Future-Oriented CMOs:
Functional Integration & Alignment Case Study Reflections

AAMC
Tomorrow's Doctors, Tomorrow's Cures

Chief Medical Officer Group &
Group on Faculty Practice
Professional Development Conference
Austin, TX - February, 2011

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Association of
American Medical Colleges

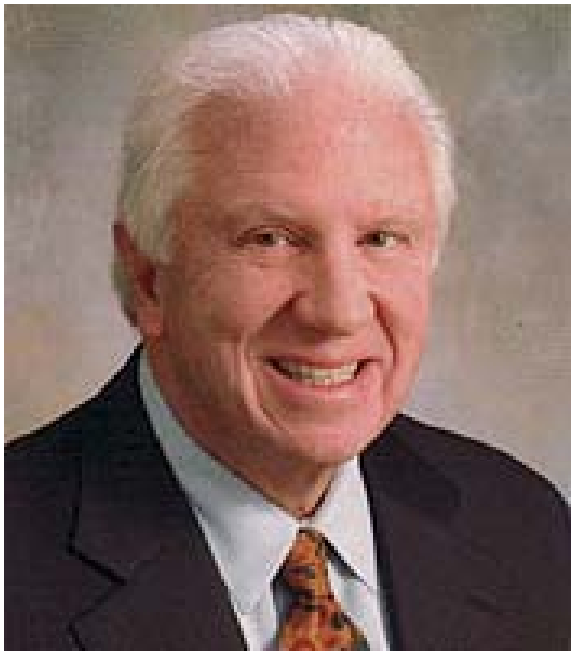
(Please Note:
This presentation does not represent an endorsement by the AAMC)

"Coming Attraction" Thoughts to Ponder (We will come back to it at the end)

- **Why are Chairs and Center-Directors critical?**
- **Why are future-oriented CMOs critical?**

Harvey Golomb, MD – CMO, Dean Clinical Affairs, and former Medicine Chair (in absentia , on service)

THE UNIVERSITY OF CHICAGO
DEPARTMENT OF MEDICINE



Department of Medicine
Hematology/Oncology

Clinical Interests	Leukemia Lung Cancer Lymphoma
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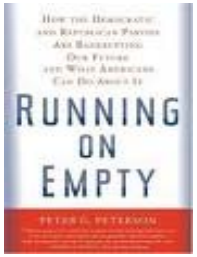
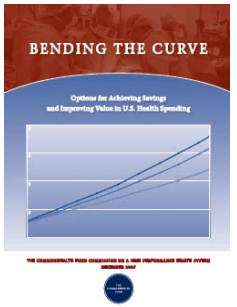
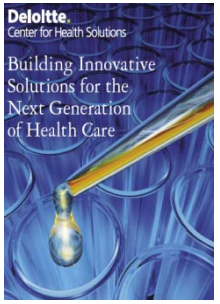
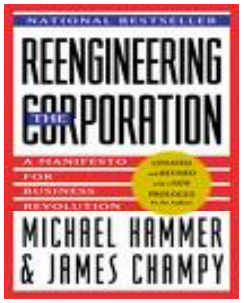
Informed Consent Intro

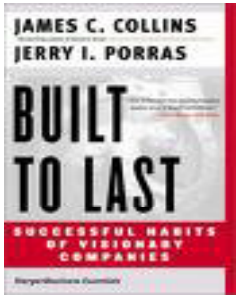
1. **We have a wholly unsustainable "system"**
2. **Universal Coverage + Financing ≠ Reform**
3. **Pre-occupation with the Revenue Curve *(which we are incredibly parochial and protective of)***
4. **Real reform lays under the Cost Curve by eliminating the waste, duplication, redundancies, inefficiencies, unnecessary variations *(redeploy $650B of $2.5T)***
5. **The Pathway to Quality is Through the Doors of Cost**
6. **Our core processes require fundamental reengineering enhanced by Information Technology & Leadership Development for sustainability**
7. **The adage *"Culture eats strategy everyday for lunch (and breakfast and dinner)"* is true. But if we don't have the courage to lead a state change, then we should stop complaining.**
8. **Lack of an 'implementation science' research framework**

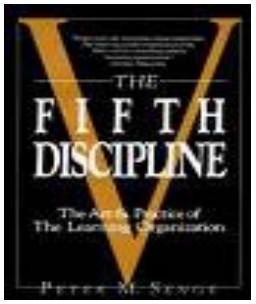












Academic Health Enterprises are Critical to Healthcare Reform

Clinical

AAMC member hospitals comprise only 6% of all hospitals, but account for[1]:

- **23% of all discharges**
- **28% of all Medicaid discharges**
- **19% of all Medicare discharges**
- **41% of charity care**

79,529 full-time MDs work in AAMC member group practices[2]

Education

Nearly 100,000 residents train at AAMC member hospitals[3]

Train full spectrum of other health professionals

Research

Perform over half of federally funded biomedical and health services research

Notes: [1]Source: AAMC analysis of American Hospital Association Survey Database, FY2008.. Data reflect short-term, general, nonfederal hospitals. COTH hospitals reflect integrated and independent COTH members; [2]Source: AAMC Faculty Roster Full-Time Faculty, December 2009. This number excludes part-time and volunteer faculty. It also excludes PhDs and MD/PhDs; [3]Source: AAMC analysis of Medicare Cost Report Data, June 30, 2010 Release; [4]Source: AAMC analysis of 2006 National Institutes of Health awards data (accessed at: http://report.nih.gov/award/trends/AggregateData.cfm?Year=2006); [5]Source: Agency for Health Care Research and Quality, Federal FY06 data.

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A Word About "Health Reform" Implications

↑ Access = ↑ Demand + Continued Perverse Incentives = ↑ ↑ Costs *(which will burden margins & potentially stress the ability to cross-subsidize)*

↑ Demand + ↑ ↑ Costs = ↓ Value = ↑ Upset

↑ consolidation of health plans, hospitals

↑ consolidation of physicians in larger medical groups and employed vehicles

SGR non-fix & CBO (re)calcs add another $400B to the $1T increased spend

NIH funding likely to be → (or possibly ↓)

GME funding likely to ↓ ($30B at-risk over 10 years through MedPac or IPAB)

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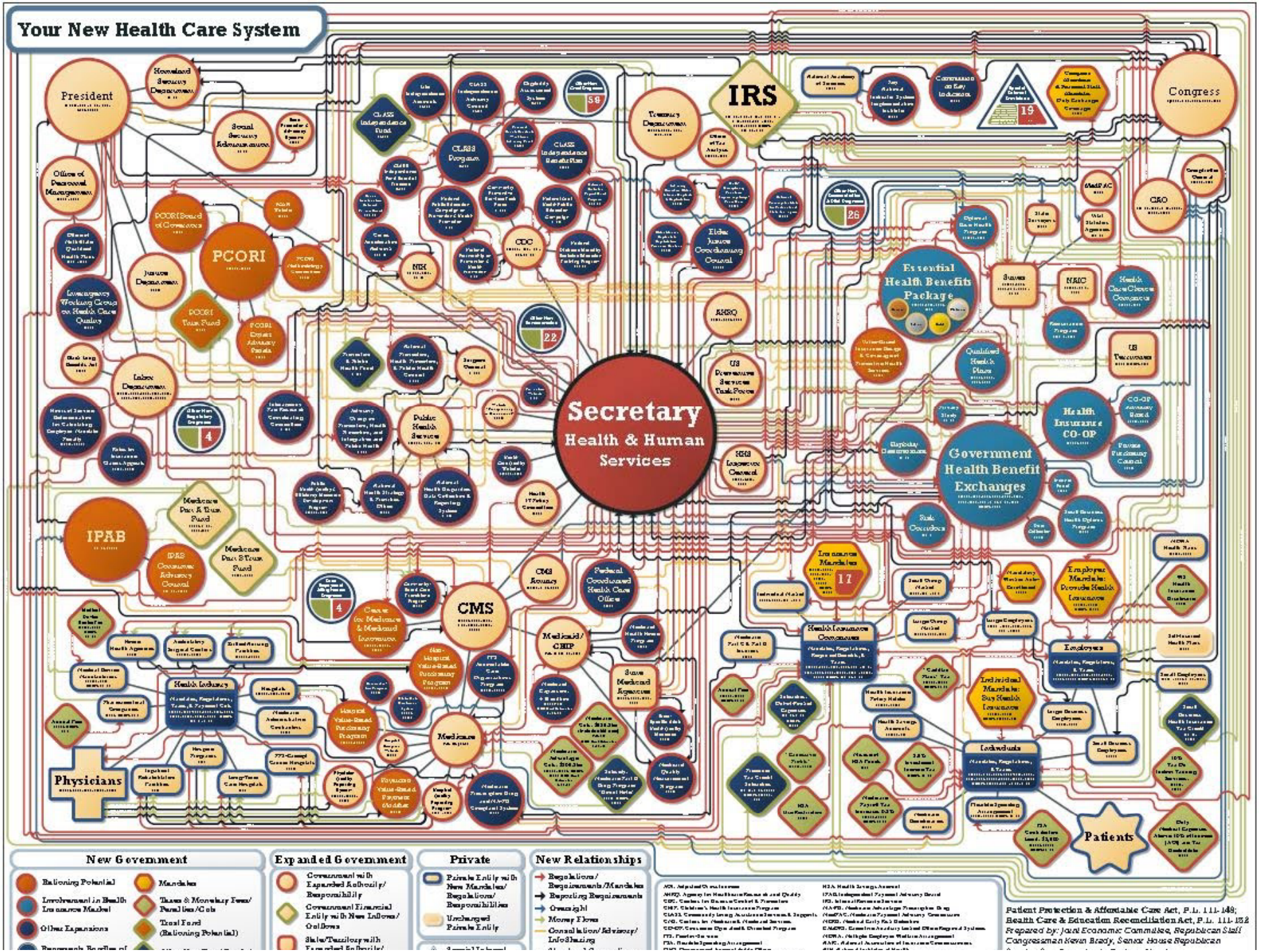
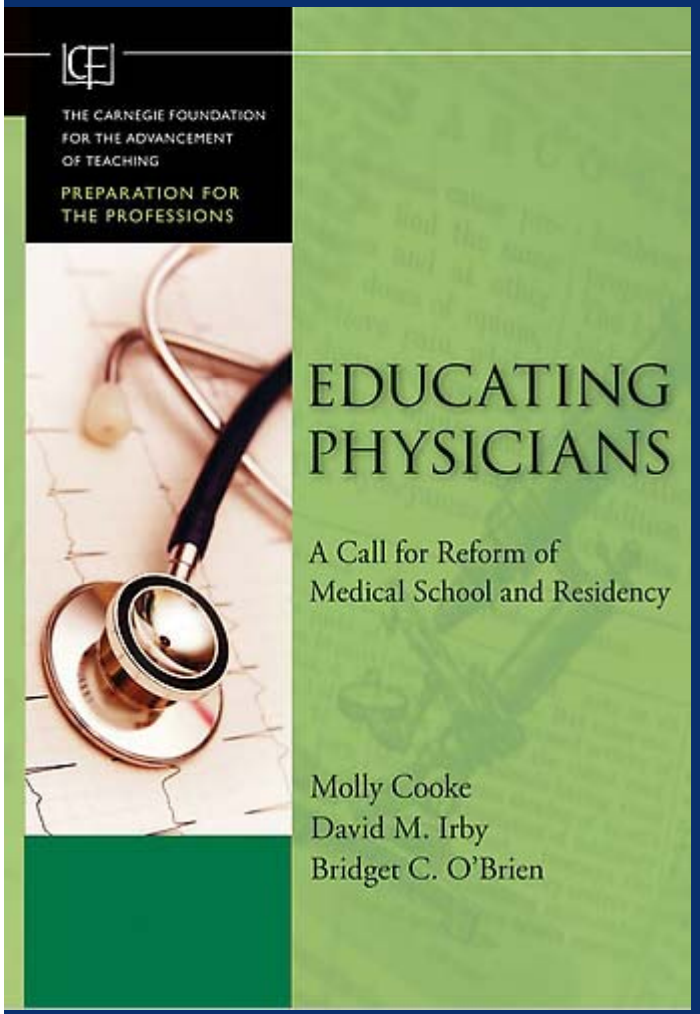
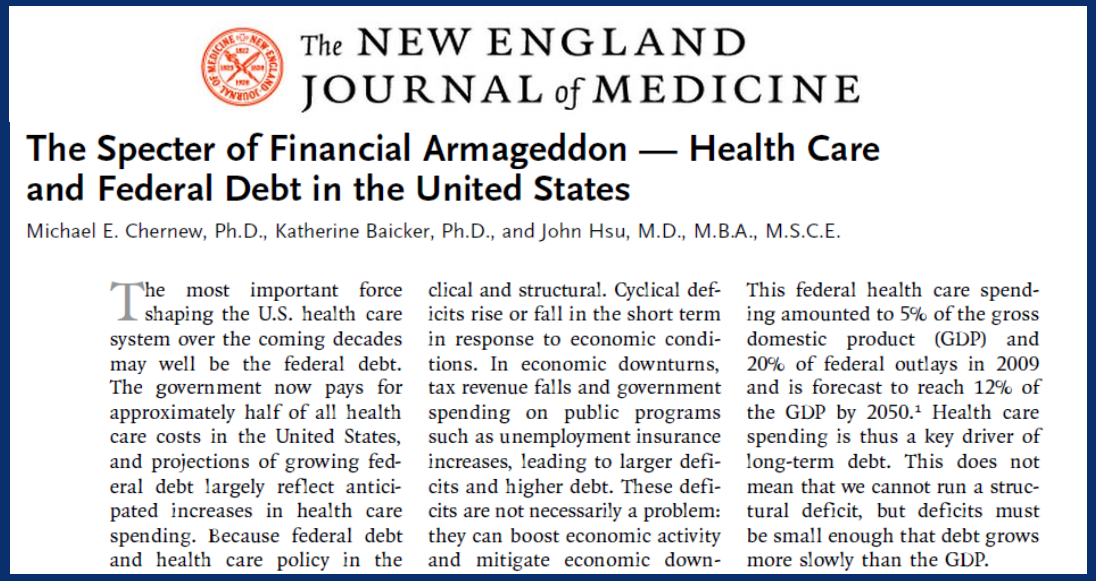

