00:44:47]

Tacey Ann Rosolowski, PhD

[00:44:47]

Oh, interesting.

[00:44:47]

Lewis Foxhall, MD

[00:44:48]

—play with that a little bit when we travel. So that's kind of fun.

[00:44:50]

Tacey Ann Rosolowski, PhD

[00:44:52]

Is there a particular subject matter you enjoy?

[00:44:53]

Lewis Foxhall, MD

[00:44:54]

Mostly things that will be still long enough for me to compose a picture. (Rosolowski laughs.) I like landscape photography and these sorts of things, so that's fun.

[00:45:08]

Tacey Ann Rosolowski, PhD

[00:45:08]

And where have you traveled that you've been able to—

[00:45:09]

Lewis Foxhall, MD

[00:45:09]

Oh, just wherever we go, you know, family vacations and whatnot. So I drag my camera along and snap a lot of pictures—

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[00:45:18]

Tacey Ann Rosolowski, PhD

[00:45:18]

Interesting. What kind of camera?

[00:45:19]

Lewis Foxhall, MD

[00:45:19]

—which is great nowadays that we have digital. You know, you can just snap to your heart's content.

[00:45:23]

Tacey Ann Rosolowski, PhD

[00:45:23]

Snap to your heart's content. What kind of camera do you have?

[00:45:25]

Lewis Foxhall, MD

[00:45:26]

It's a Nikon camera.

[00:45:27]

Tacey Ann Rosolowski, PhD

[00:45:28]

Has it got a lot of bells and whistles?

[00:45:30]

Lewis Foxhall, MD

[00:45:30]

Mm-hmm.

[00:45:30]

Tacey Ann Rosolowski, PhD

[00:45:31]

All right. So you really are a photographer.

[00:45:32]

Lewis Foxhall, MD

[00:45:32]

Knobs and buttons, that's right. (Rosolowski laughs.) Not that I know how to work them all that well, but—

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[00:45:37]

Tacey Ann Rosolowski, PhD

[00:45:38]

I know with those you have to spend a lot of time with the instruction manual.

[00:45:41]

Lewis Foxhall, MD

[00:45:42]

That's right. But anyway, it's kind of fun.

[00:45:44]

Tacey Ann Rosolowski, PhD

[00:45:44]

Yeah. Is there anything in our conversation about your role at MD Anderson that I've missed? Because I don't know what I don't know, I mean, is there anything that you would like to share for the record right now?

[00:45:57]

Lewis Foxhall, MD

[00:45:58]

Well, I think we've covered all the major stuff that I could think of. So we have, I think, hit on all the primary activities, so you've done a good job [unclear].

[00:46:14]

Tacey Ann Rosolowski, PhD

[00:46:14]

All right. Thank you. Is there anything else that you would like to add?

[00:46:16]

Lewis Foxhall, MD

[00:46:16]

Well, I appreciate your taking time to do this and the program putting all this together. I think it's a great opportunity to get perspective from lots of different people here in the institution about life in this place. It's a good story to tell.

[00:46:33]

Tacey Ann Rosolowski, PhD

[00:46:34]

Well, thank you, and thank you very much for devoting the time.

[00:46:36]

Lewis Foxhall, MD

[00:46:36]

No, no, glad to do it. Sure thing.

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[00:46:38]

Tacey Ann Rosolowski, PhD

[00:46:38]

All right, Dr. Foxhall, I'm turning off the recorder at 1:45.

[00:46:44] (end of session four)

Lewis Foxhall, MD

Session 5 — May 13, 2014

Chapter 00E

Interview Identifier

[00:00:00]

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. We are recording. Today is May 13th, 2014, and today I'm on the nineteenth floor of Pickens Tower in the Office of Health Policy for my fourth [fifth] session with Dr. Foxhall, Vice President for Health Policy.

Interview Segment: 05
Interview Date: May 13, 2014

Chapter 20

B: The Finances and Business of MD Anderson Texas and the Affordable Care Act

Story Codes

B: MD Anderson and Government
D: The Healthcare Industry
D: Politics and Cancer/Science/Care
C: The Institution and Finances
B: MD Anderson History
D: On Texas and Texans

\$\$

Tacey Ann Rosolowski, PhD

[00:00:00]+

So thank you for agreeing to this final and supplementary session about the Affordable Care Act and all the changes that came to healthcare, particularly cancer care, in Texas in 2010. So what would be a good place to start with that? I mean, my first question was what decisions did Texas make about the Affordable Care Act, but maybe there's a better place to start to give context, so I'll let you make the decision. I know it's a very complex situation. (laughs)

[00:00:53]

Lewis Foxhall, MD

[00:00:54]

Sure. Well, the Affordable Care Act and its cohort is really intended to provide insurance coverage for people who had not been able to get it, and in the cancer world, that's been a significant problem. We have, of course, a very high rate of uninsured here in the State of Texas.

