

A Century After Flexner – Will Johns Hopkins Lead the Next Transformation?



Tomorrow's Doctors, Tomorrow's Cures

Johns Hopkins School of Medicine
Clinical Practice Association

Board of Governors Meeting

Darrell G. Kirch, M.D.
President and CEO, AAMC

David S. Hefner, M.P.A.
Senior Advisor, AAMC
EVP for Clinical Affairs, GHSU

May 3, 2011

Learn

Serve

Lead



Association of
American Medical Colleges

Your Tradition

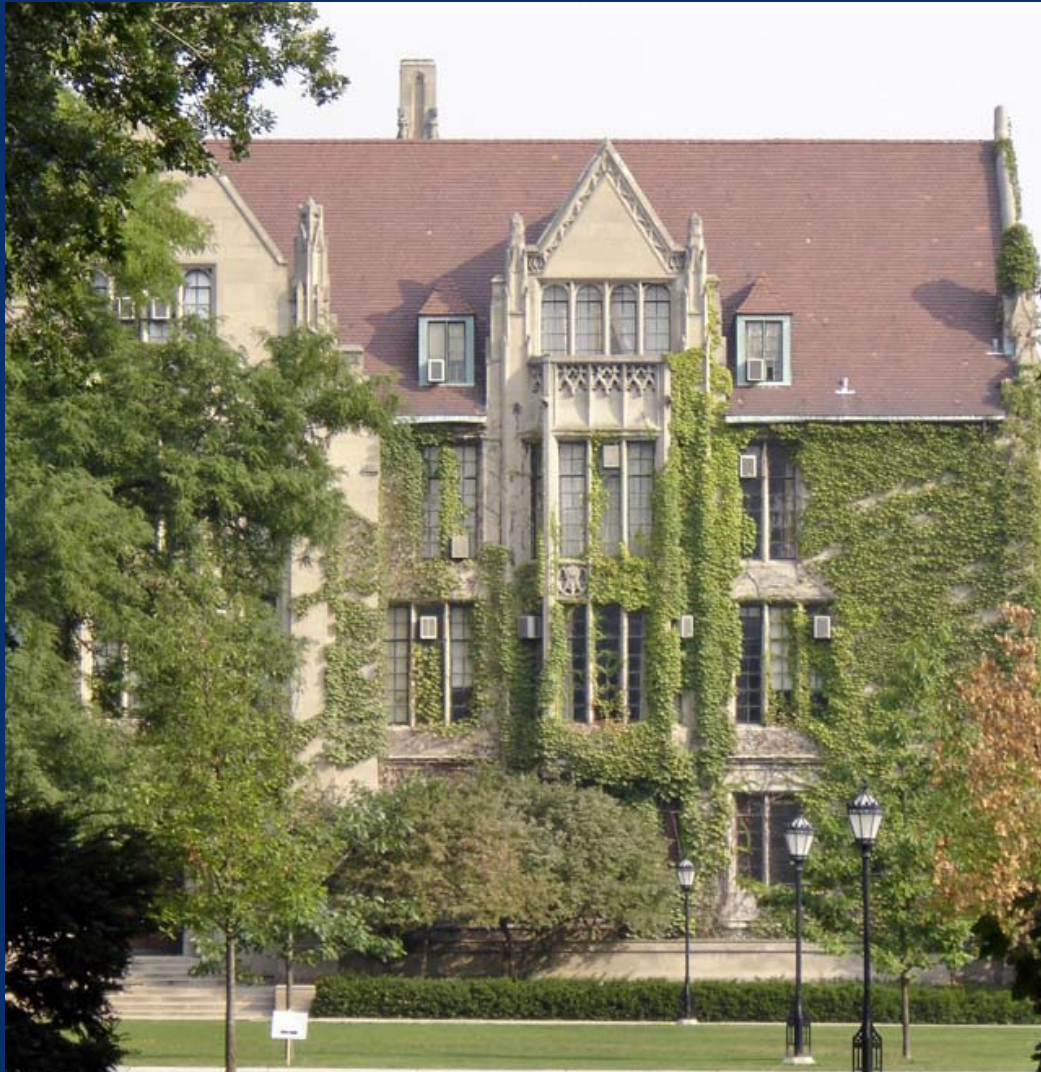


The reality of our historical legacy!

The Legacy of Abraham Flexner for Medical Education



The Culture of the University



The Legacy of James B. Wyngaarden, M.D. for Biomedical Research



The Culture of Biomedical Research



The Legacy of Lyndon B. Johnson for Health Care

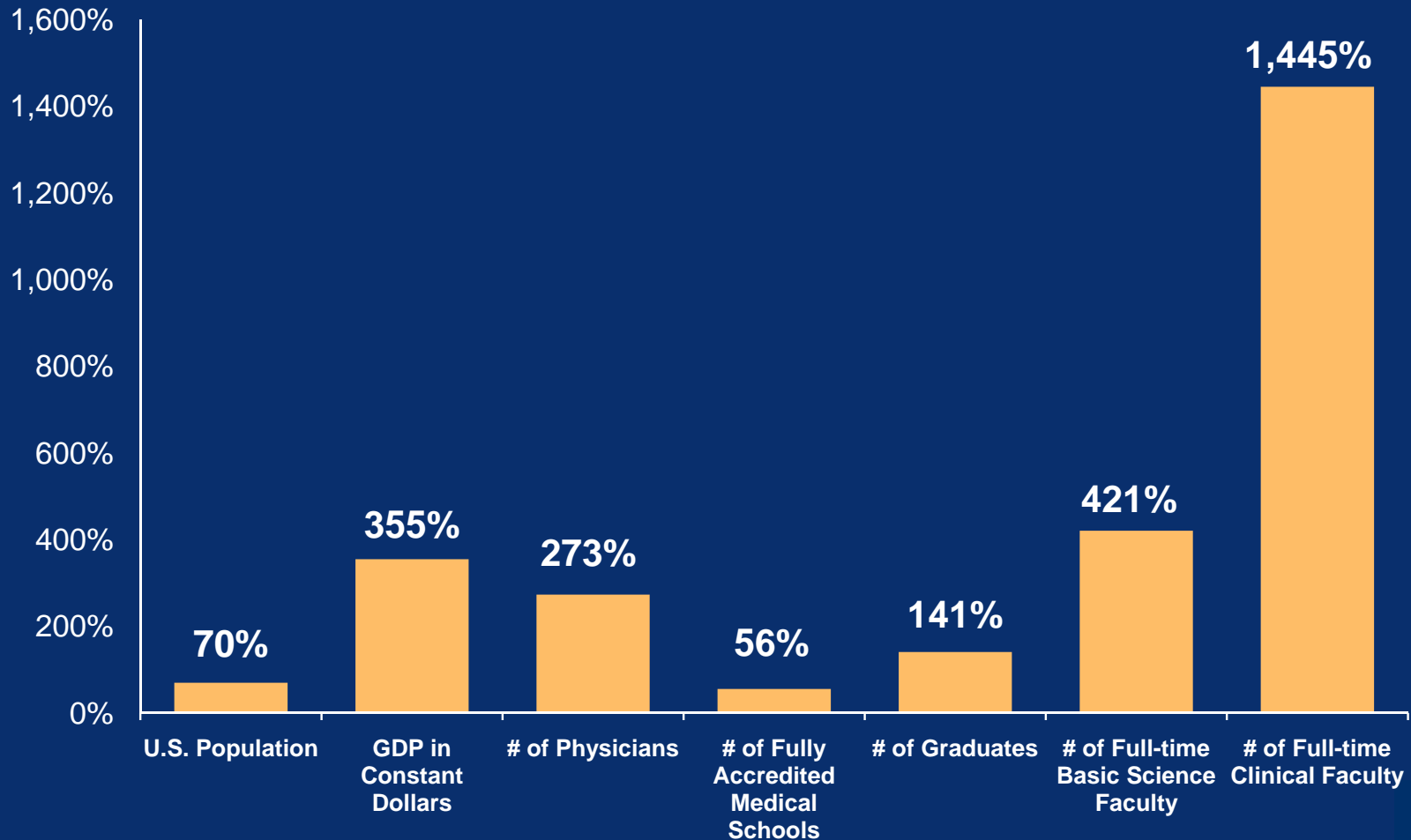


The Culture of Health Care



Five Decades of Medical School Growth

**Growth in U.S. Population, GDP, and Medicine
1960-61 to 2009-10**



Academia as a Major Provider of Health Care

AAMC-member teaching hospitals represent 6% of all hospitals

Their work represents:

- 40% of all Medicare inpatient days
- 22% of all Medicaid inpatient days
- 41% of all hospital charity care

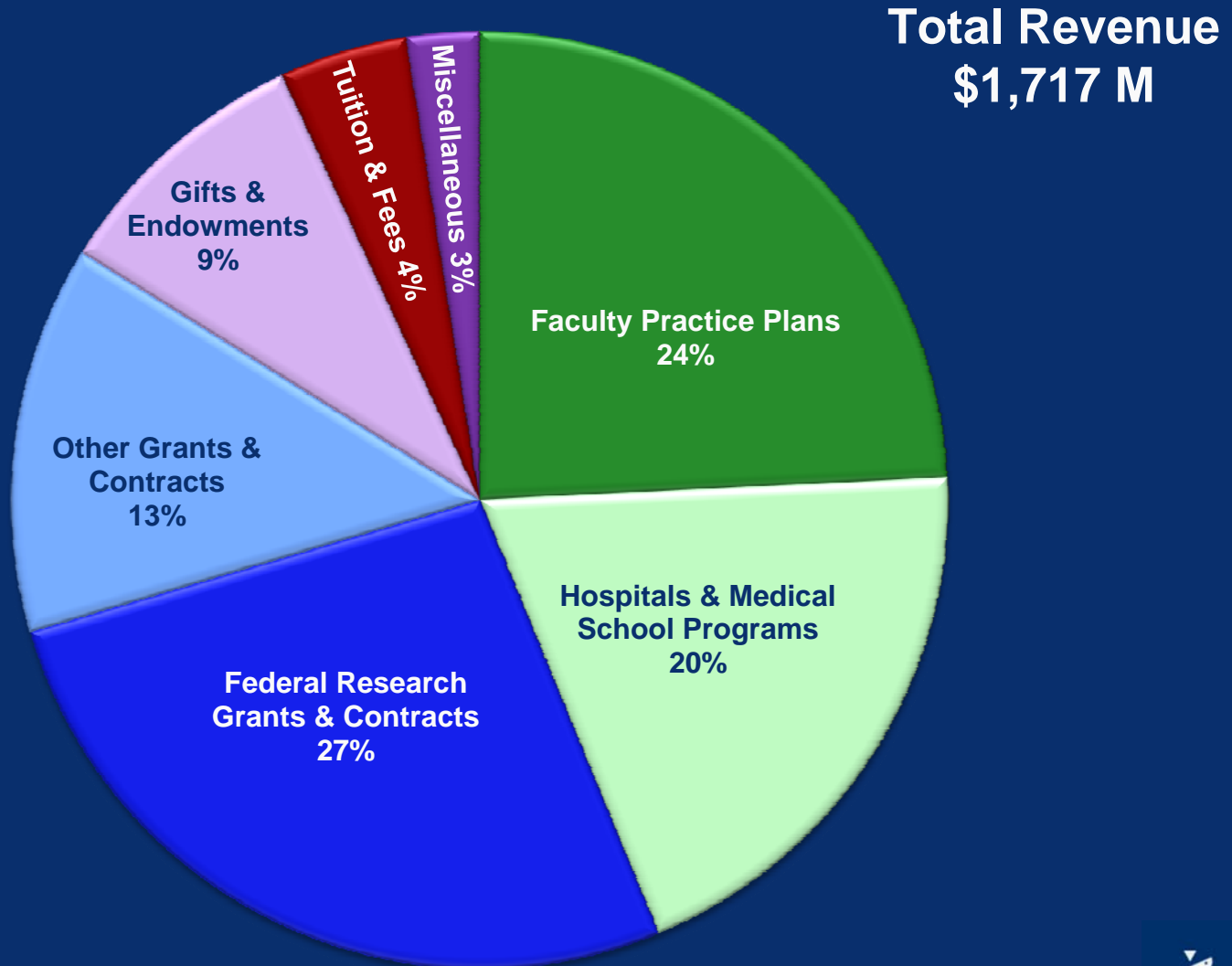
They provide:

- 79% of all burn center beds
- 40% of neonatal intensive care beds
- 83% of all Level 1 regional trauma centers