Your New Health Care System
President
Secretary
Health & Human Services
IRS
Congress
PCORI
IPAB
CMS
Medicaid/ CHIP
Medicare
Physicians
Patients
Essential Health Benefits Package
Government Health Benefit Exchanges
Health Insurance CO-OP
Qualified Health Plans
Insurance Mandates
Employer Mandate: Provide Health Insurance
Individual Mandate: Buy Health Insurance
Employers
Individuals
Public Health Services
CLASS Program
Federal Coordinated Health Care Office
Health Insurance Commissions
New Government
Expanded Government
Private
New Relationships
Patient Protection & Affordable Care Act, P.L. 111-148;
Health Care & Education Reconciliation Act, P.L. 111-152
Prepared by: Joint Economic Committee, Republican Staff
Congressman Kevin Brady, Senior House Republican

Why This Time is Different…?





The NEW ENGLAND JOURNAL of MEDICINE

The Specter of Financial Armageddon — Health Care and Federal Debt in the United States

Michael E. Chernew, Ph.D., Katherine Baicker, Ph.D., and John Hsu, M.D., M.B.A., M.S.C.E.

The most important force shaping the U.S. health care system over the coming decades may well be the federal debt. The government now pays for approximately half of all health care costs in the United States, and projections of growing federal debt largely reflect anticipated increases in health care spending. Because federal debt and health care policy in the clical and structural. Cyclical deficits rise or fall in the short term in response to economic conditions. In economic downturns, tax revenue falls and government spending on public programs such as unemployment insurance increases, leading to larger deficits and higher debt. These deficits are not necessarily a problem: they can boost economic activity and mitigate economic down- This federal health care spending amounted to 5% of the gross domestic product (GDP) and 20% of federal outlays in 2009 and is forecast to reach 12% of the GDP by 2050.[1] Health care spending is thus a key driver of long-term debt. This does not mean that we cannot run a structural deficit, but deficits must be small enough that debt grows more slowly than the GDP.

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

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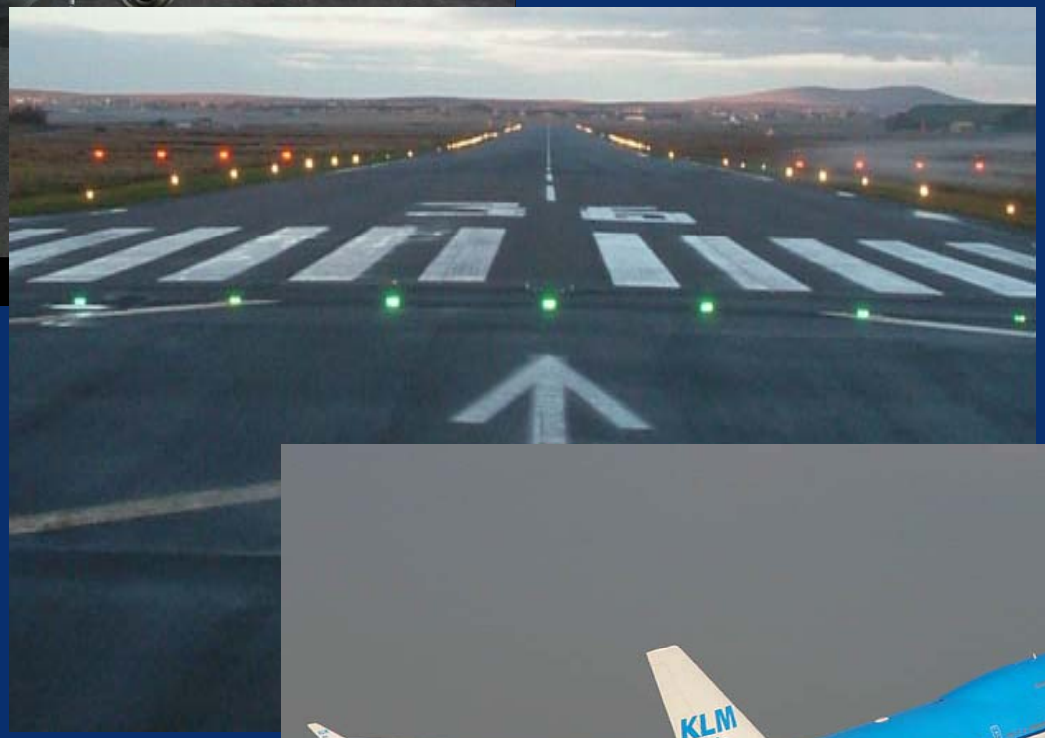
Identifying the Gaps vs. Filling the Gaps