[00:01:22]

7

Tacey Ann Rosolowski, PhD

[00:01:22]

I read it was like 33 percent.

[00:01:23]

Lewis Foxhall, MD

[00:01:24]

Yeah, it's about 25 in the state, and around 30-plus here in the Houston region, so we certainly have had the highest rate in the country for quite a long time, and nothing much has been able to budge that. We have a significant number of people here in the state who are also low-income, and the Medicaid program that provides federal coverage for the low-income populations is limited in our state to primarily women, pregnant women, and children, and aged, blind, and

Commented [T20]: In this segment, Dr. Foxhall discusses the Affordable Care Act (ACA) passed on 23 March 2010 and its impact on Texas Health and the activities of MD Anderson. He begins by noting that Texas has the highest rate of uninsured individuals in the nation and that only a limited number of categories of individuals are eligible for Medicaid, with the result that a percentage of individuals who are diagnosed with cancer are uninsured. He explains the hopes that the ACA would provide coverage to the uninsured, to cancer survivors unable to get affordable insurance, and to low income individuals in need of cancer prevention services. He then goes into more detail about the Texas limitations on Medicaid as well as some alternatives under discussion in the Texas Legislature to provide coverage to ineligible individuals.

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disabled. So the otherwise adult population is not covered by that. So we wind up with a number of people who get cancer and don't have any insurance coverage, so we have provided a program, our Financial Assistance Program, to take care of patients in that situation who need our cancer care.

[00:02:27]

Tacey Ann Rosolowski, PhD

[00:02:28]

About what percentage of the cancer patients are uninsured?

[00:02:32]

Lewis Foxhall, MD

[00:02:33]

In our institution?

[00:02:35]

Tacey Ann Rosolowski, PhD

[00:02:36]

Or in general, [unclear] the numbers?

[00:02:38]

Lewis Foxhall, MD

[00:02:38]

In our institution we see around 5 percent or so that are on our charity program, and roughly an equal number on the Medicaid program, so that kind of bounces up and down over time. But this has been a persistent problem for a long time.

So at any rate, the Affordable Care Act we were hoping would be a way to provide coverage for those low-income individuals who couldn't afford care and also for an important group who are primarily cancer survivors, who previously had cancer, who were not able to get insurance because of their history of having had cancer. So it was very difficult for them to get any sort of coverage. There was a state program which provided coverage outside the regular insurance track, but it's very expensive.

So we were hopeful that this would allow us to have better coverage for individuals who get cancer but also provide coverage for cancer prevention services which they're not able to access. So people without insurance, especially low-income people, get cancer screenings at much lower rates, smoke at higher rates and generally are at higher risk of getting lung cancer. So there were several areas that we were hopeful that this would help us out.

The Act, of course, was finally passed. It was done in a very partisan way, but, nonetheless, had different components that address some of these big concerns that we have. So this has gradually been rolled out bit by bit over time.

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[00:04:30]

Tacey Ann Rosolowski, PhD

[00:04:31]

Let me just ask before we go on, what is your view of why Texas made the decisions it did vis-à-vis Affordable Care Act?

[00:04:40]

Lewis Foxhall, MD

[00:04:41]

Regarding the Medicaid?

[00:04:44]

Tacey Ann Rosolowski, PhD

[00:04:44]

Mm-hmm.

[00:04:44]

Lewis Foxhall, MD

[00:04:45]

Well, part of the provisions in the Act included an expansion of the Medicaid program to cover low-income people, so this was intended to be paid for primarily but not entirely by the federal government, at least for the first several years, and this is a way to enroll individuals in some coverage that was less expensive than paying for subsidies for an additional low-income group to enroll in commercial insurance or to provide them with Medicare, which would have been another alternative, but, again, that's more expensive. So this was the low-cost or lower-cost alternative that the federal government had offered up as part of the package. The Supreme Court determined that that was not constitutional to require states to participate in that part of the Act, and it was made optional, and about half the states decided to keep it. The other half decided not to, and Texas was one of those. So there are—

[00:05:58]

Tacey Ann Rosolowski, PhD

[00:05:58]

Why?