Overall, AAMC-member teaching hospitals provide 20% of all hospital care



Johns Hopkins University School of Medicine Revenues by Fund Source, FY2010

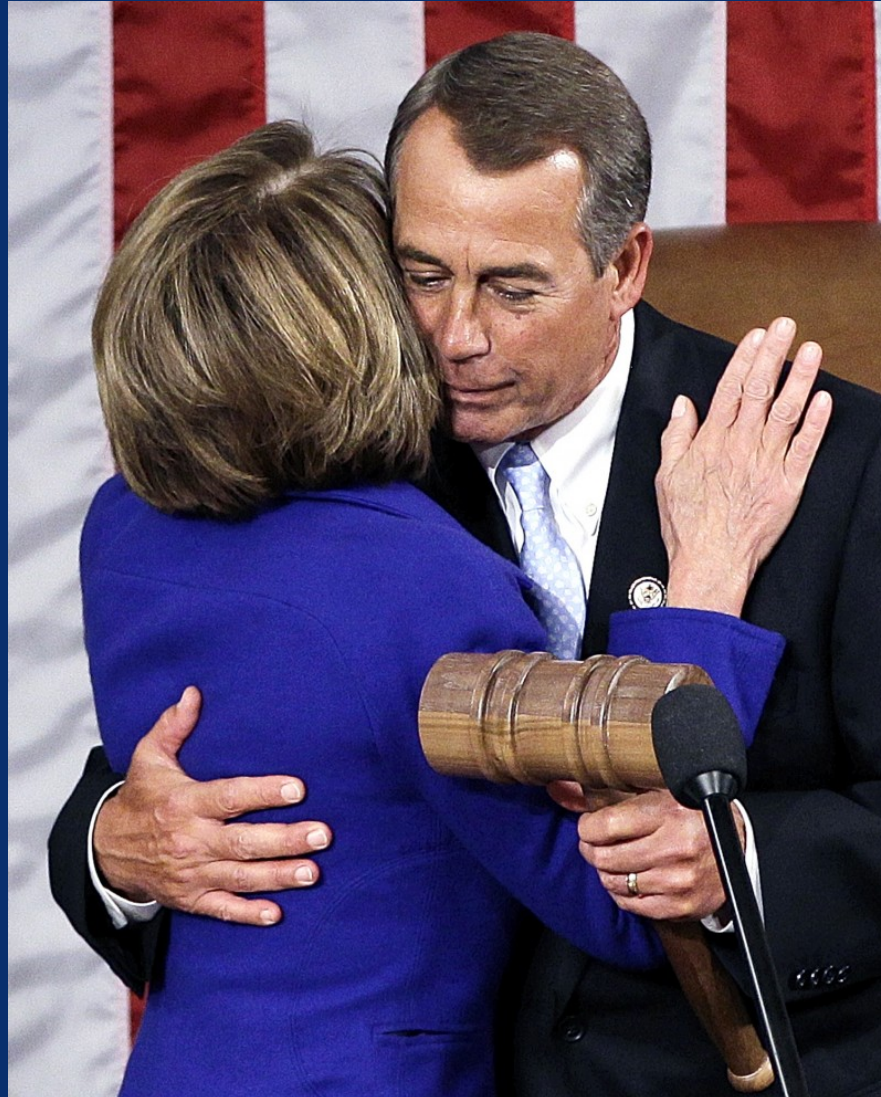


Source: LCME Part I-A Annual Financial Questionnaire, FY2010 (Permission to display from Dean Edward Miller)

© 2011 AAMC. May not be reproduced without permission.

Our national political reality!

A Bipartisan Moment...



...Followed by a Partisan Statement...

112TH CONGRESS
1ST SESSION

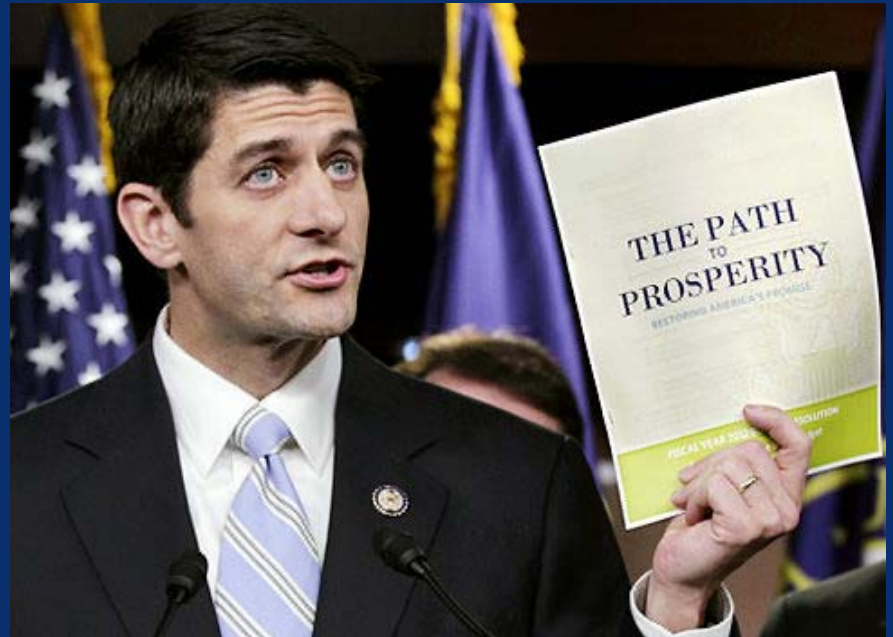
H. R. 2

To repeal the job-killing health care law and health care-related provisions in the Health Care and Education Reconciliation Act of 2010.

...Followed by Conflict at the State Level...



...And Now the Real Battle Begins



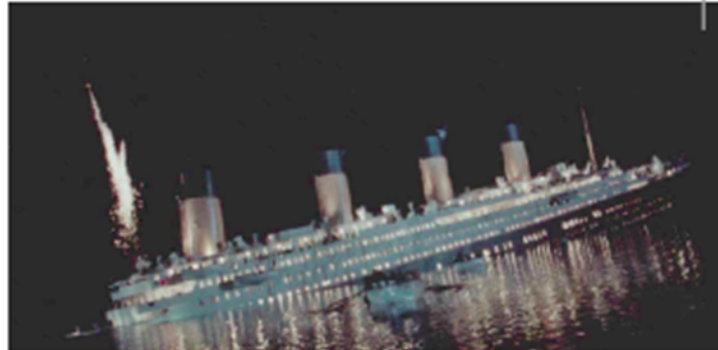
Our national economic reality!

“Stocks Plunge After S&P Shifts Rating On US Debt To Negative”

—The Hill

18 April 2011

Spring | 09



The End of the Third Bubble

Neal C. Hogen, PhD



BDC Advisors

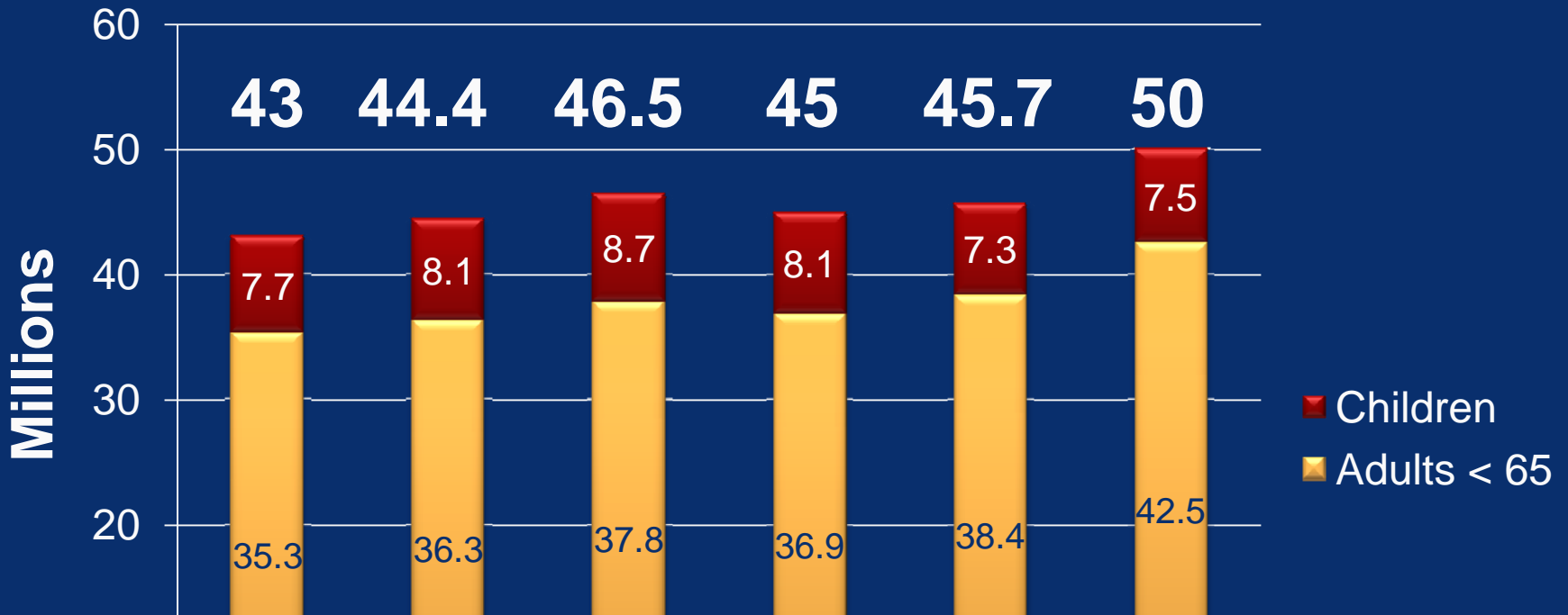
Moody's Outlook on Providers, Payers, and Universities is Negative for the First Time Ever



Our national health care reality!

Deficits in Insurance Coverage

Number of Uninsured Children and Non-elderly Adults- 2004-2009

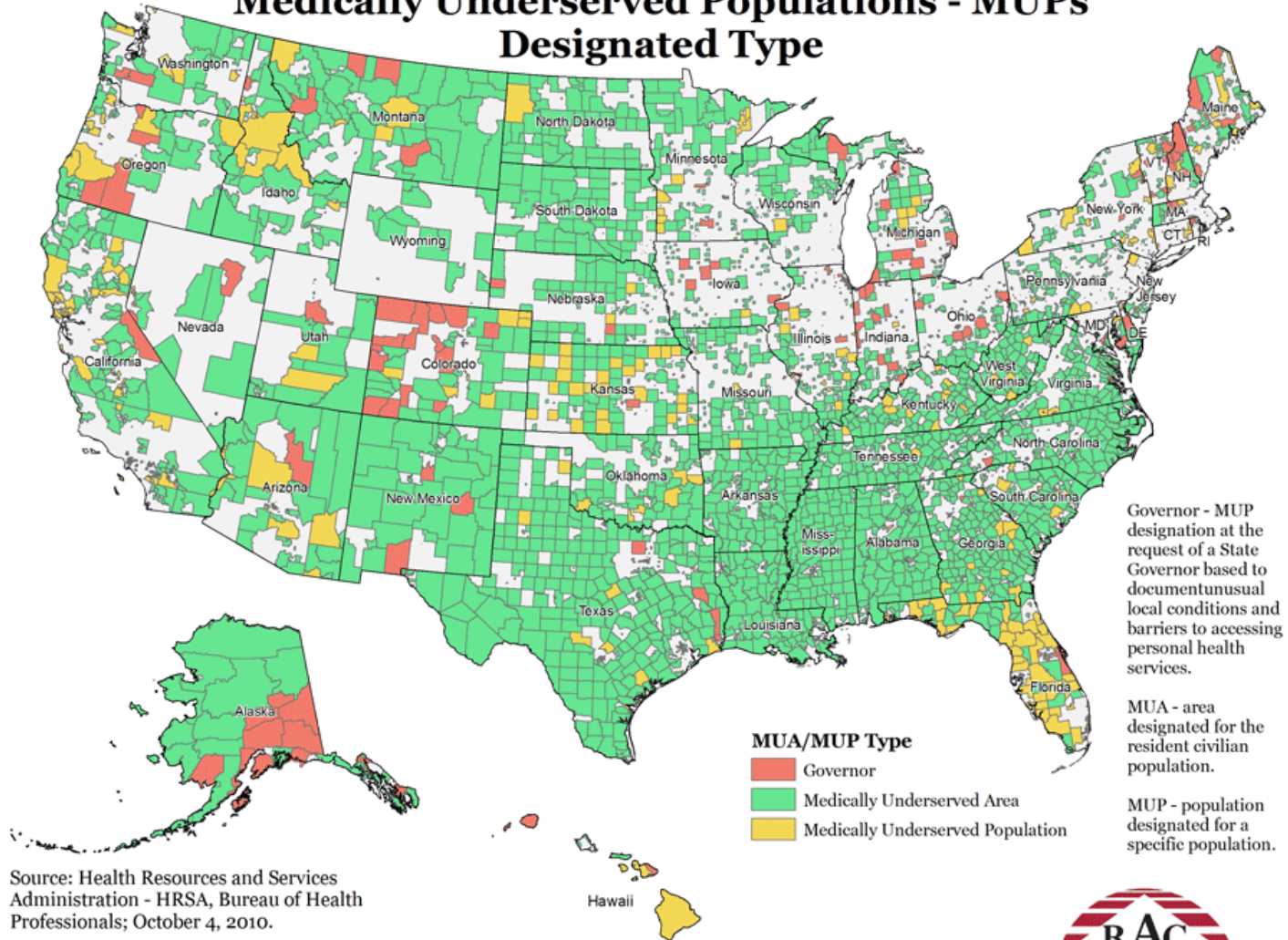


“Uninsured Rate Soars, 50+ Million Americans Without Coverage”

**— Kaiser Health News
16 September 2010**

Deficits in Access

Medically Underserved Areas - MUAs and Medically Underserved Populations - MUPs Designated Type



Governor - MUP designation at the request of a State Governor based to document unusual local conditions and barriers to accessing personal health services.