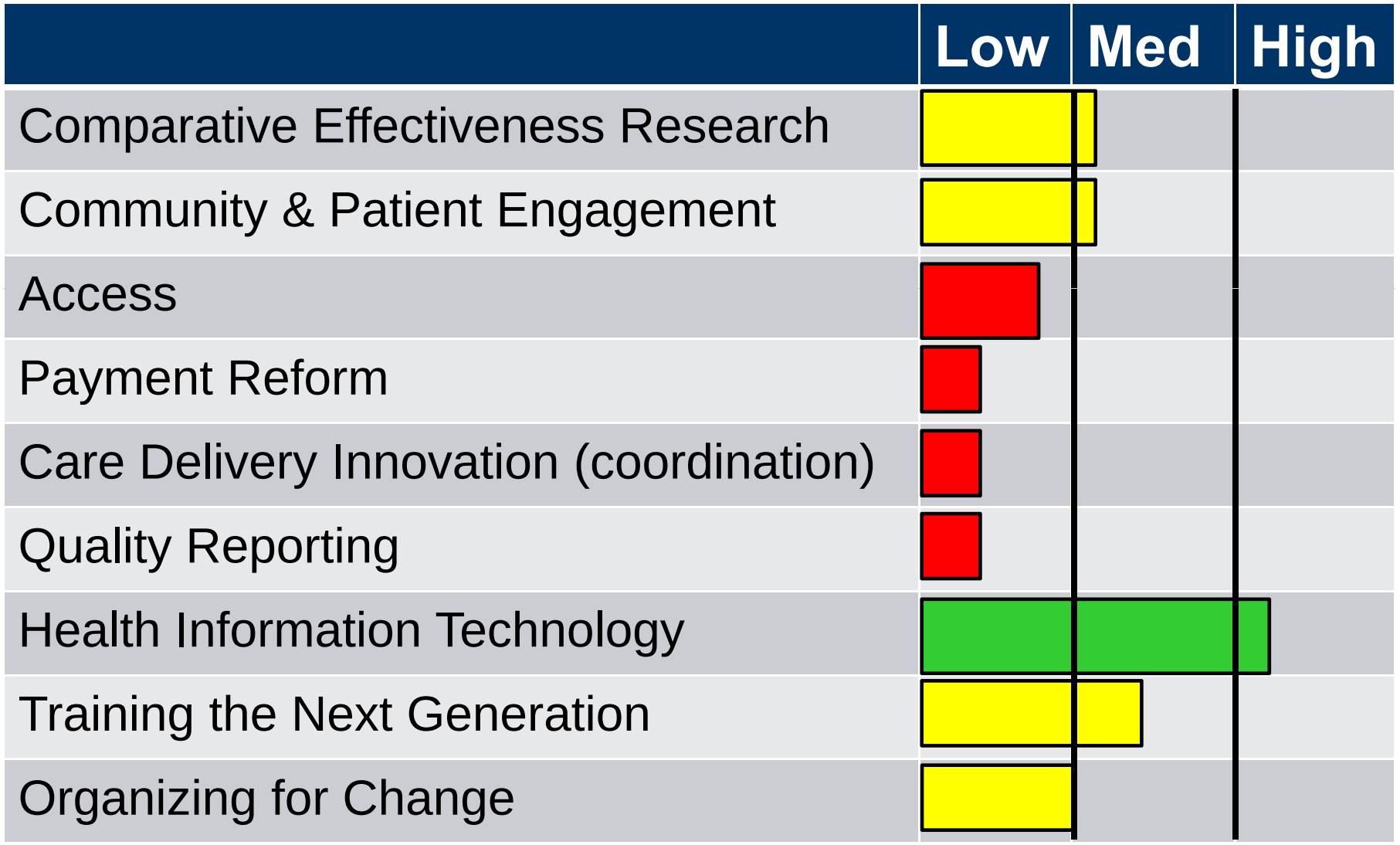
Respondents

Atlantic Health
BJC HealthCare
Boston Medical Center
Cedars-Sinai Medical Center
Children's Hospital
Children's Hospital Central California
Children's Hospital of Philadelphia
Christiana Care Health System
Cleveland Clinic Foundation
Dartmouth-Hitchcock Medical Center
Drexel University College of Medicine
Duke University Health System
Emory Healthcare
Fletcher Allen Health Care
Froedtert Hospital and Health System
George Washington University Hospital
Greenville Hospital System
Health Alliance of Greater Cincinnati
HealthPartners, Inc.
Henry Ford Hospital
Hospital of the University of Pennsylvania
Howard University Hospital
INOVA Fairfax Hospital
LeBonheur Children's Medical Center Medical Center
Lehigh Valley Hospital
Loma Linda University School of Medicine
Maimonides Medical Center
Massachusetts General Hospital
Medical College of Georgia Hospital and Clinics
Medical University of South Carolina Medical Center
Methodist Hospital
Montefiore Medical Center
NewYork-Presbyterian Hospital The
University Hospital of Columbia and Cornell
Northwestern Memorial Hospital
NYU Hospitals Center
Oakwood Hospital and Medical Center
Oregon Health & Science University
OU Medical Center
Palmetto Health
Saint Francis Hospital and Medical Center
Saint Louis University Hospital
Saint Luke's Shawnee Mission Health System
Southern Illinois University School of Medicine
St. John's Mercy Medical Center
Stony Brook University Hospital
Strong Memorial Hospital
SUNY Downstate Medical Center/University Hospital of Brooklyn
The Milton S. Hershey Medical Center
Truman Medical Center Hospital Hill
U of L Health Care University Hospital
UCLA Medical Center
UCSF Medical Center
UMass Memorial Health Care
UNC Health Care System
University Health System
University Hospitals Case Medical Center
University Hospitals HeatlhSystem
University of Alabama School of Medicine
University of California, Davis, Health System
University of Chicago Division of the Biological Sciences The Pritzker School of Medicine
University of Colorado Hospital
University of Iowa Hospitals and Clinics
University of Kansas Hospital
University of Mississippi School of Medicine
University of Missouri Health Care
University of New Mexico School of Medicine
University of South Alabama College of Medicine
University of South Florida College of Medicine
University of Texas Health Center at Tyler
University of Texas Medical Branch Hospitals at Galveston
University of Virginia Medical Center
University of Washington Academic Medical Center
University of Wisconsin Hospital and Clinics
Vanderbilt University School of Medicine
Virginia Commonwealth University
Wake Forest University Baptist Medical Center
Washington Hospital Center
Washington University School of Medicine
West Virginia University Hospitals, Inc.
Yale-New Haven Hospital



What is the length of your runway?

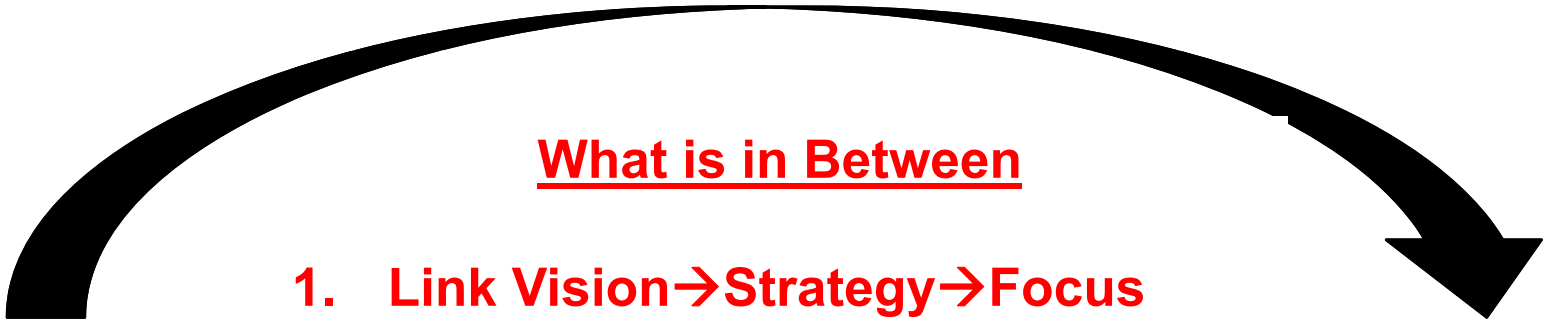
Summary – Health Reform Preparedness



Future-Oriented CMO Implications

1. **Not your grandfather's VPMA**
2. **Each will need to determine appropriate pace of change – "evolution", "revolution", or elements of both**
3. **Will require new attitudes, aptitudes and alignments**
   - ❖ Value-based purchasing and bundled payment demands removing unwarranted variations in resource use and outcome
   - ❖ Data needs will drive new partnerships
   - ❖ Population health requires different inputs than those extant at most AHCs

Are We Experiencing a Leap of Logic?



What is in Between

1. Link Vision→Strategy→Focus
2. Multi-mission integrated budgets
3. Funds flow redesign
4. Core process redesign & reduce cost base by 20%
5. Care management capabilities
6. Continuum-of-care linkages
7. Multi-mission education redesign
8. Rebalancing research mission
9. Functional integration across AHE
10. IT-enablement
11. Leadership development
12. Comp & incentive redesign
13. Employee health redesign
14. Etc; etc; etc….

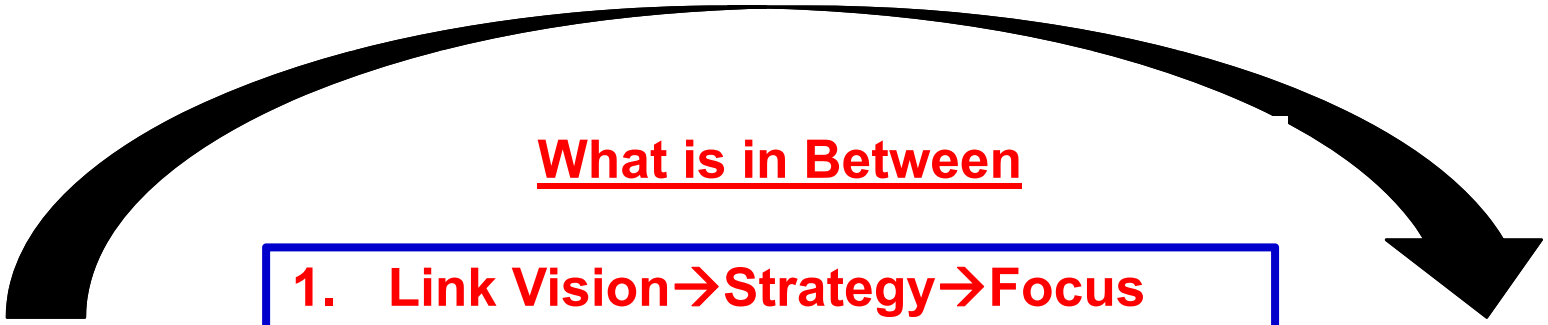
Today

- FFS
- Volumes
- 'All Things to All People'

Tomorrow

- ACOs
- HIZs
- Populations
- Bundling
- Capitation

Example #1



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Today

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- Volumes
- *'All Things to All People'* across the missions