[00:05:58]

Lewis Foxhall, MD

[00:05:59]

Well, [unclear]. But there are a number of issues. It's a political football, still, and there are political considerations, I think, in any of these things, because, as I said, it was really a very partisan vote that passed it. There are certainly considerations regarding the cost to the state. It's

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really unknown how much that would be, how many more people would enroll, how much that would cost, and there were concerns about that.

So that's still, I think, under discussion at the state level as far as whether there could be some other solutions besides the straight expansion, perhaps block-grant funding or a way to use that money to provide subsidies for people to get insured through the health exchange marketplace approach, so I think that's still being discussed, but so far we're not participating. So that leaves us with a large number of people that are 100 percent [unclear] who don't have any insurance. We also have a large number of undocumented persons, unauthorized immigrants in the state, who have never been eligible for it and are still without insurance, for the most part. So we will continue to have our challenges going forward.

But there's been some people that have signed up through the marketplace exchanges, so I think we had around 190,000 or so here in the Houston region, and that's some encouragement. And I think we'll probably see more of this next year when the penalties are a bit higher, to provide a little more incentive to get people to sign up. So hopefully those that are in those income categories will be able to participate and get some sort of coverage.
[00:08:01]

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Chapter 21

B: The Finances and Business of MD Anderson MD Anderson's Response to the Affordable Care Act; ACA Requirements; Value-Based Purchasing

Story Codes

B: MD Anderson and Government
D: The Healthcare Industry
D: Politics and Cancer/Science/Care
C: The Institution and Finances
B: Growth and/or Change
B: MD Anderson History
D: On Texas and Texans

Tacey Ann Rosolowski, PhD

[00:08:02]

Now, what was the reaction—or I shouldn't say "reaction." I mean response. Did MD Anderson have to take certain steps or put certain plans in place to counteract the decision in 2010?

[00:08:22]

Lewis Foxhall, MD

[00:08:23]

Well, there wasn't anything really that could be done about that situation, so we continued our Financial Assistance Program. We have asked—or we have enrollment brokers who work with us to help get people signed up for anything that they might be eligible for, so we work with them to counsel individuals, particularly those that were in the State Highways [unclear] and preexisting-condition insurance plan that the federal government had to then switch over to some sort of coverage. So I think that was helpful.

Anybody who is being considered for care here through the Financial Assistance Program already gets counseled, so during the time that the enrollment was open, they were given assistance as was allowable, to help them get registered if they were potentially eligible. So it's really been our effort to try to get everybody who is eligible, eligible, and to be sure we've maintained our support program for those that were not able to sign up. Then we maintain our program at LBJ, which is our oncology program there at the county hospital, to help take care of patients [unclear].

[00:09:46]

Tacey Ann Rosolowski, PhD

[00:09:46]

I'm sorry, I missed—which program was that?

Commented [T21]: In this segment, Dr. Foxhall notes that, after passage of the ACA, MD Anderson continued with its existing programs to help with financial assistance. He briefly describes these programs.

Dr. Foxhall then talks about other dimensions of the ACA. First he talks about the requirement that institutions report on the quality of care. He explains that this involves looking at healthcare delivery processes to find areas for improvement, giving examples. He notes that this is important because, historically, medical practices have not had enough transparency in care and outcomes. Reporting enables consumers to have a better idea of how well providers are doing. In addition, this information will be used as a basis for determining payment. Next Dr. Foxhall explains that the ACA requires that institutions participate in an Accountable Care Organization. He explains the reasoning for this, and notes that it is not clear how a specialized hospital will engage with them.

Next Dr. Foxhall talks about the ACA's requirement for Value-Based Purchasing, giving examples of how examining processes has revealed unnecessary costs in deliver of care.

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[00:09:48]

Lewis Foxhall, MD

[00:09:48]

LBJ Hospital through the Harris County Hospital District [unclear] Healthcare System, as it's now called. So we have our own [unclear] program out there, so patients who live in Harris County can be seen by our faculty at that location.

[00:10:01]

Tacey Ann Rosolowski, PhD

[00:10:04]

Have there been any other—because I'm thinking about that decision, the decision in 2010, which is a reaction to but set in the larger context of big changes in the economics of healthcare. How do you see some of those? How do you see that situation and MD Anderson kind of at the point of connection with them?