MUA - area designated for the resident civilian population.

MUP - population designated for a specific population.

MUA/MUP Type

- Governor
- Medically Underserved Area
- Medically Underserved Population

Source: Health Resources and Services Administration - HRSA, Bureau of Health Professionals; October 4, 2010.

Note: Alaska and Hawaii not shown to scale



Deficits in Outcomes

U.S. Comparison to Developed Nations

2007 Life Expectancy

Bottom third

(77.9 yrs compared to Japan at 82.6)

2006 Infant Mortality

4th Highest

(6.7% compared to average 5.1%)

2006 Adult Obesity*

1st

(Over 1/3 of U.S. population)

*Only 5 nations reported data on this indicator

Source: OECD Health Data 2010, June 2010

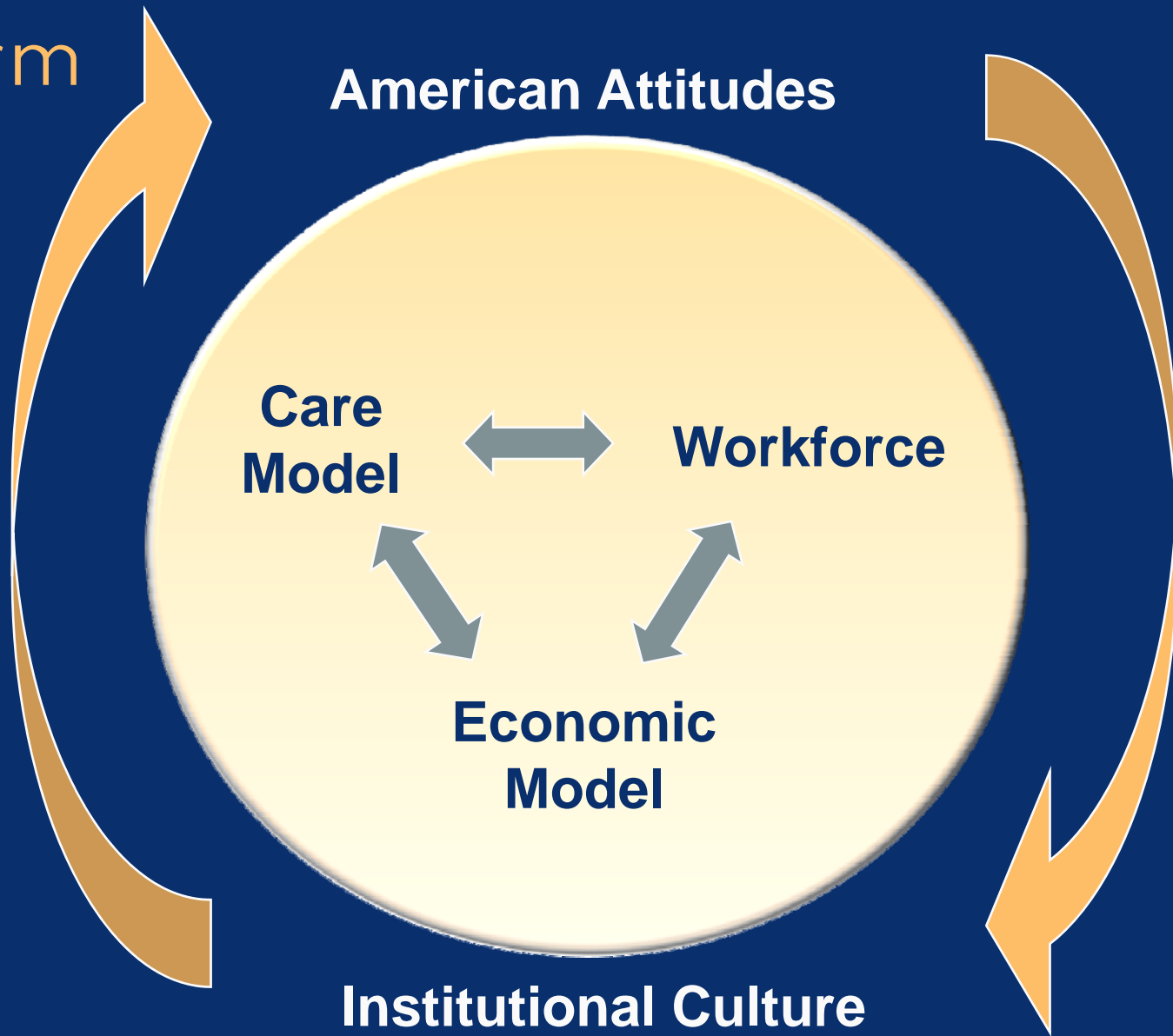
© 2011 AAMC. May not be reproduced without permission.

Maryland Health Status

	Maryland	U.S. average
Life expectancy	78 years	78 years
Infant mortality rate (per 1,000 live births)	7.9	6.8
Heart disease rate (per 100,000)	202.4	190.9
Diabetes rate (per 100 adults)	7.2	5.5
Overweight/obese adults	60.1%	60.8%

In the face of these realities, have we really “reformed” health care?

The Dimensions of "True" Health Care Reform



**Will we create a true continuum
of medical education?**

Can We Rethink Our Approach to the Medical Education Continuum?

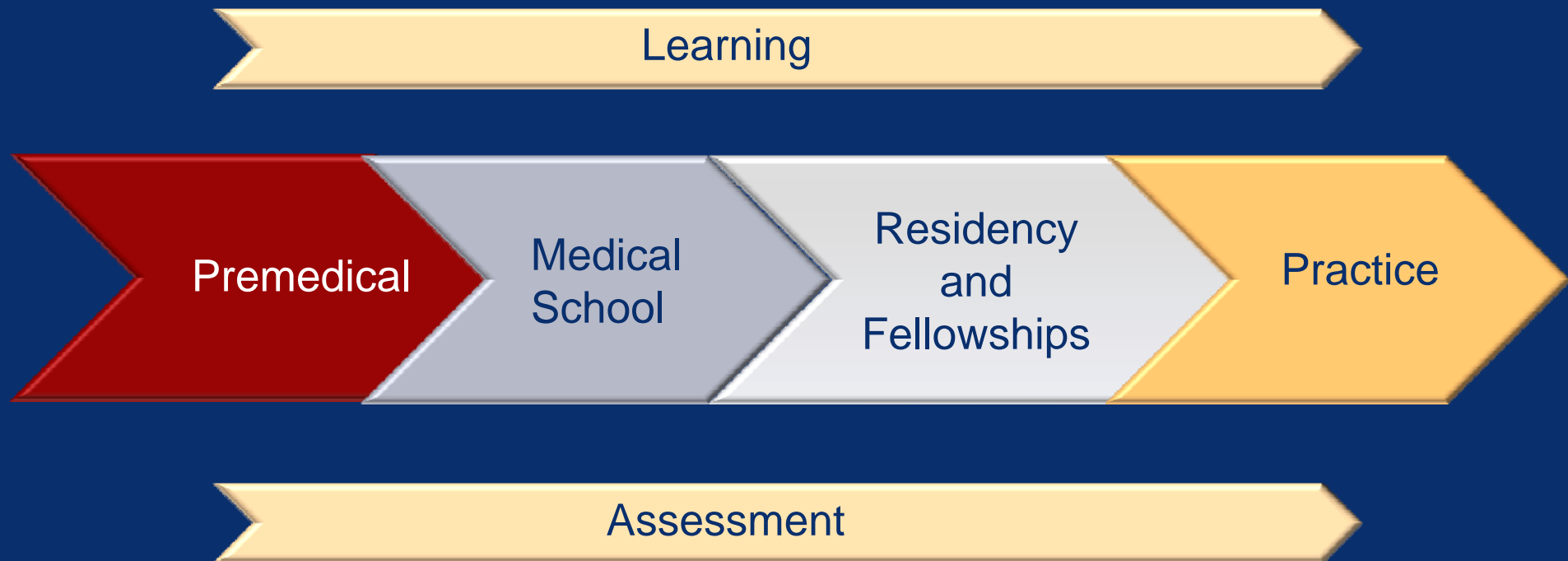
Premedical

Medical
School

Residency
and
Fellowships

Practice

Creating a True Continuum of Medical Education



Creating True Health Care Teams

American Association of Colleges of Nursing

aacom[®]
AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

ASPH
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH


American Association of Colleges of Pharmacy AACP
Patient • Team • Care • Improved Health

ADEA | AMERICAN DENTAL EDUCATION ASSOCIATION

AAMC
Tomorrow's Doctors. Tomorrow's Cares.[®]

Core Competencies for Interprofessional Collaborative Practice

Sponsored by the Interprofessional Education Collaborative*



Pre-publication recommendations from the IPEC Expert Panel
February 2011

*IPEC sponsors:
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Dental Education Association
Association of American Medical Colleges
Association of Schools of Public Health

Will biomedical research connect more directly with improving the health of the population?

Can We Rethink Our Approach to the Cycle of Research?



Transforming Health Care Through Cross-Mission Alignment

“(xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

The Need for New Health Care Partners



The Need for New Community Partners

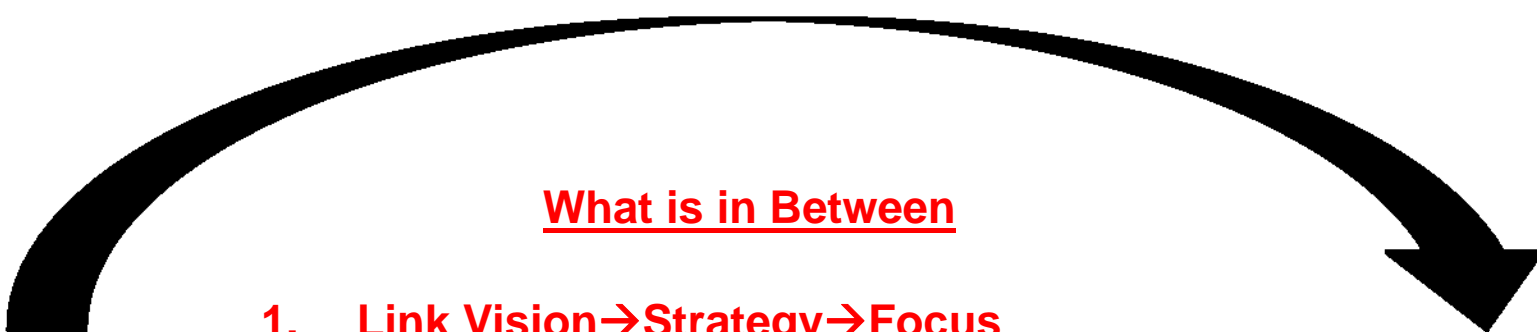


What is the length
of your runway?



If cross-mission transformation is required, what are the critical precursors?

Precursors for Success



What is in Between

Hopkins Today?