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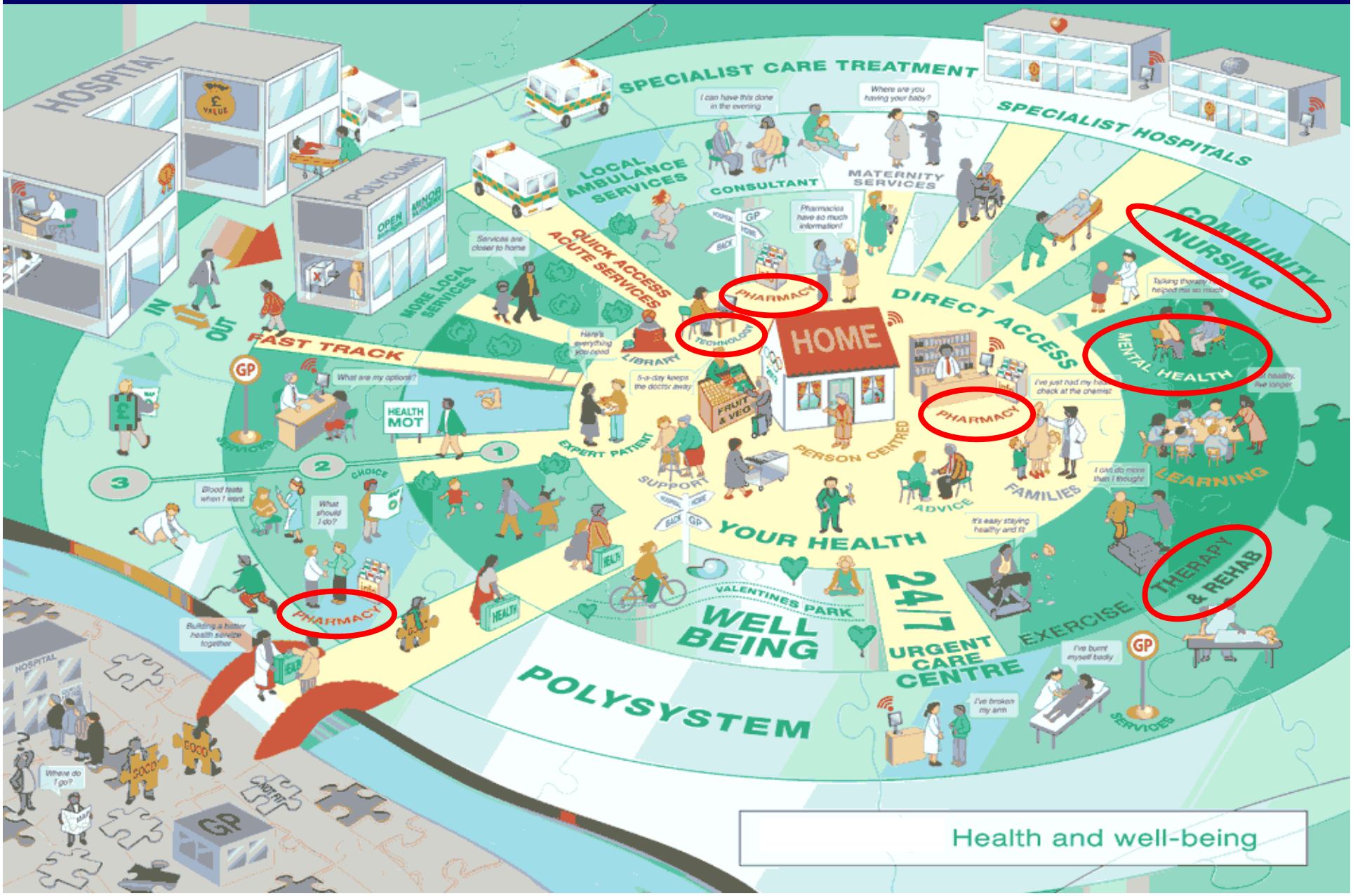
Vision of A Possible Academic Health Enterprise?

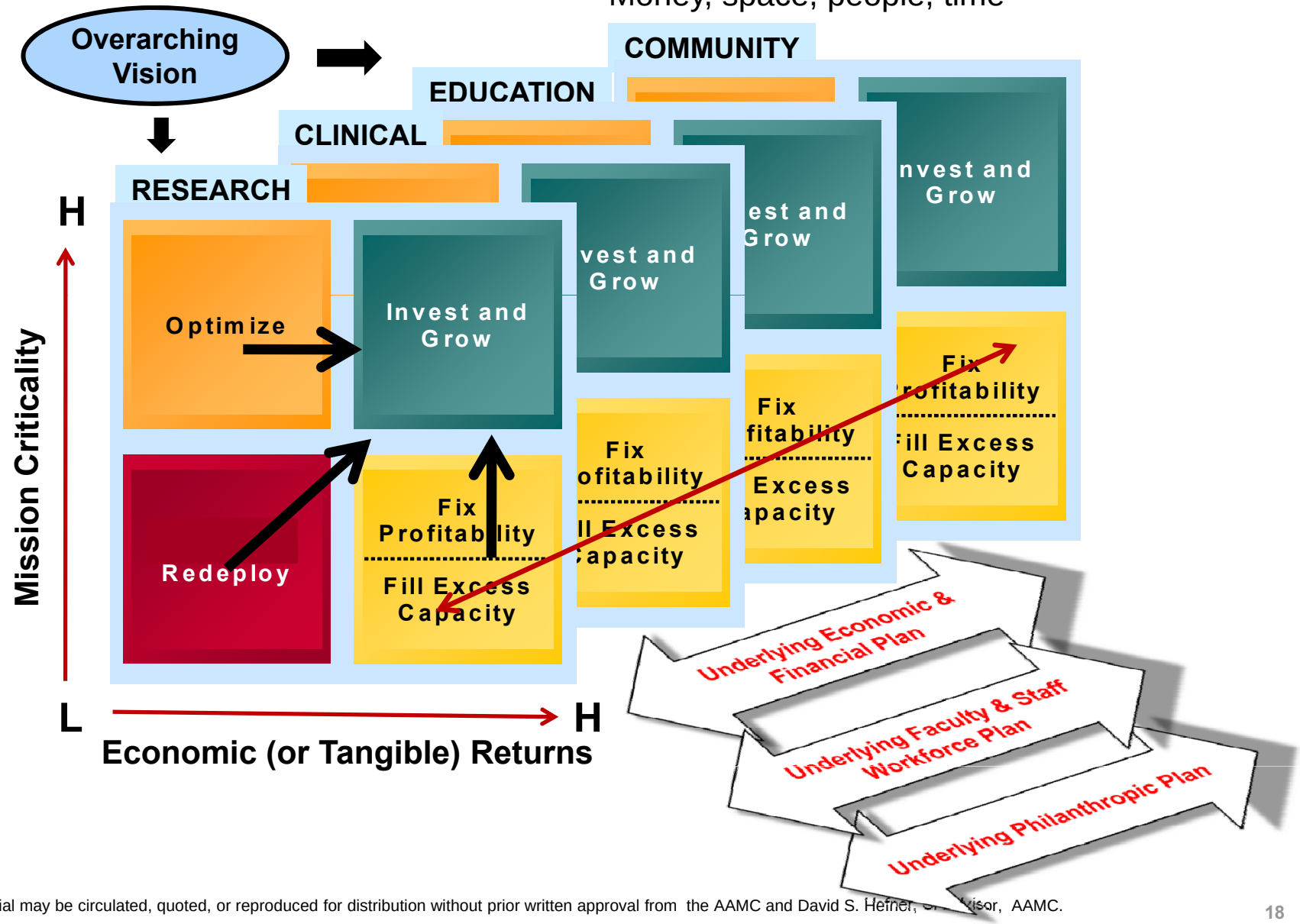


Linking Vision → Strategy → Focus

Should We Be All Things To All People?

Resources to Allocate:
Money, space, people, time

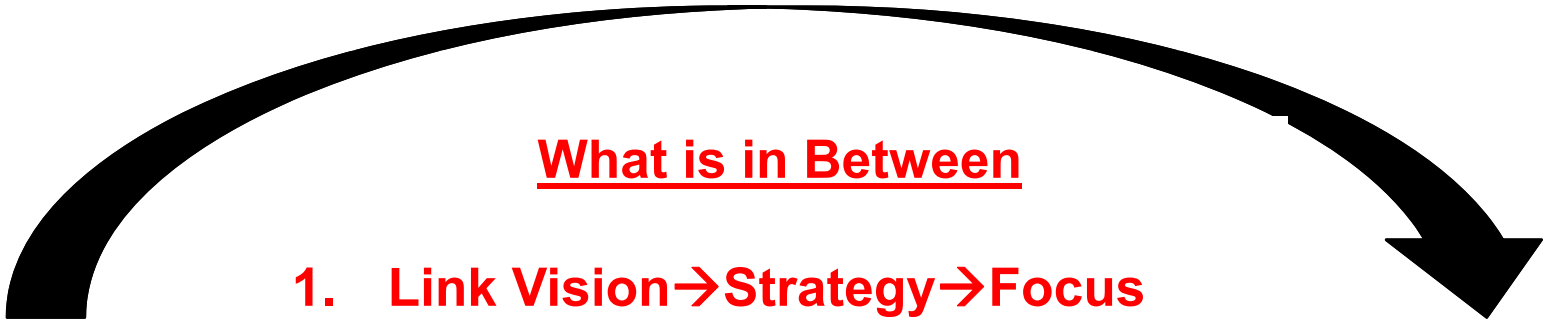
ILLUSTRATIVE



Future-Oriented CMO Implications

1. **A view from the balcony <u>with</u> both feet on the dance floor**
   - ❖ Maintaining clinical credibility can be an asset
   - ❖ Embrace clinical champions and constructive thought leaders
2. **Moving parts touch all mission areas – few will have your ability to provide balanced perspective across silos of vested interests**