[00:10:32]

Lewis Foxhall, MD

[00:10:32]

Well, there are a number of other parts of the Affordable Care Act which are those related to reporting, required reporting, quality measures. So we've been working with the Alliance of Dedicated Cancer Centers and other groups to be sure we can obtain the appropriate measures that are being asked for and provide input into what measures are reported so that we can participate in that, which we had not been required to do before.

[00:11:04]

Tacey Ann Rosolowski, PhD

[00:11:05]

And what does participation in that organization mean?

[00:11:08]

Lewis Foxhall, MD

[00:11:09]

Well, we work with them in trying to identify measures. The Act required that the exempt Cancer Centers, of which we are one, report. All other hospitals have been reporting for some time, but we have a different patient population, so it was not felt appropriate for us to use the regular approach to things. So we've been working with them to try to develop measures and the other national bodies that have been looking at reporting measures. So we've started reporting some. We'll report more over the next couple of years.

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[00:11:49]

Tacey Ann Rosolowski, PhD

[00:11:49]

Now, is this the same or different than the value-based care issue?

[00:11:54]

Lewis Foxhall, MD

[00:11:54]

Well, it's a part of it. So, we report. So, value is often described as cost over quality. So this is sort of how you report your outcomes, sort of measures that can be used to really look at how people do when they're treated at different facilities. A lot of them are more process-related measures, but they're [unclear].

[00:12:16]

Tacey Ann Rosolowski, PhD

[00:12:16]

Can you give me an example?

[00:12:18]

Lewis Foxhall, MD

[00:12:18]

Well, whether patients are treated using recommended therapies or what sort of outcomes are related to surgical interventions and things like that. So there are a series of those that are out there that we're starting to use, and we use more over time.

[00:12:36]

Tacey Ann Rosolowski, PhD

[00:12:36]

And this may be a dumb question, but why is that important?

[00:12:40]

Lewis Foxhall, MD

[00:12:42]

Well, there's been a concern historically about medical care in general, that there has not been the level of transparency in the outcomes of medical treatment in general, so this is across the board. This is not just related to oncology care but for all sorts of care. People go in and get treated for this or that. There previously had not been much way to know what happened or how they did. So this has really been a national movement over the last decade or so to gradually begin to provide reporting.

One of the state agencies I was involved in a number of years ago was the Healthcare Information Council, where we used information from claims data to report on hospital

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activities, approach those [unclear]. So that is, is if consumers can get a little better idea what sort of job different healthcare providers are doing, then they can make more informed choices about the healthcare that they're planning to obtain. So that's sort of the general idea. Rather than asking Aunt Sally, that's what it is. (Rosolowski laughs.) So at any rate, the—
[00:14:10]

Tacey Ann Rosolowski, PhD

[00:14:11]
Can I ask one other question about that? Because you talked about the benefit for consumers. What is the benefit for institutions in doing that kind of self-review?
[00:14:22]

Lewis Foxhall, MD

[00:14:23]
Well, it can be used for self-evaluation or comparison with other institutions, you know, how our outcomes related to other similar sorts of facilities, all things being equal, which is sort of the hard part. But potentially you can kind of gauge how you're doing compared to other facilities, and either be proud of it or figure out how you can do a better job. So there's that sort of aspect, a process improvements aspect.
[00:14:55]

Tacey Ann Rosolowski, PhD

[00:14:55]
What has MD Anderson been doing with the information collected here?
[00:14:59]

Lewis Foxhall, MD

[00:14:59]
Well, it's tracked on a regular basis, and it involves a number of measures, both clinical as well as patient satisfaction. So we try to understand what the reports mean and try to help feedback into our patient-care processes, our patient-support processes, about what we can do to help improve situations. So in time, that will be used for [unclear] payment for Medicare payments, so there will be a feedback link there that will say that if your measures are not up to snuff or you're not improving, then you wouldn't get paid as much in the Medicare system. So there's all that.

Then there's the whole value-based purchasing sort of arrangement. Affordable Care Act also calls for implementation of accountable-care organizations, which are really demonstration projects to determine if groups of physicians or hospitals can work together to help provide better care at a lower cost. So it's all sort of pursuing this triple-aim idea that we talked about before.