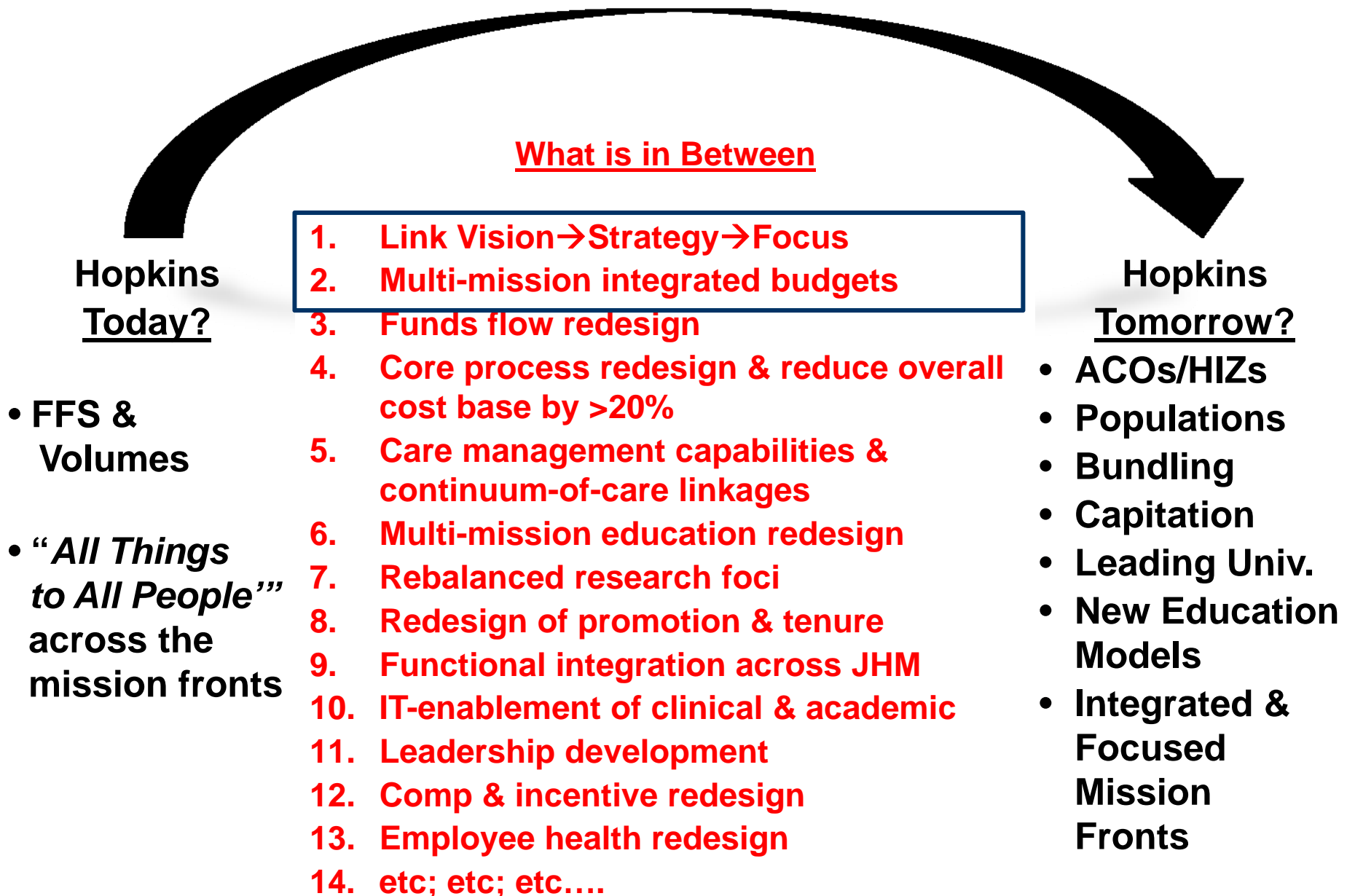
- FFS & Volumes
- “All Things to All People” across the mission fronts

1. Link Vision→Strategy→Focus
2. Multi-mission integrated budgets
3. Funds flow redesign
4. Core process redesign & reduce overall cost base by >20%
5. Care management capabilities & continuum-of-care linkages
6. Multi-mission education redesign
7. Rebalanced research foci
8. Redesign of promotion & tenure
9. Functional integration across JHM
10. IT-enablement of clinical & academic
11. Leadership development
12. Comp & incentive redesign
13. Employee health redesign
14. etc; etc; etc....

Hopkins Tomorrow?

- ACOs/HIZs
- Populations
- Bundling
- Capitation
- Leading Univ.
- New Education Models
- Integrated & Focused Mission Fronts

Precursors for Success

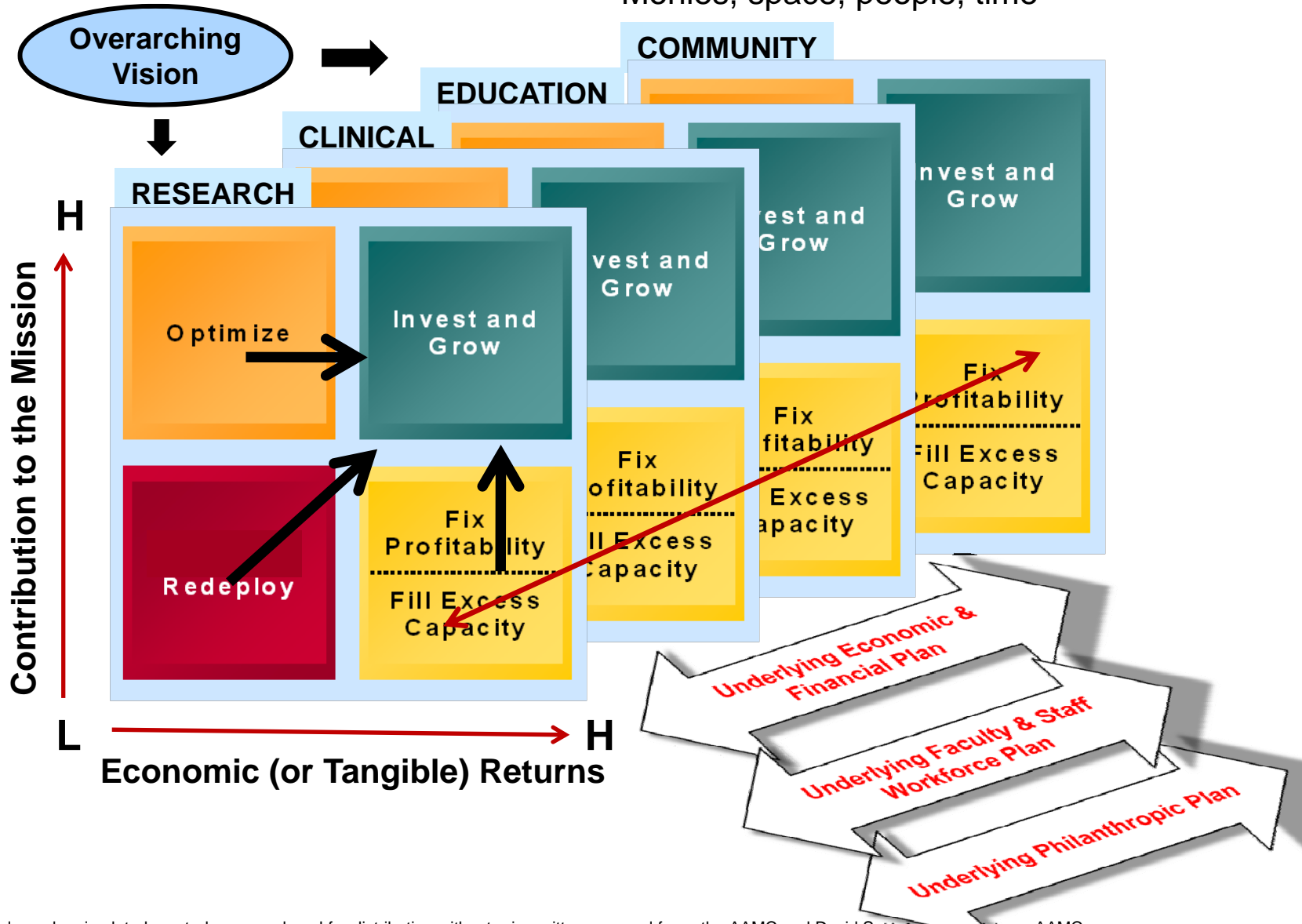


Linking Vision → Strategy → Focus

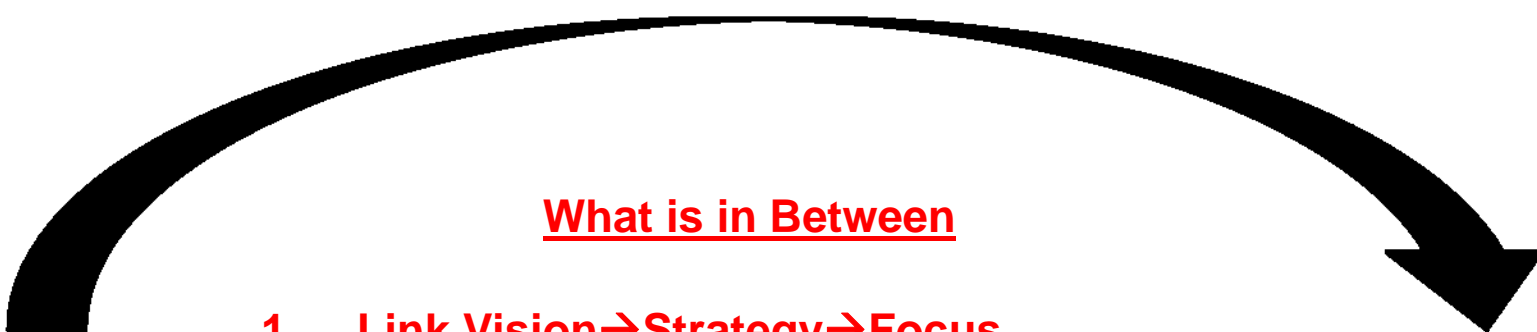
Should We Be All Things To All People?

Resources to Allocate:
Monies, space, people, time

ILLUSTRATIVE



Precursors for Success



What is in Between

Hopkins Today?

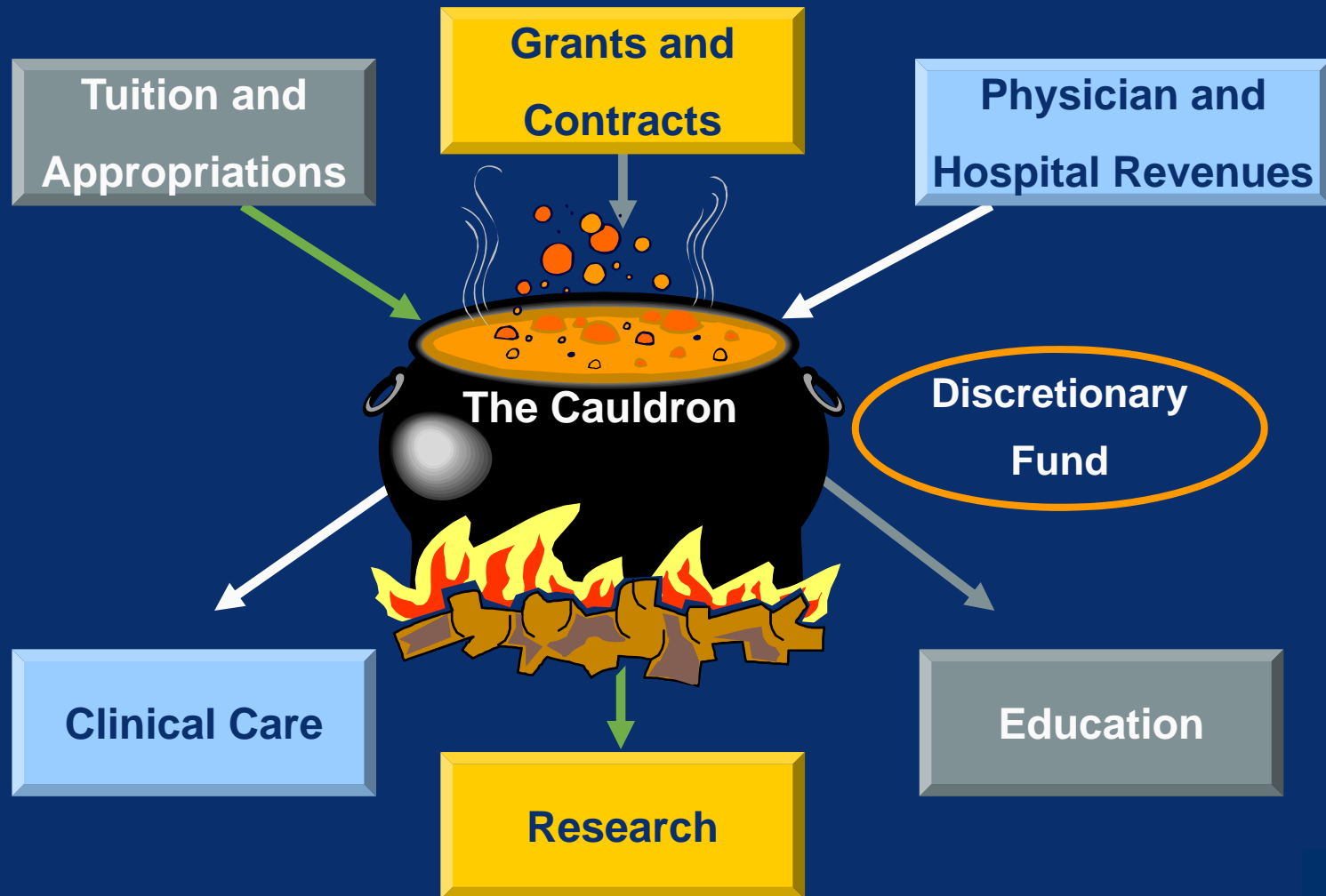
- FFS & Volumes
- “All Things to All People” across the mission fronts

1. Link Vision → Strategy → Focus
2. Multi-mission integrated budgets
3. Funds flow redesign
4. Core process redesign & reduce overall cost base by >20%
5. Care management capabilities & continuum-of-care linkages
6. Multi-mission education redesign
7. Rebalanced research foci
8. Redesign of promotion & tenure
9. Functional integration across JHM
10. IT-enablement of clinical & academic
11. Leadership development
12. Comp & incentive redesign
13. Employee health redesign
14. etc; etc; etc....