Example #1



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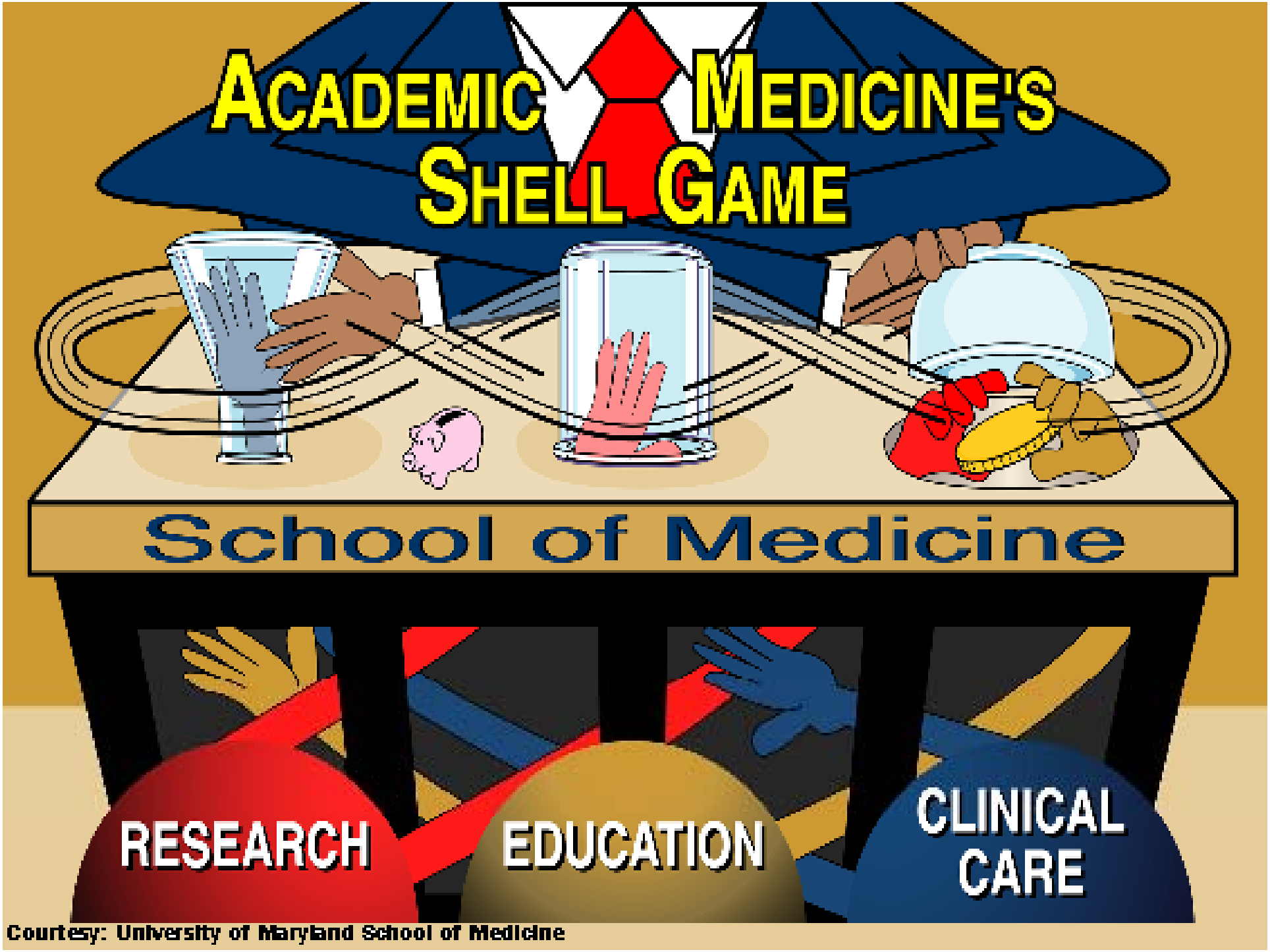

Courtesy: University of Maryland School of Medicine

Funds Flow Plinko

“Book of Deals Hell”

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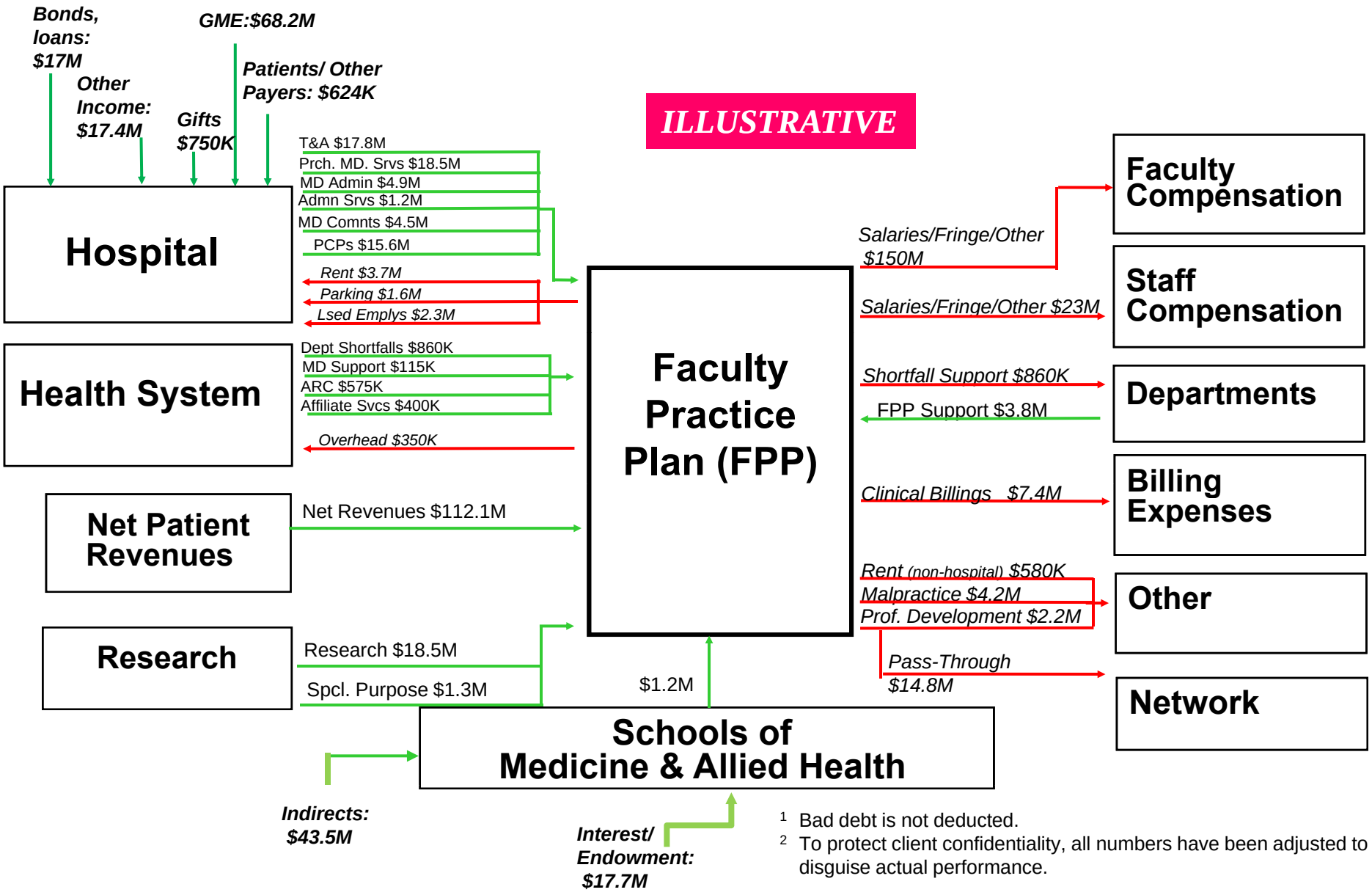
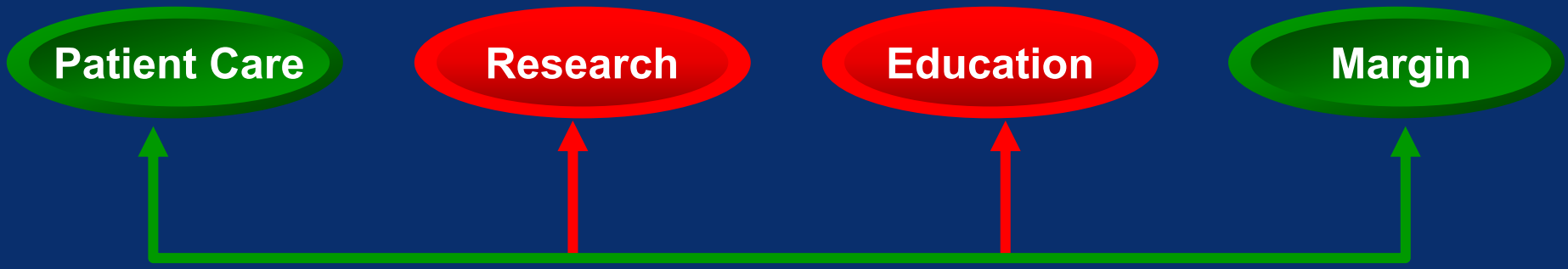
Academic Health Enterprise Funds Flow By Key Sources[1] (FYxx Budget[2])



1 Bad debt is not deducted.

2 To protect client confidentiality, all numbers have been adjusted to disguise actual performance.

Economic Interdependencies of Our Missions: Creating a Common Fact Base



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

"80/20" Exceptions

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

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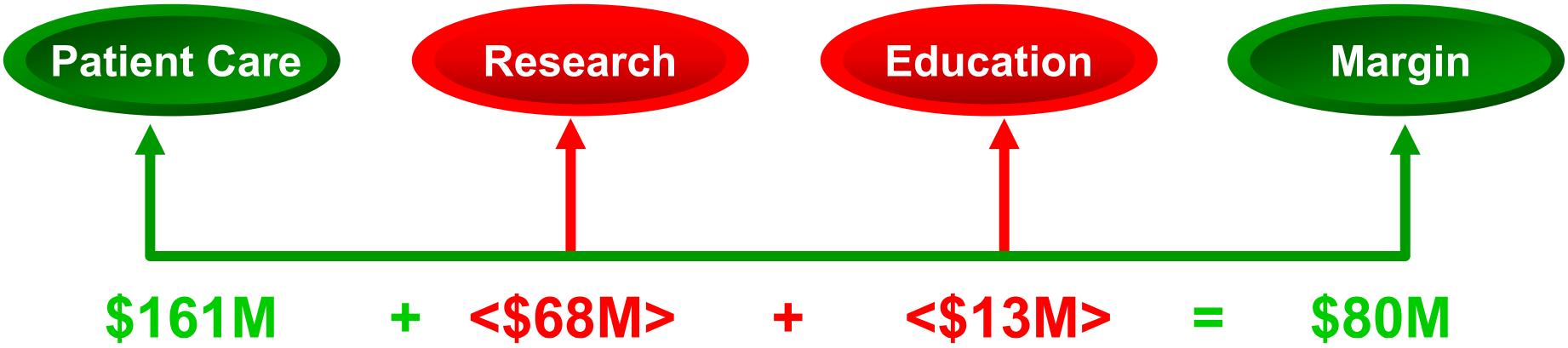
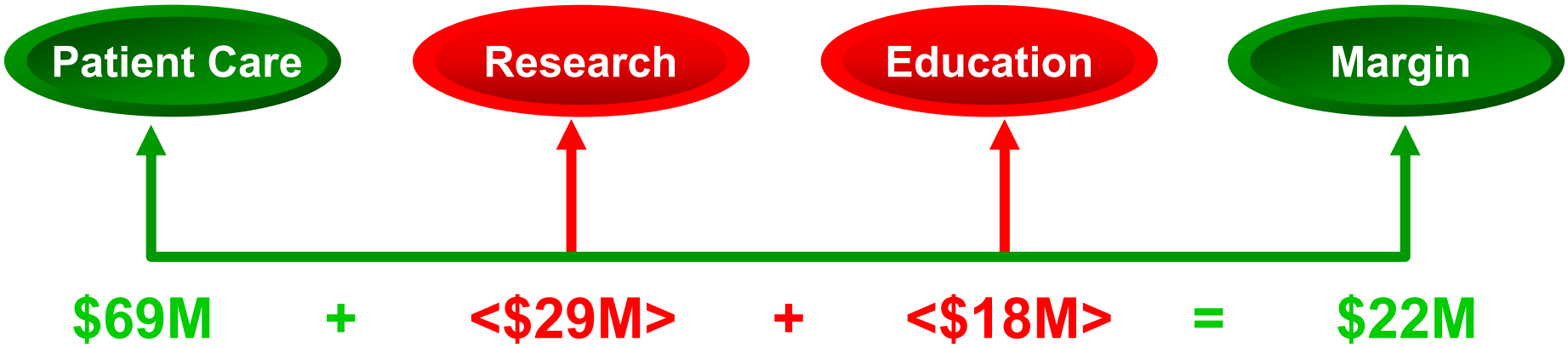
Why the Research Mission Inherently Requires Investment