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[00:16:13]

Tacey Ann Rosolowski, PhD

[00:16:13]

Can I ask one other question? I was curious, since this tracking of processes, I hadn't—I mean, I'd heard a little bit about that, but I'm wondering is there a new department that's been established or office to take care of processing that information [unclear]?

[00:16:28]

Lewis Foxhall, MD

[00:16:29]

Well, we have a number of groups. We have a Process Improvement Office. They're involved in it. Dr. Ron Walters [phonetic] in Medical Affairs is involved in some of that, Dr. Feeley and his team with the Institute for Cancer Care Excellence. So all those groups are really kind of looking at what the measures are, what the measures should be, which ones we think are appropriate for us, and trying to argue for that. You know, it's really not our decision, but we can provide input into it to try to get measures that seem to be reasonable things that we feel represent what we do and how we do it.

[00:17:10]

Tacey Ann Rosolowski, PhD

[00:17:10]

Interesting. I'm sorry I interrupted you. You were talking about the participation in accountable-care organizations. Have there been—is there more on that?

[00:17:23]

Lewis Foxhall, MD

[00:17:24]

Well, this is a new aspect or new delivery model that's part of the Act that's been encouraged by—it was part of the Medicare program. It can be done outside the Medicare program, but there are hundreds of these across the country that are starting to form. It's not exactly clear how MD Anderson or any other subspecialty hospital could really engage with those sorts of organizations.

So here in Houston, for example, the more general-care organizations have begun to look at that. So like Memorial Hermann system and groups like that, that have a broad primary-care base, that have multispecialty clinical operations, are trying to [unclear] those. So the idea is that they would eventually work with insurance companies to take risk and provide some sort of payment mechanism that's based on quality and outcomes, and that they're accountable for the care that they deliver as well as just the fee-for-service sort of arrangement. So those are still kind of early in the process.

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[00:18:37]

Tacey Ann Rosolowski, PhD

[00:18:38]

Why isn't it clear how an institution like MD Anderson would dovetail with that [unclear]?

[00:18:44]

Lewis Foxhall, MD

[00:18:44]

[unclear] it's just not part of the thing. It's really set up for general-care organizations, not subspecialty. So it requires a broad population base and a primary-care infrastructure and things that we just don't have. So we may be able to contract with them, provide some pieces of care for them related to cancer sort of things. It's just not worked out yet.

[00:19:12]

Tacey Ann Rosolowski, PhD

[00:19:13]

Okay. So that's kind of in the process of figuring out how that linkage will take place.

[00:19:19]

Lewis Foxhall, MD

[00:19:19]

Yeah, how or if it'll take place. It's just not clear.

[00:19:22]

Tacey Ann Rosolowski, PhD

[00:19:22]

Right. Interesting.

[00:19:22]

Lewis Foxhall, MD

[00:19:24]

But, anyway, it's just a new approach. And then there's value-based purchasing, which [unclear] and pay-for-performance initiatives, which are actually specifically targeting specialty centers like ours. So that's kind of what Dr. Feeley and his team have been trying to sort out, how we

can get ourselves organized to participate in those sort of ventures.

[00:19:49]

Tacey Ann Rosolowski, PhD

[00:19:50]

What sort of issues are coming up with that? What are some of the challenges?

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[00:19:55]

Lewis Foxhall, MD

[00:19:57]

Well, Dr. Feeley's whole team has kind of focused on all that effort. He's trying to understand what we spend on care, how that care is managed, and what we can do to address cost of care. So there have been a number of initiatives across the institution for the last several years to try to identify costs that are not necessary, drive those down, and try to provide better efficiencies in [unclear] care.

[00:20:26]

Tacey Ann Rosolowski, PhD

[00:20:29]

What's an example of a situation in which there would be costs that were unnecessary?

[00:20:36]

Lewis Foxhall, MD

[00:20:37]

Well, if we have procedures in the operating room and they pull out every instrument known to exist for a given surgery that only a few are ever used, but at some point somebody asks for something, so they have it ready to go just in case. It's better done if you determine exactly what's necessary or at least have some group-thought about what really needs to be provided and reduce the number of things that are sterilized and opened and not used and put back. So just any way we can identify ways to [unclear] or try to improve quality if there are ways we can provide better services or prepare patients for surgeries, such as head and neck surgery, giving them some exercises or instructions before they get operated on so they're better able to deal with the surgeries that may impact their quality of life afterwards. So there are all different ways to approach it.