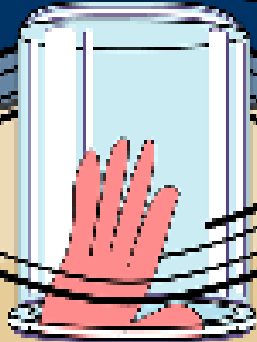
Hopkins Tomorrow?

- ACOs/HIZs
- Populations
- Bundling
- Capitation
- Leading Univ.
- New Education Models
- Integrated & Focused Mission Fronts

Aligning Resources with Effort



ACADEMIC MEDICINE'S SHELL GAME



School of Medicine

RESEARCH

EDUCATION

CLINICAL CARE

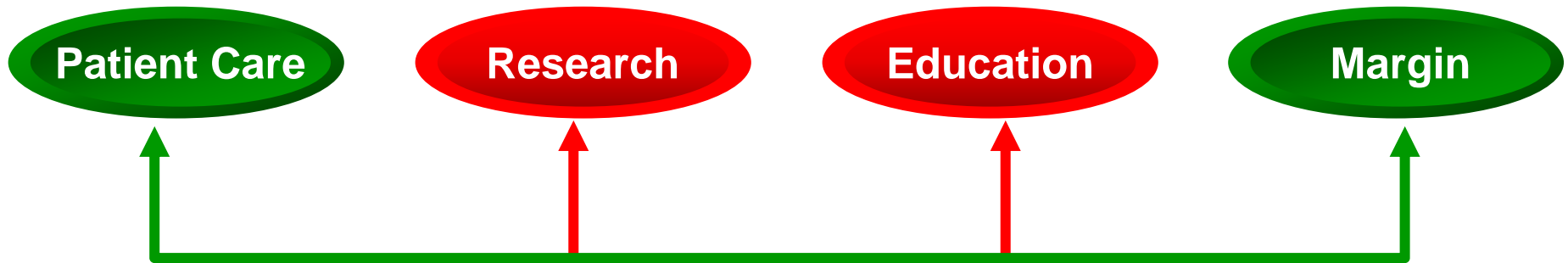
“Book of Deals” Hell



"Funds Flow Plinko"



Economic Interdependencies of Our Missions



Clinical Enterprise cross-subsidies to Academics tend to be the rule:

"80/20" Pareto Exceptions

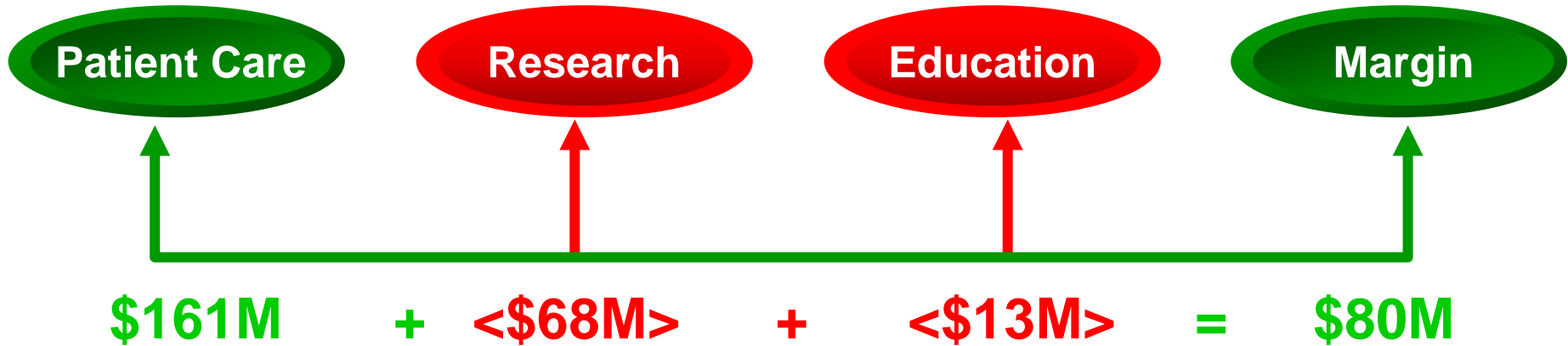
- Secure large corporate sponsorship (e.g., Wash U)
- Grow renewable patent streams (e.g., NYU Remicade, UF Gatorade)

Why Research Inherently Requires Investment

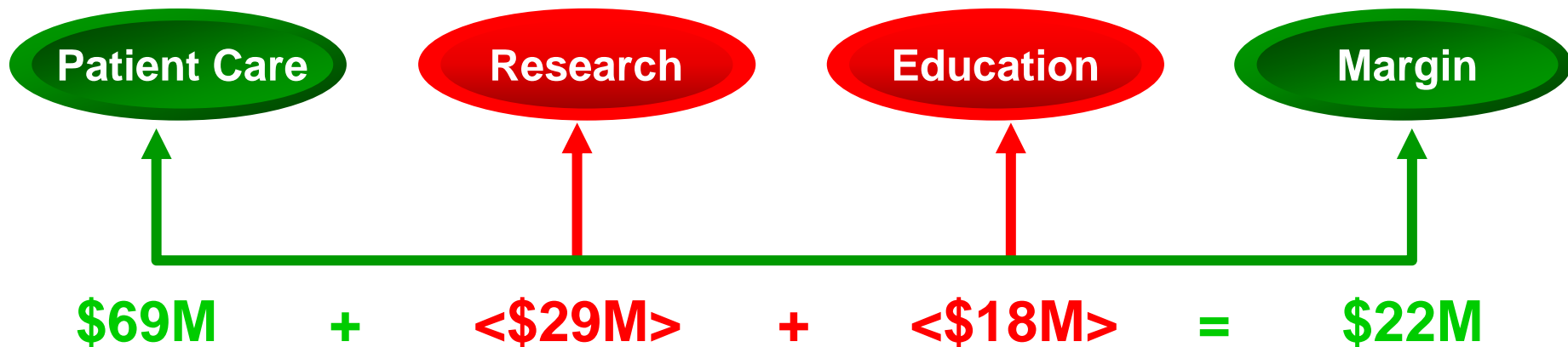
- 1. Investments in start-up costs (aka, seed funding)**
- 2. Investigator salary cost-sharing above the NIH cap**
- 3. Planned bridge funding**
- 4. Unplanned, long-term bridge funding**
- 5. Insufficient NIH Indirect rate**
- 6. Low non-NIH Indirect rate**
- 7. “Star” recruitment packages (similar to #1)**
- 8. Under-productive lab space**
- 9. Over-reliance on other sources**
- 10. Under-recovered core facilities**
- 11. High local costs of wages and/or supplies (under modular funding only)**
- 12. New R01 rules introduce the opportunity to lose/profit through better cost control**
- 13. Faculty doing small amounts of research without grant coverage attributable**
- 14. *Fundamental question of “why are we doing the research we are doing” has not been addressed***

Economic Interdependencies of Our Missions

Interdependencies of Missions – Case Study #1 (private, RI)

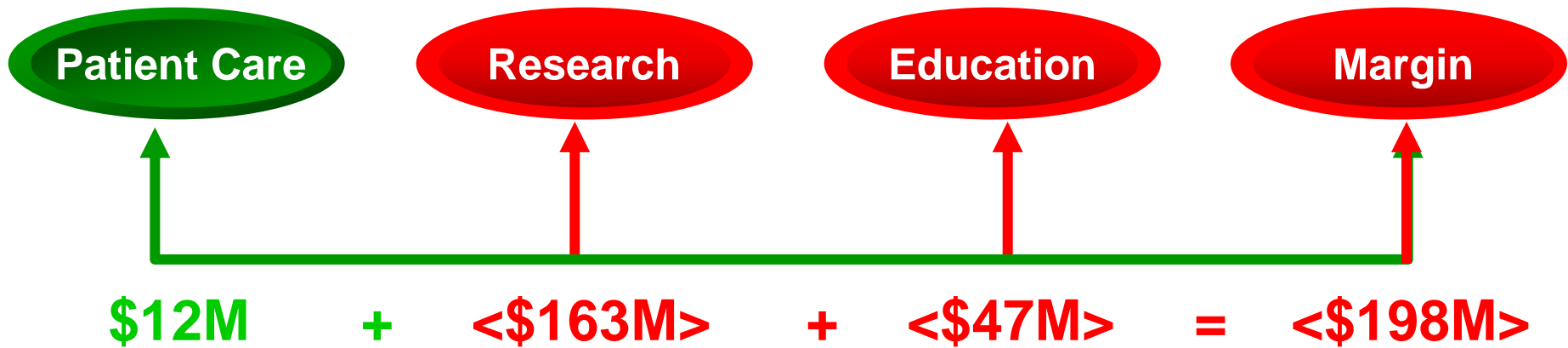


Interdependencies of Missions – Case Study #2 (public)



Economic Interdependencies of Our Missions

Interdependencies of Missions – Case Study #3 (private, RI)



\$12M

+

<\$163M>

+

<\$47M>

=

<\$198M>

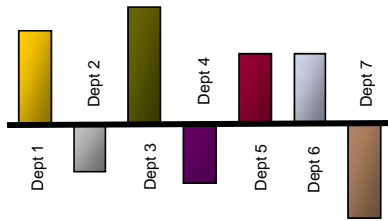
Investment Income, Philanthropy of \$198M = \$ 0

Investment Income, Philanthropy of \$125M = <\$ 74M>

"Funds Flow Hell"

Illustrative

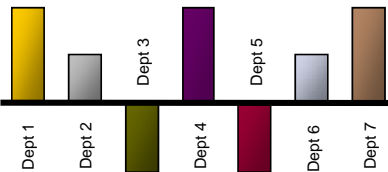
College, Department , Business Unit Margins



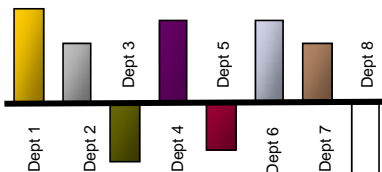
OTHER EXAMPLES OF DISTORTION

1. Fragmented, duplicative resources
2. Transfer pricing for IT services
3. Schedulers
4. Malpractice insurance
5. Anesthesia techs
6. etc; etc; etc.....