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 <u>not</u> been addressed***

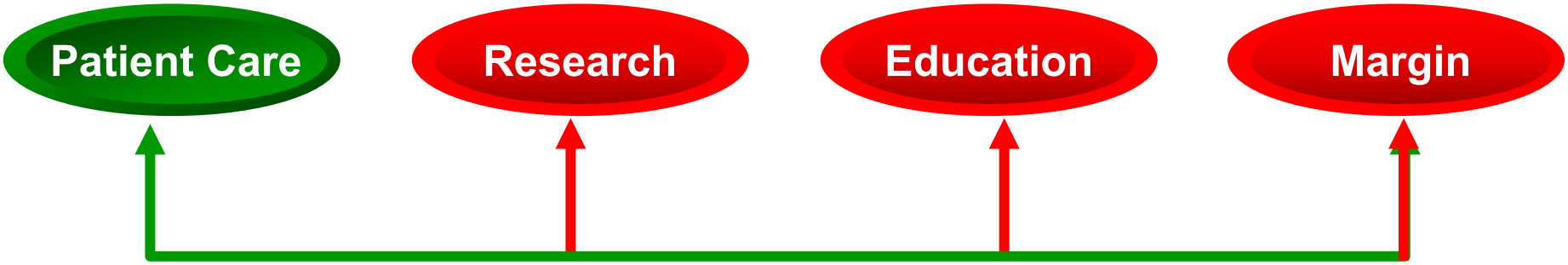
Interdependencies of Missions – Case Study #1



Interdependencies of Missions – Case Study #2



Interdependencies of Missions – Case Study #3



$12M + <$163M> + <$47M> = <$198M>

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

"I Know a Way Out of Hell"

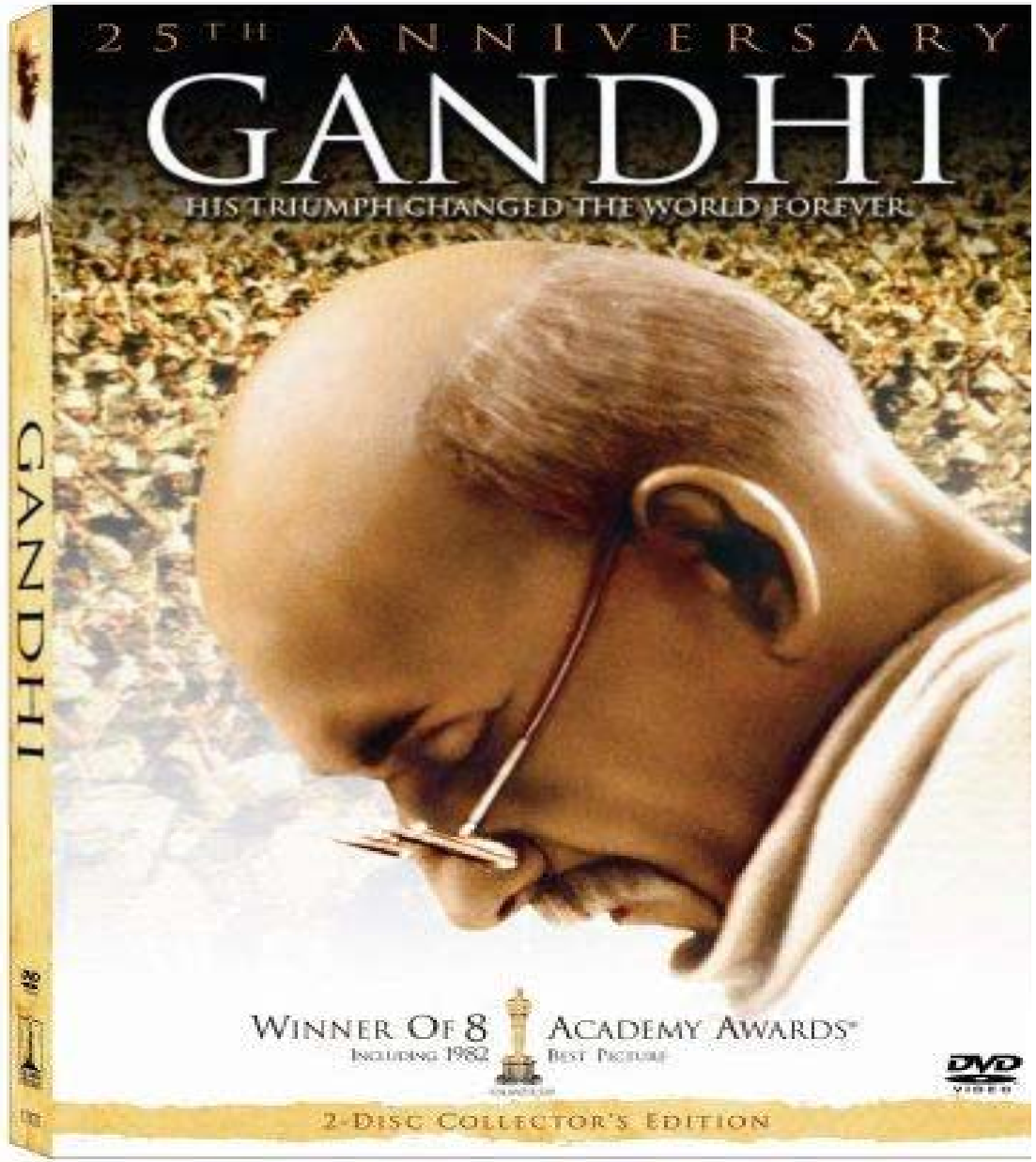
Nahari: I'm going to Hell! I killed a child! I smashed his head against a wall.

Gandhi: Why?

Nahari: Because they killed my son! The Muslims killed my son!
[*indicates boy's height*]

Gandhi: I know a way out of Hell. Find a child, a child whose mother and father have been killed and raise him as your own. [*indicates same height*]

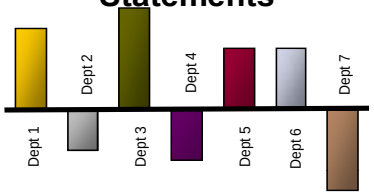
Gandhi: Only be sure that he is a Muslim and that you raise him as one.



"Funds Flow Hell"

THE LINEAR & INCREMENTAL FUNDS FLOW APPROACH **Illustrative**

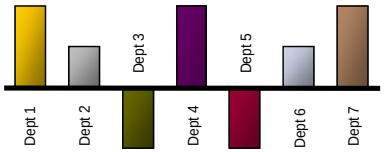
CURRENT
Department Financial Statements



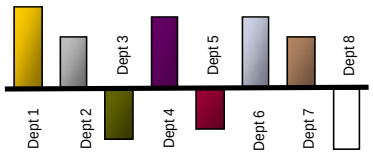
OTHER EXAMPLES OF DISTORTION

1. Fragmented nursing, IT resources
2. COM transfer pricing for IT services
3. Schedulers
4. Malpractice insurance
5. Anesthesia techs
6. Etc…..

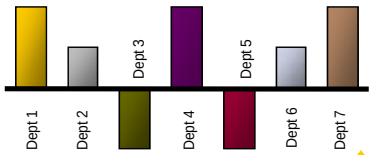
STEP 2:
New Clinic Cost Allocations



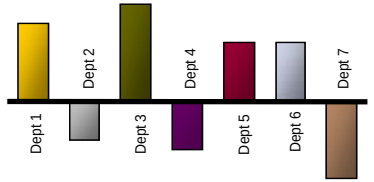
STEP 3:
New PAT Redistribution



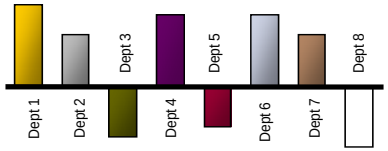
STEP 4:
Removal of Historical "Side Deals"