[00:21:42]

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Chapter 22

B: The Finances and Business of MD Anderson The Future Under the Affordable Care Act: the Value of Prevention Services

Story Codes

B: MD Anderson and Government
D: The Healthcare Industry
D: Politics and Cancer/Science/Care
C: The Institution and Finances
B: Growth and/or Change
B: MD Anderson History
D: On Texas and Texans

Tacey Ann Rosolowski, PhD

[00:21:43]

I see. Okay. Interesting. What's the long-term prognosis for dealing with this issue, the challenges of the uninsured and wrestling with the provisions of the Affordable Care Act? What are some of the big points?

[00:22:05]

Lewis Foxhall, MD

[00:22:06]

Well, the Act is law and it's being implemented and it's potentially going to be able to enroll more people down the road, so I think for those that are in the income categories that are open to participation we'll see that continue to increase. The penalties go up year after year, so it'll be more of an incentive for individuals to participate. It's not clear what businesses will do, if they'll just accept the penalties or if they will go ahead and provide care. But regardless, with that individual being required to have coverage or get taxed extra, then this kind of shoves a lot of people into the participation categories. So I think that'll continue to increase. So it won't take care of everybody. We still have our issues with low-income groups, and time will tell what the state decides to do. It all has to do with state leadership in this election cycle, so they may have a slightly different approach to how that will be managed in relationship to the federal government. So that's kind of in the TBD department. (laughter)

[00:23:30]

Tacey Ann Rosolowski, PhD

[00:23:32]

Yes, yes.

Commented [T22]: In this segment, Dr. Foxhall sketches what the future looks like under the Affordable Care Act, noting that the a change in leadership in Texas might change any predictive scenario and the state will continue to have poor and undocumented individuals to cover.

Dr. Foxhall explains that the focus on preventive services is a very positive feature of the ACA. He explains the requirements and notes the benefits that can come from screening services and tobacco cessation programs. He cites statistics for the increase cancer risk that comes with smoking and obesity. He explains why institutions tend not to invest in prevention, noting that the ACA is unusual in adding this to its requirements.

In conclusion, Dr. Foxhall notes that the ACA is "still a political football" and that politics has an impact on each decision connected with it.

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[00:23:34]

Lewis Foxhall, MD

[00:23:34]

But there will still be poor people in Texas. We will still have people who are here who are unauthorized immigrants [unclear]. We want to take care of them the best we can.

[00:23:44]

Tacey Ann Rosolowski, PhD

[00:23:45]

Is the number of undocumented individuals growing?

[00:23:47]

Lewis Foxhall, MD

[00:23:48]

It declined, actually, or at least stabilized during the economic recession, but it's, I think, starting to creep back up again. So a lot of it is an economic pressure to encourage people to take the risk of [unclear].

[00:24:09]

Tacey Ann Rosolowski, PhD

[00:24:14]

Is there anything else that you'd like to add about this [unclear] problem? (laughs)

[00:24:19]

Lewis Foxhall, MD

[00:24:20]

Yeah. Well, yeah, it's just a work in progress. The other positive thing, I think, is the coverage for preventive services, which is part of the Act. So the requirements that each plan offered have some sort of benefits related to prevention. of which several are related to cancer risk, so that's a good thing. So there's no out-of-pocket cost for people who have coverage to get those sorts of either screenings or access treatment for tobacco use or obesity counseling, sorts of things. So that's a positive aspect. Over time that will help.

[00:25:06]

Tacey Ann Rosolowski, PhD

[00:25:08]

How long do you think—I mean, those are kind of behavioral and sometimes addiction issues that can be very resistant. How long do you think it will take before those sort of supports for patients will register?

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[00:25:25]

Lewis Foxhall, MD

[00:25:26]

Well, screening is immediate if people do it. I mean, that helps identify people that have early disease and get them treated where we can actually have a lot better outcome. So that's a fairly immediate sort of thing. Getting somebody who's a smoker to quit has some positive immediate benefits, but it just increases over time, and with treatment, at least 30 to 50 percent of smokers can stop. So our program here at Anderson has about a 50 percent success rate.

[00:25:59]

Tacey Ann Rosolowski, PhD

[00:25:59]

Oh, really?