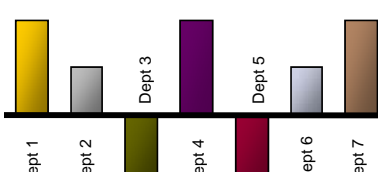
STEP 2: New Clinic Cost Allocations



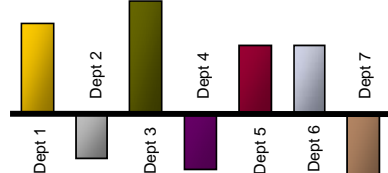
STEP 3: New Medical Direction Redistribution



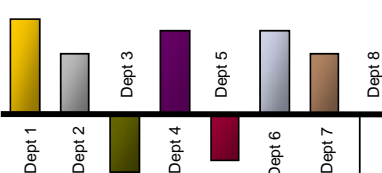
STEP 4: Removal of Historical "Side Deals"



STEP 5: Redistribution of Tuition Funds



STEP 6: Realignment of Strategic Investments

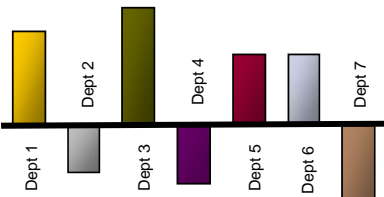


**Organizational
confusion,
mistrust, and
chaos**

"Creating A Trusted Purse"

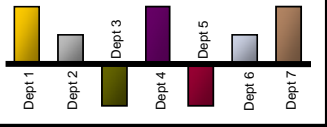
Illustrative

College, Department ,
Business Unit Margins



The new context
transitions key leaders from
an "individual" performer
to a "team"

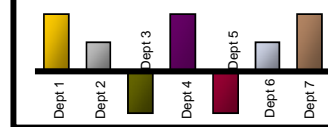
STEP 2:
New Clinic
Cost Allocations



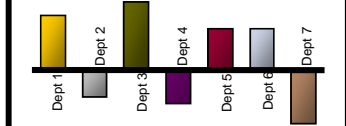
STEP 3:
New PAT
Redistribution



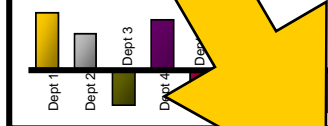
STEP 4:
Removal of Historical "Side
Deals"



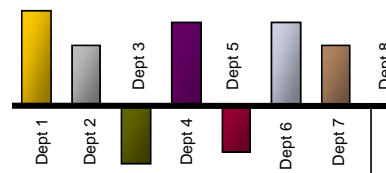
STEP 5:
Redistribution of Teaching
Funds



Realignment Strategic
Investments

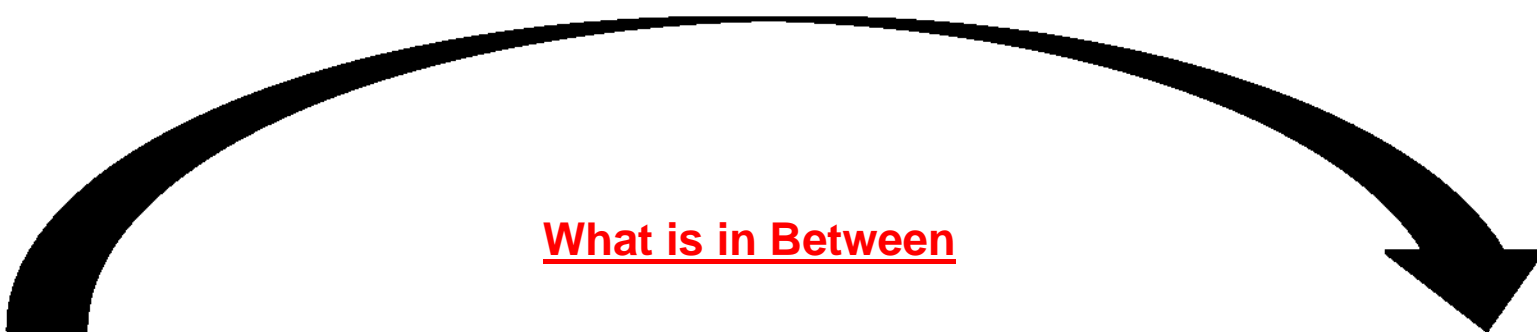


NEW
New Expectation of
"Managing to a Margin"



Transition the
implementation
(1 – 2 years) with
Leaders accountable
for a new redistributed
bottom line

Precursors for Success



What is in Between

Hopkins Today?

- FFS & Volumes
- “All Things to All People” across the mission fronts

1. Link Vision→Strategy→Focus
2. Multi-mission integrated budgets
3. Funds flow redesign
4. Core process redesign & reduce overall cost base by >20%
5. Care management capabilities & continuum-of-care linkages
6. Multi-mission education redesign
7. Rebalanced research foci
8. Redesign of promotion & tenure
9. Functional integration across JHM
10. IT-enablement of clinical & academic
11. Leadership development
12. Comp & incentive redesign
13. Employee health redesign
14. etc; etc; etc....

Hopkins Tomorrow?

- ACOs/HIZs
- Populations
- Bundling
- Capitation
- Leading Univ.
- New Education Models
- Integrated & Focused Mission Fronts

Vision

Penn State Heart & Vascular Institute Vision

With balanced excellence in care, research and education, the Penn State Heart & Vascular Institute will be the preferred provider of tertiary and quaternary heart and vascular care for people of central Pennsylvania and a national model of total heart and vascular health.

The Penn State Heart & Vascular Institute (PSHVI) is a multi-specialty academic clinical entity. It was formed to:

- Improve care
- Enhance research
- Provide a cross-discipline educational platform for trainees and the community

**Academic
Departments**

Missions

**Support of
Missions**

Medicine
Nursing
Radiology
Surgery
Primary Care
Other

Clinical Care
Education
Research

Capital
H.R.
Information Tech.
Physical Res.

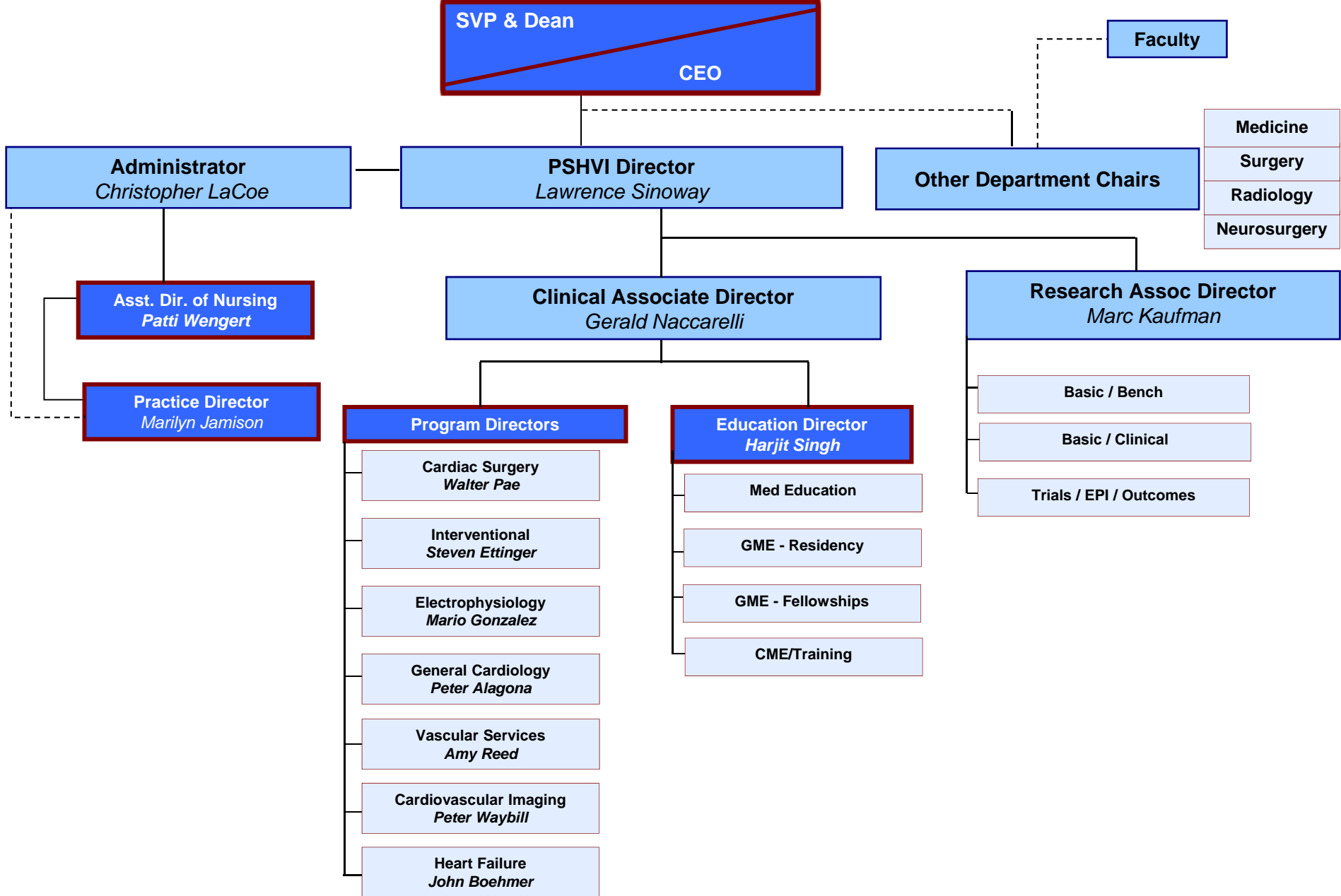
Penn State Heart & Vascular Institute

Touch Points



- Departments
 - Medicine
 - Radiology
 - Surgery
 - Anesthesia
 - Nursing
 - Emergency Department
 - Family & Community Medicine
 - Neurology
- Education
 - Fellowships
 - CT
 - Cards
 - Vascular
- Research
 - Basic Science
 - Artificial Organs
 - General Clinical Research Center (GCRC)
 - Clinical Trials (Cardiology/CT)
- Professional Cost Centers
 - Cardiology - 260030130
 - CT Surgery - 260110050
 - Vascular Surgery - 260080250
 - Vascular Radiology - 260080250
- Hospital Cost Centers
 - Cardiovascular Center Admin 155150125
 - Cardiac Catheterization Lab 155150030
 - Electrophysiology Lab 155150040
 - Non-Invasive Cardiology 155150100
 - Adult Echocardiography Lab 155150090
 - Cardiac Rehabilitation 155150010
 - Heart Acquisition 155020020
 - Vent Assist Device (LVAD) 155090070
 - CV Observation Unit (CVOU) 155150115
 - CV Care Unit (CVCU) 150010123
 - Outpatient Acute Care (OPAC) 155150150
 - Perfusion 155090020
 - Cardiac OR's (Main OR) 155090010
 - Cardiovascular ICU (Spring 06) 150010165
 - Vascular Lab 155150110
 - Vascular Radiology 155050140
 - I.O. Silver Cardiovascular Specialties 157030880

PSHVI Organizational Structure



SVP & Dean
CEO

Faculty

Administrator
Christopher LaCoe

PSHVI Director
Lawrence Sinoway

Other Department Chairs
Medicine
Surgery
Radiology
Neurosurgery

Asst. Dir. of Nursing
Patti Wengert

Clinical Associate Director
Gerald Naccarelli

Research Assoc Director
Marc Kaufman

Practice Director
Marilyn Jamison

Program Directors

Education Director
Harjit Singh

Cardiac Surgery
Walter Pae

Med Education

Interventional
Steven Ettinger

GME - Residency

Electrophysiology
Mario Gonzalez

GME - Fellowships

General Cardiology
Peter Alagona

CME/Training

Vascular Services
Amy Reed

Cardiovascular Imaging
Peter Waybill

Heart Failure
John Boehmer

Basic / Bench

Basic / Clinical

Trials / EPI / Outcomes

Precursors for Success



What is in Between

1. Link Vision→Strategy→Focus
2. Multi-mission integrated budgets
3. Funds flow redesign
4. Core process redesign & reduce overall cost base by >20%
5. Care management capabilities & continuum-of-care linkages
6. Multi-mission education redesign
7. Rebalanced research foci
8. Redesign of promotion & tenure
9. Functional integration across JHM
10. IT-enablement of clinical & academic
11. Leadership development
12. Comp & incentive redesign
13. Employee health redesign
14. etc; etc; etc....