STEP 5:
Redistribution of Teaching Funds



STEP 6:
Realignment of Strategic Investments

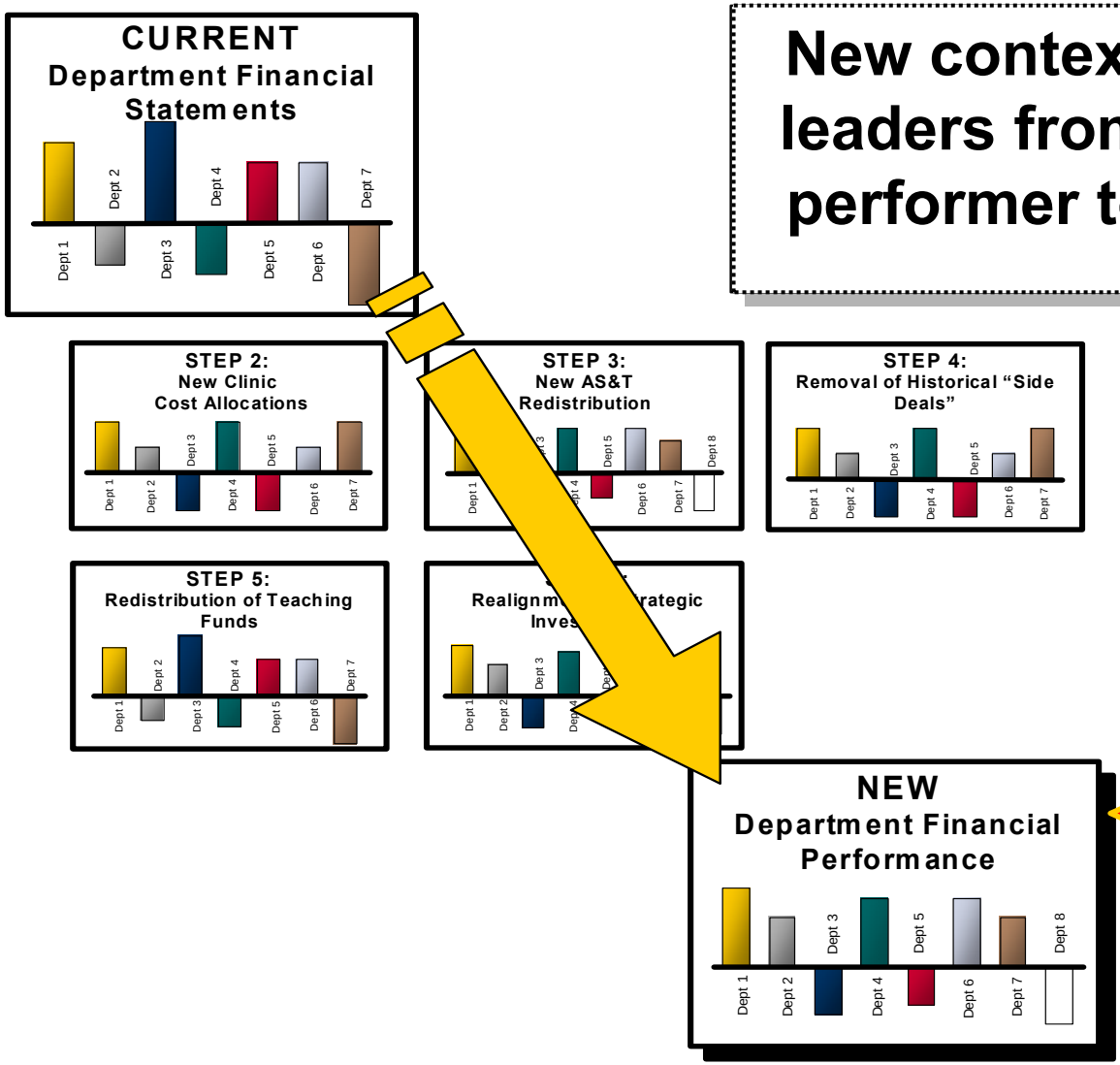


Organizational confusion, mistrust, and chaos

"A Way out of Hell"

THE COMPREHENSIVE FUNDS FLOW APPROACH

Illustrative



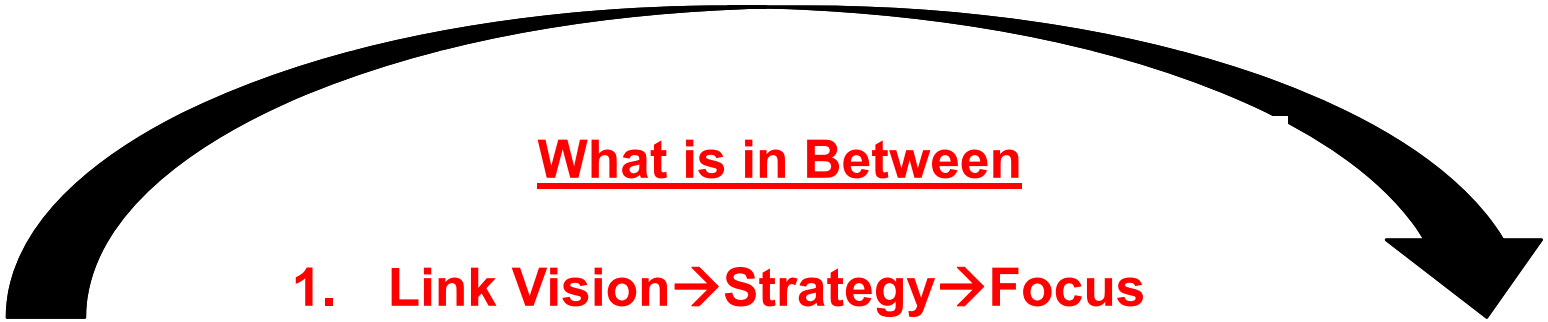
New context transitions key leaders from an "individual" performer to a "team sport"

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

Future-Oriented CMO Implications

1. Recruit and retain to your desired culture – at Penn State, some decided to leave and some had to leave
2. Interdisciplinary Centers and Institutes – PSHVI, PSCI, PSNS – are not as "natural" as a patient-centered, market-based "white paper" make it sound
3. Clinical support payments necessary to "zero out" departmental budgets should be as transparent as possible – they shine bright lights on cross-subsidies, market realities, and strategic priorities

Example #2



What is in Between

1. Link Vision→Strategy→Focus
2. Multi-mission integrated budgets
3. Funds flow redesign
4. Core process redesign & reduce cost base by 20%
5. Care management capabilities
6. Continuum-of-care linkages
7. Multi-mission education redesign
8. Rebalancing research mission
9. Functional integration across AHE
10. IT-enablement
11. Leadership development
12. Comp & incentive redesign
13. Employee health redesign
14. Etc; etc; etc….

Today

- FFS
- Volumes
- *'All Things to All People'* across the missions

Tomorrow

- ACOs
- HIZs
- Populations
- Bundling
- Capitation

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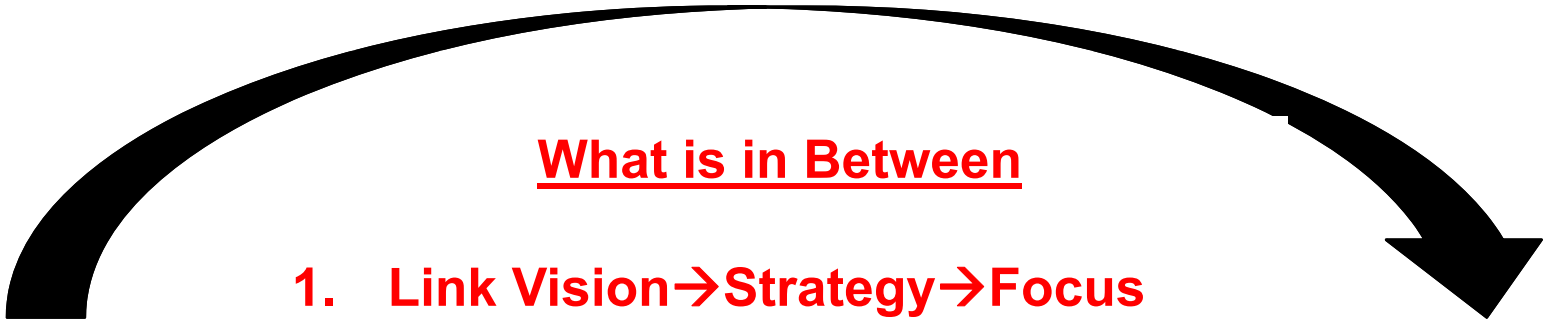