[00:25:59]

Lewis Foxhall, MD

[00:26:00]

Overall, I think it's about 30, so people that partake of that help. Dealing with obesity is more challenging, but there are some success formulations there as well. So all that helps, and those kind of big risk factors take their toll over time, so while there is some positive immediate benefit, it's primarily related to cardiovascular disease risk reduction, and cancer risk is more a longer-term thing. But if we can do some things like not have this next generation of kids smoke than the previous generations have, then that starts the clock ticking, and over time we'll see some very significant benefits.

[00:26:46]

Tacey Ann Rosolowski, PhD

[00:26:47]

I read somewhere, too, that obesity levels are dropping among children in certain ethnic groups, which is good news.

[00:26:53]

Lewis Foxhall, MD

[00:26:54]

Slightly, yeah, so it's a little bit. Well, they're not increasing. (laughter)

[00:26:57]

Tacey Ann Rosolowski, PhD

[00:26:59]

I guess you read a less optimistic report than I did.

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[00:27:01]

Lewis Foxhall, MD

[00:27:01]

Well, a little bit better, but anyway. And it's not exactly clear why that's going on, but it's relatively good news at least for that population. But we still have a third of the population that's in the significant obese categories, so they're at increased risk. So that's a 15, 20 percent increase cancer risk, and then, of course, tobacco accounts for probably 30 percent of all cancers. Lung cancer kills more people than the next four cancers combined. It's still a huge problem for us. Of course, a lot of that's just the legacy of tobacco use that has occurred over decades, so we'll try to work our way through that. But meanwhile, we're looking at potentially screening for lung cancer with CAT scans and things of that sort that may help a little bit. But the main thing is to quite exposing people to burning tobacco leaves.

[00:27:01]

Tacey Ann Rosolowski, PhD

[00:28:05]

Why do you think that institutions have been relatively slow or haven't thrown themselves into prevention as thoroughly as they have thrown themselves into discovering drugs, for example? What's the value system that's kind of creating that balance?

[00:28:30]

Lewis Foxhall, MD

[00:28:30]

Well, in research, research funding for prevention is significantly less than research funding for other things. That's a big part of it. In the treatment world, up until just recently, a lot of prevention services were not covered by insurance, and it's costly for people to do that. You make a lot more money taking care of people who are sick than keeping them from getting sick. So there's some financial disincentives to all that going on. So it's just sort of the way things are set up.

[00:29:07]

Tacey Ann Rosolowski, PhD

[00:29:08]

Is the Affordable Care Act unusual in the way it has stressed prevention to the degree that it has?

[00:29:16]

Lewis Foxhall, MD

[00:29:18]

Well, it's a change. There are some insurance policies previously that covered those sorts of things, but they've generally been more expensive policies that were really available to higher-income individuals. So the change here is that this is something that even low-income people can access.

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[00:29:39]

Tacey Ann Rosolowski, PhD

[00:29:47]

Is there anything else you'd like to say about this situation?

[00:29:49]

Lewis Foxhall, MD

[00:29:50]

Well, I think it's just a work in progress here, and, you know, the difficult part is still a political football, and the challenges that we face with trying to implement it are impacted by political considerations, and that's just the nature of the beast. But hopefully we can focus on the potential benefits for people who might avoid getting cancer and for people who have or have had cancer. So there are some significant pluses in the legislation for the population that we're concerned about, but it's going to getting pushed back and forth for years to come, I'm sure.

[00:30:31]

Tacey Ann Rosolowski, PhD

[00:30:34]

Well, if there's nothing else you'd like to add, Dr. Foxhall, I thank you very much for your time this morning.

[00:30:40]

Lewis Foxhall, MD

[00:30:41]

You're quite welcome.

[00:30:41]

Tacey Ann Rosolowski, PhD

[00:30:41]

This has been really, really helpful, and I'm glad we took the time to kind of flesh out this dimension.

[00:30:46]

Lewis Foxhall, MD

[00:30:46]

Yeah, that's a good piece of what's going on.

[00:30:48]

Tacey Ann Rosolowski, PhD

[00:30:48]

It is indeed. It is indeed. Well, thank you very much.

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[00:30:51]

Lewis Foxhall, MD

[00:30:52]

Okay. Thanks.

[00:30:52]

Tacey Ann Rosolowski, PhD

[00:30:53]

And I am turning off the recorder at about two minutes after ten. And I don't think I mentioned earlier that I turned on the recorder at precisely 9:30. Okay.

[00:31:03] (end of session five)