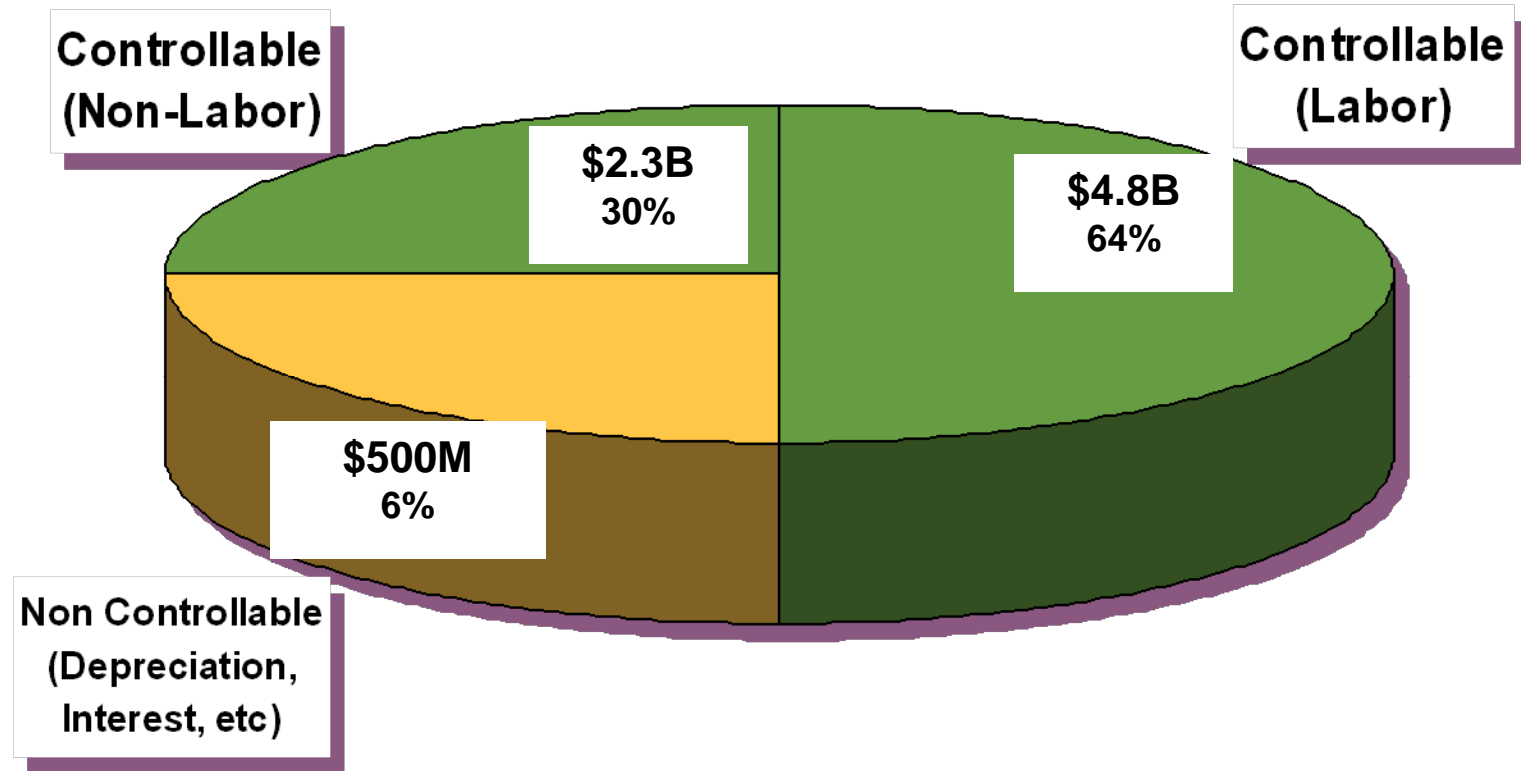
Today?

• \$7.6B

Tomorrow

• \$6.1B

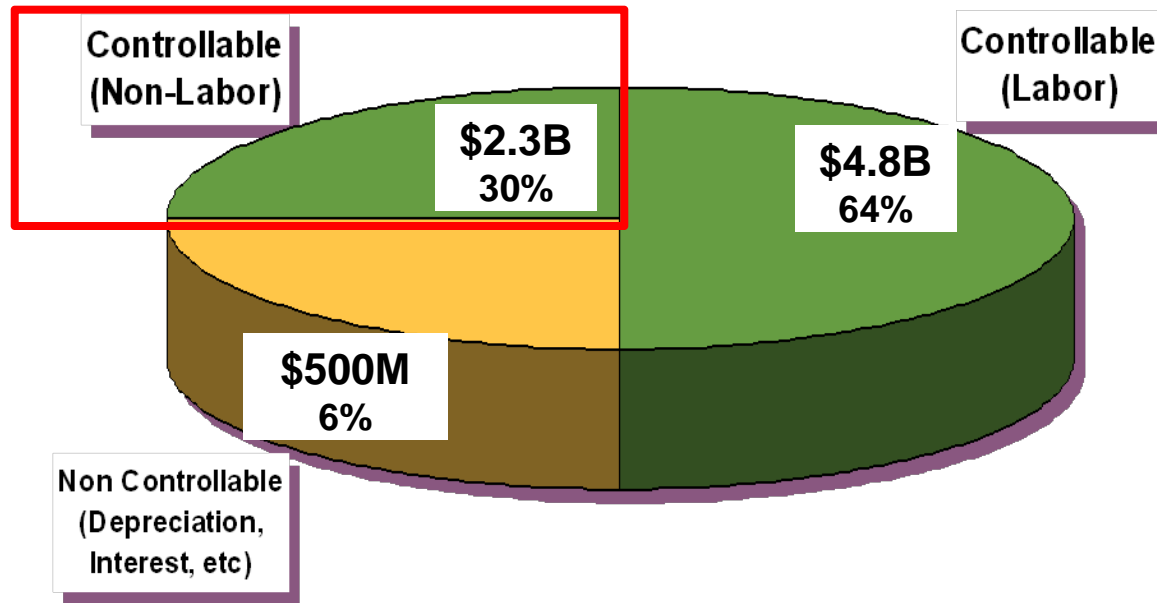
Precursors for Success



The \$7.6B economy can be depicted as “Controllable” and “Non-Controllable” expenses.

A 20% reduction of the controllable expense base equates to a **\$1.4B restructuring**.

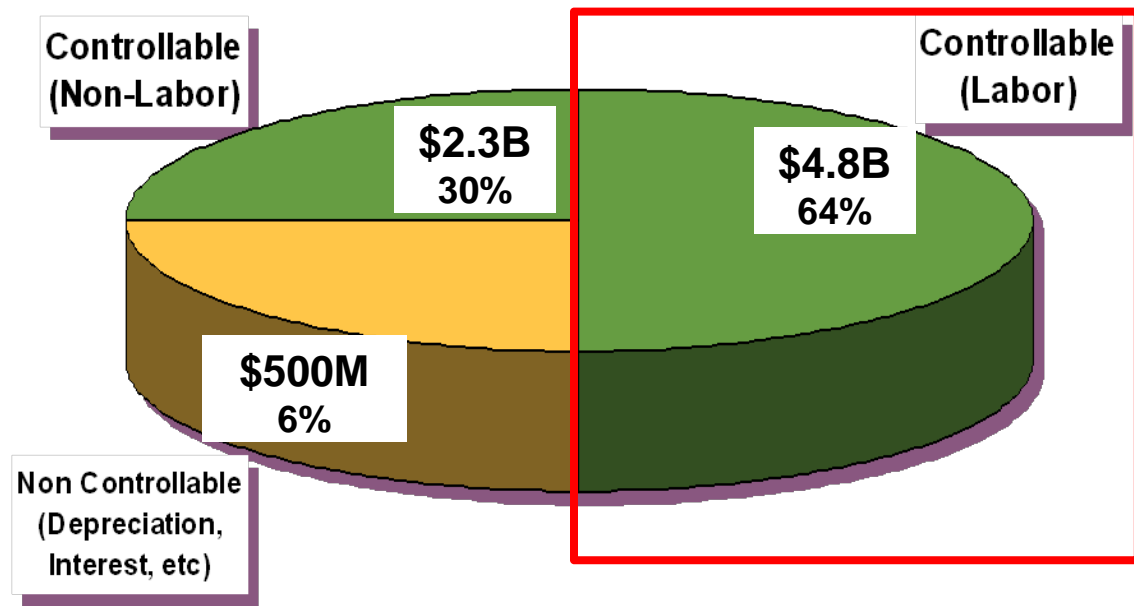
Thought Experiment → Non-Labor



...the \$2.3B non-labor pool is comprised of supplies and purchased services. **A 20% reduction would require an annually savings of \$460M**

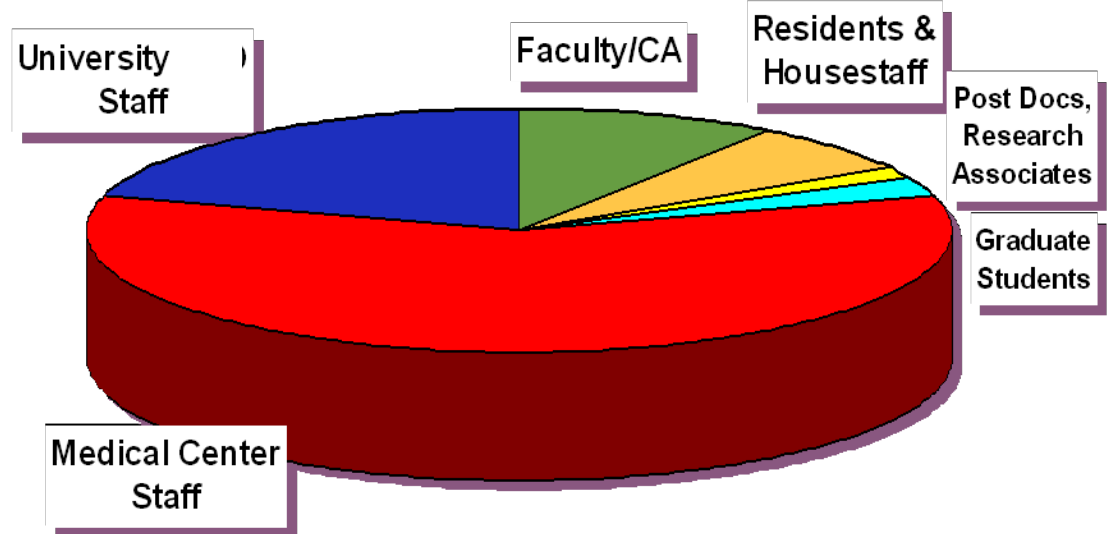
(and it still requires another \$840M of labor savings)

Thought Experiment → Labor

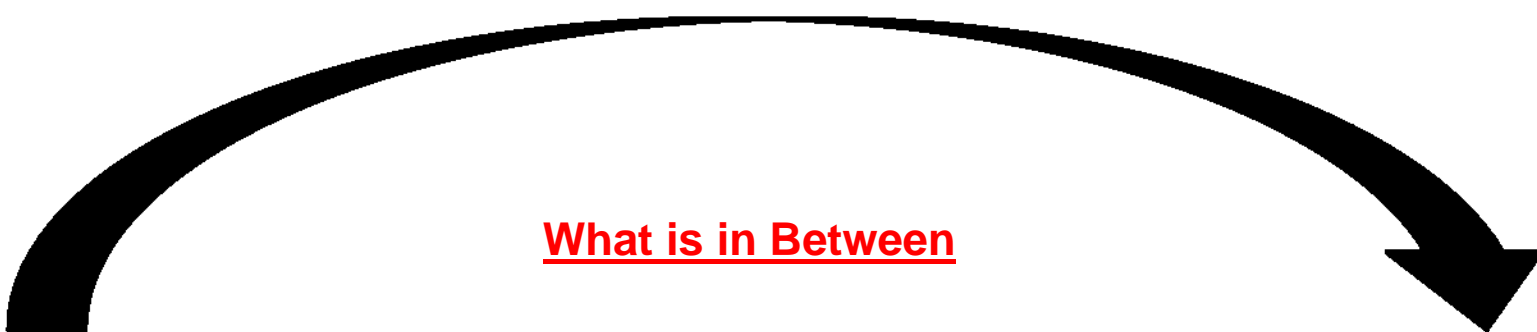


...the \$4.8B labor pool has 90,000 individuals with varying talents and skill sets.

N = 90,000



Precursors for Success



What is in Between

Hopkins Today?

- FFS & Volumes
- “All Things to All People” across the mission fronts

1. Link Vision→Strategy→Focus
2. Multi-mission integrated budgets
3. Funds flow redesign
4. Core process redesign & reduce overall cost base by >20%
5. Care management capabilities & continuum-of-care linkages
6. Multi-mission education redesign
7. Rebalanced research foci
8. Redesign of promotion & tenure
9. Functional integration across JHM
10. IT-enablement of clinical & academic
11. Leadership development
12. Comp & incentive redesign
13. Employee health redesign
14. etc; etc; etc....

Hopkins Tomorrow?

- ACOs/HIZs
- Populations
- Bundling
- Capitation
- Leading Univ.
- New Education Models
- Integrated & Focused Mission Fronts

State Change for FUDs, Chairs, Chiefs, VPs?

The Past...

1. Grow Department or Institute by whatever means available
2. One-off side deals with Hospital, Dean, University
3. Rewarded for Unit results
4. Anecdotal knowledge of performance of other Units
5. Compete for resources against other Units



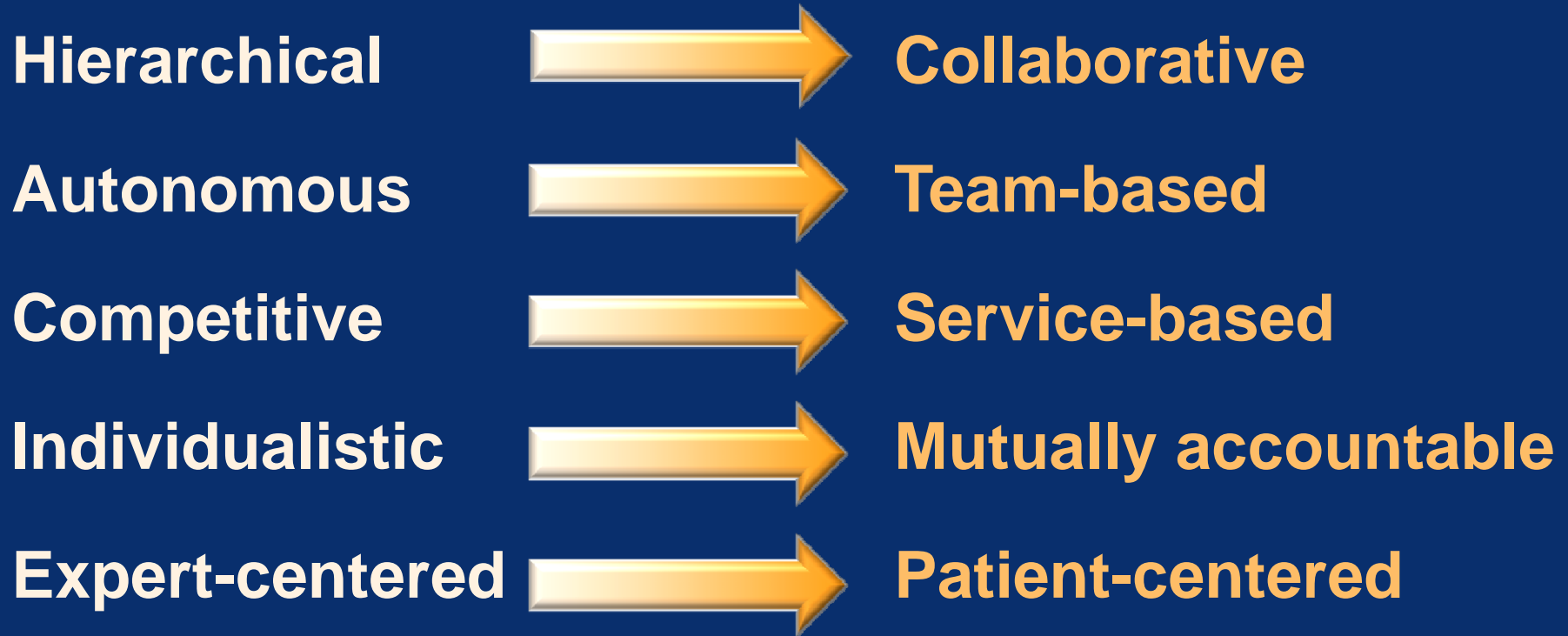
The Future...

1. Successes and failures more visible
2. Deep understanding of, and engagement in, the success of the entire organization
3. Frank dialogue and mentoring with each faculty member
4. Change agent
5. Work collaboratively with peers, while holding peers accountable for results (and being held accountable)

If cross-mission transformation is required, what is required of me as a leader?

#1 Make values explicit and use them visibly in everyday decisions to create the desired culture!

An Emerging Culture for Health Care



#2 “Grow your own” through broad-based programs focused on creating integrative leadership!

Your Tradition



“(An) important new book...Mr. O’Toole puts soul and values squarely back into a vital topic, leadership.”

—TOM PETERS, *The New York Times Book Review*

LEADING CHANGE

**THE ARGUMENT FOR
VALUES-BASED LEADERSHIP**

JAMES O’TOOLE

#3 Foster collaboration and accountability, accepting nothing short of high-performance teams!

THE 100,000-COPY NATIONAL BESTSELLER

THE WISDOM OF TEAMS

INCLUDING
THE TEAMS
QUESTION
AND ANSWER
GUIDE

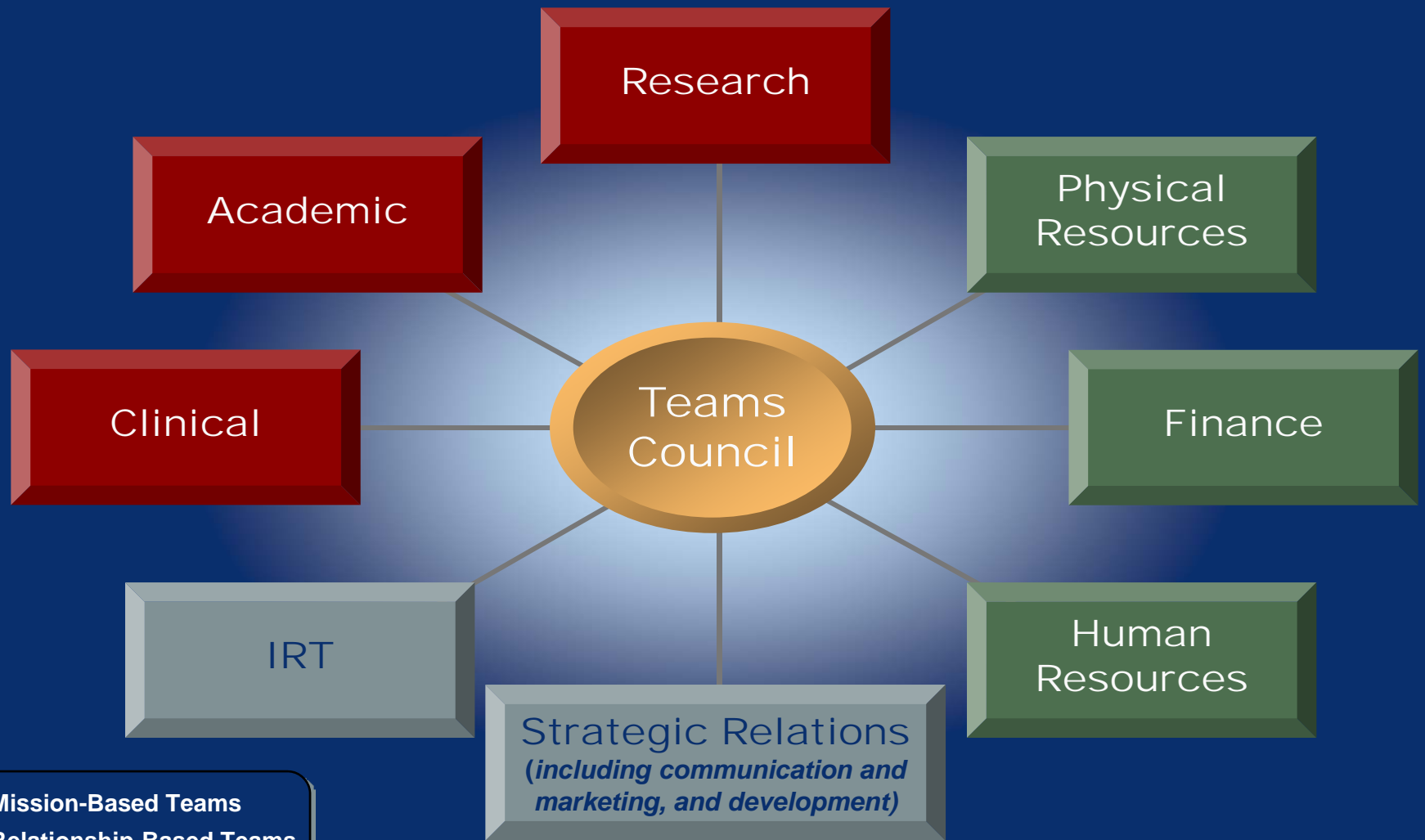
*Creating the
High-Performance
Organization*

“You’ll be hard-pressed to find a better
guide to . . . the essential building
block of the organization of the future.”

—John Byrne, *Business Week*

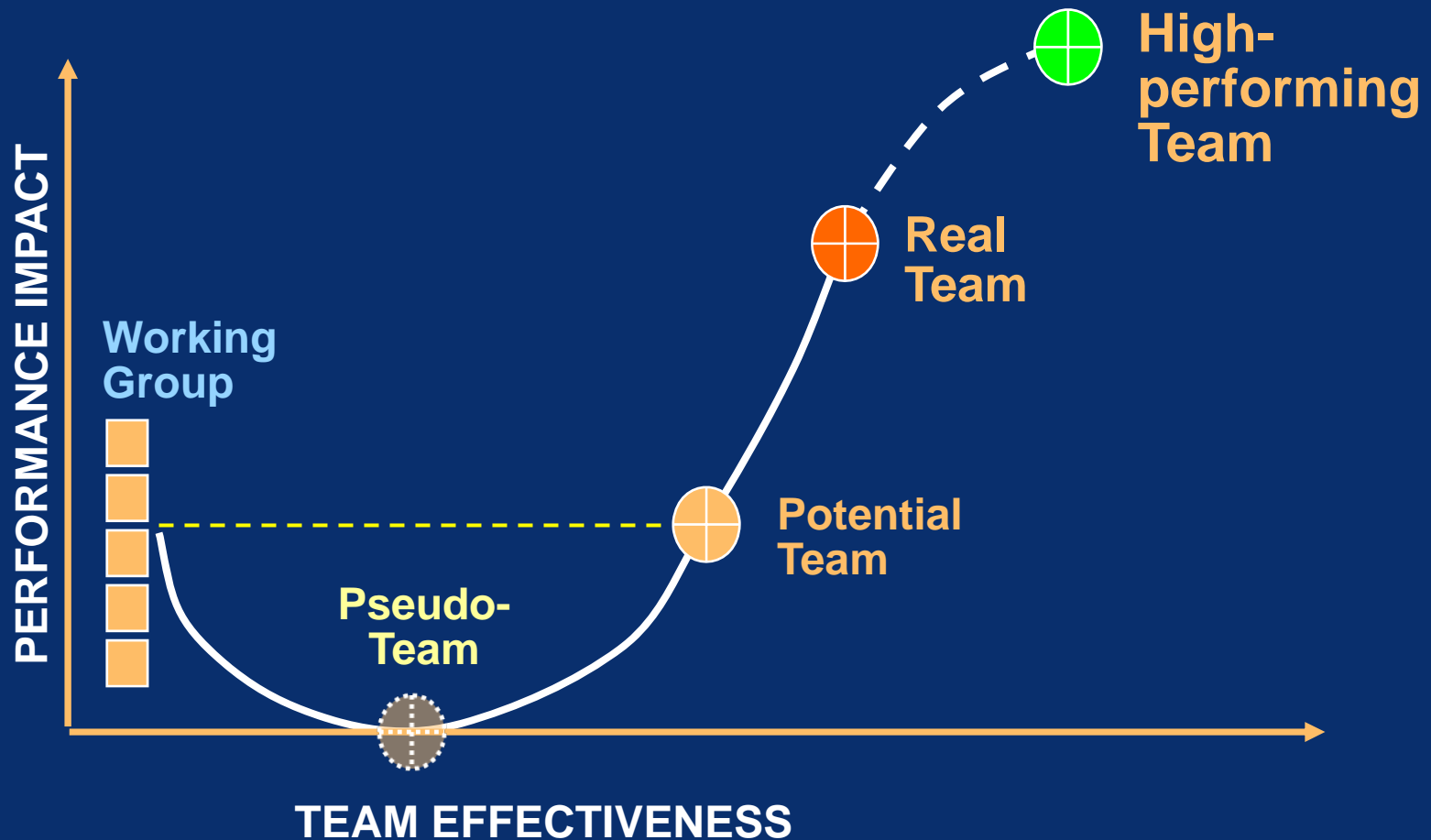
JON R. KATZENBACH
DOUGLAS K. SMITH

The Teams Approach



- Mission-Based Teams
- Relationship-Based Teams
- Resource Teams

A New Model for the Organization – Creating High Performance Teams



#4 Rethink our use of performance measures!

The Impact of our Traditional Academic Rewards System

Folly is rewarding “A” – while hoping for “B”

- In research
- In teaching
- In clinical care

#5 Do not allow yourself to believe that this is all a matter of “politics.”

Core Ethical Principles

- Beneficence
- Non-maleficence
- Autonomy
- Social Justice

A Future That Inspires

“The best way to predict the future is to invent it.”

—Alan Kay



Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Association of
American Medical Colleges