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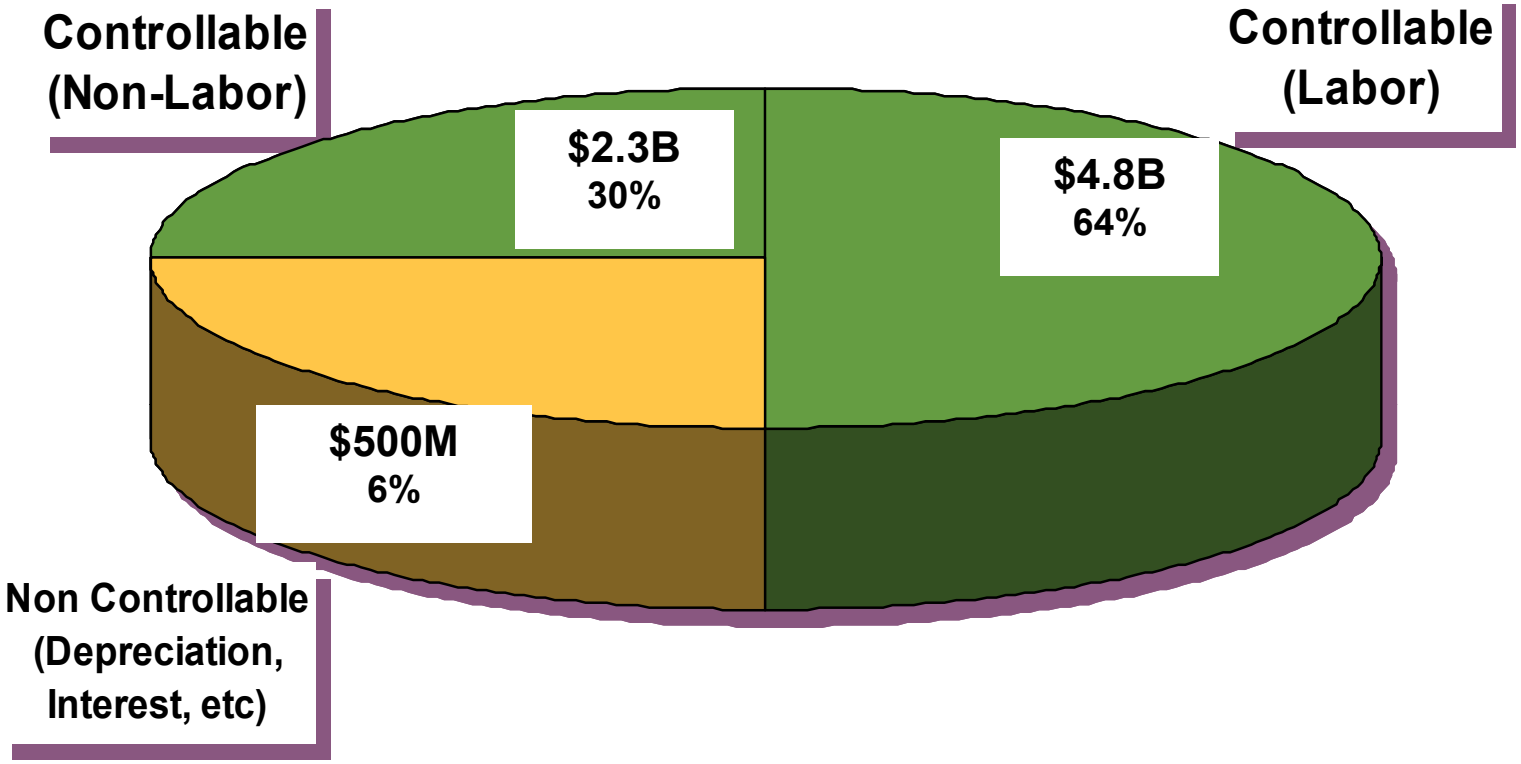
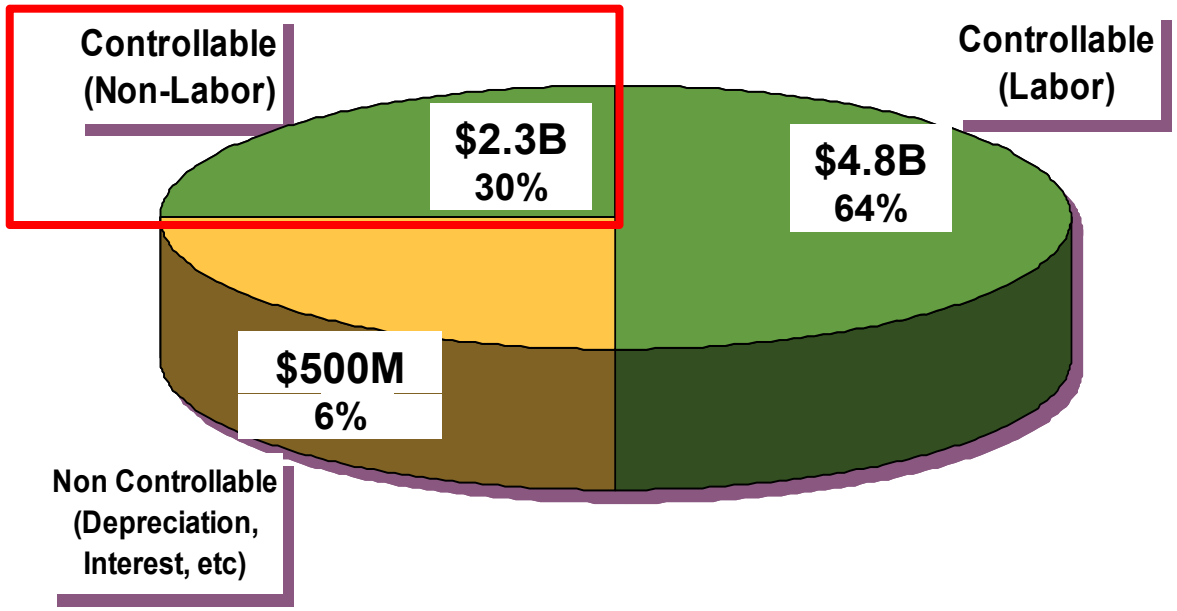
Today
- $7.6B

Tomorrow
- $6.1B

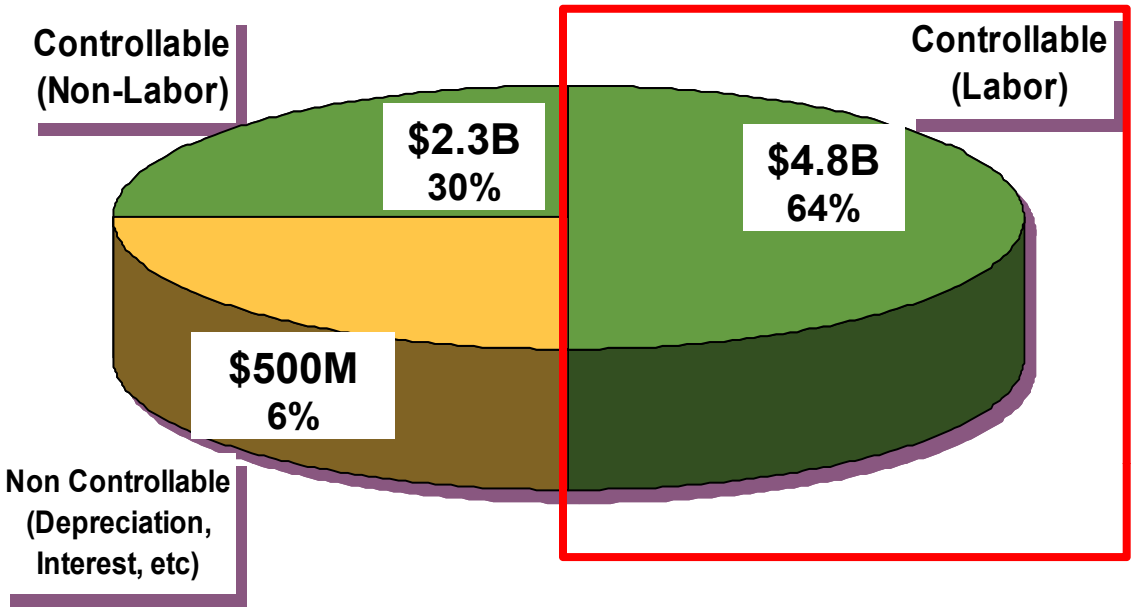


The $7.6B academic health enterprise economy can be depicted as "Controllable" and "Non-Controllable" expenses.

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

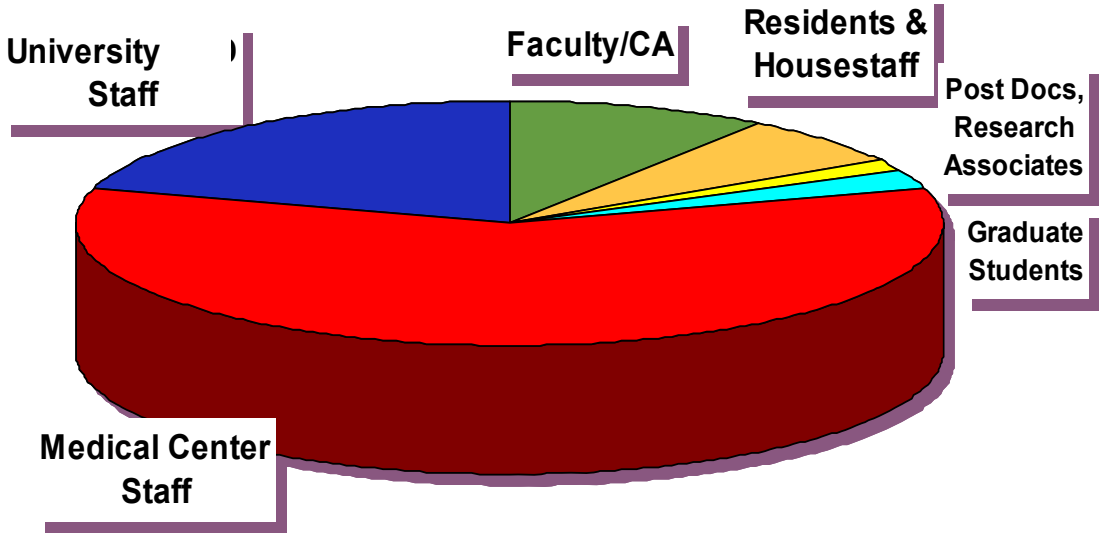


…The $2.3B non-labor pool is comprised of supplies and purchased services. A 20% reduction would require an annually savings of $460M



…The $4.8B labor pool has 90,000 individuals with varying talents and skill sets.
However, the economic climate and long-term future necessitates reducing these numbers by xx% over the next __ months.

N = 90,000



Execute from a Core Process Redesign Point of View

1. Manage the Strategy

Core Processes

2. Develop Distinctive Programs

Identify Programs & Service Opportunities	Develop Concepts & Recruit Faculty	Develop New Service Delivery Models	Prototype & Pilot	Rollout & Refine; Retain Faculty

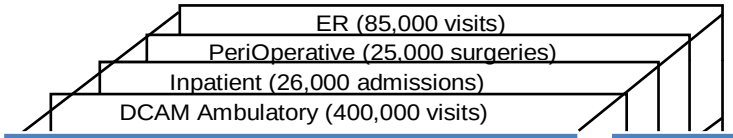
3. Build & Maintain Physical Capacity

Manage CON & Regulatory Process	Rationalize and Optimize Physical Plant Capacity	Build/ Renovate/ Redeploy Space as needed	Examine and Integrate Alternate Delivery Sites/ (strategic affiliations & UHI)

- 4M sq. ft.

4. Generate Demand (Marketing/Branding)

Identify Target Patients and Referring Physicians	Generate Awareness	Generate Inquiries	Establish & Manage Payer Relationships	Acquire/ Affiliate Providers & Capitated Populations



5. Deliver Superior Care

Provide Ancillary Services	Provide Patient & Family Centered Care	Provide Perioperative Care	Provide Hoteling Services

6. Streamline Patient Flow

Manage Admissions • ER • Routine • Transfers • Referrals	Coordinate Pre-Admission Testing	Patient Transfer/ Transport	Manage the Discharge Processes

7. Coordinate Continuum of Care

Develop/Use Care Pathways, Protocols, and order sets	Coordinate Care for Exceptional Cases	Review Clinical Utilization	Access Level of Care Needed

Supporting Processes

8. Develop People *(HR)*

- 6300 staff
- Professional Development

9. Manage Money *(Managed Care Contracting and Revenue Cycle)*

- $1.2B

10. Manage Information *(IT, Medical Records)*

- 6M Medical Records
- "Phoenix", "T2", "Oracle"
- Bioinformatics

11. Manage Regulatory & Medico-Legal Environment

- $50M Malpractice
- Agencies & Regulators (too numerous to count)

12. Manage Supply Chain

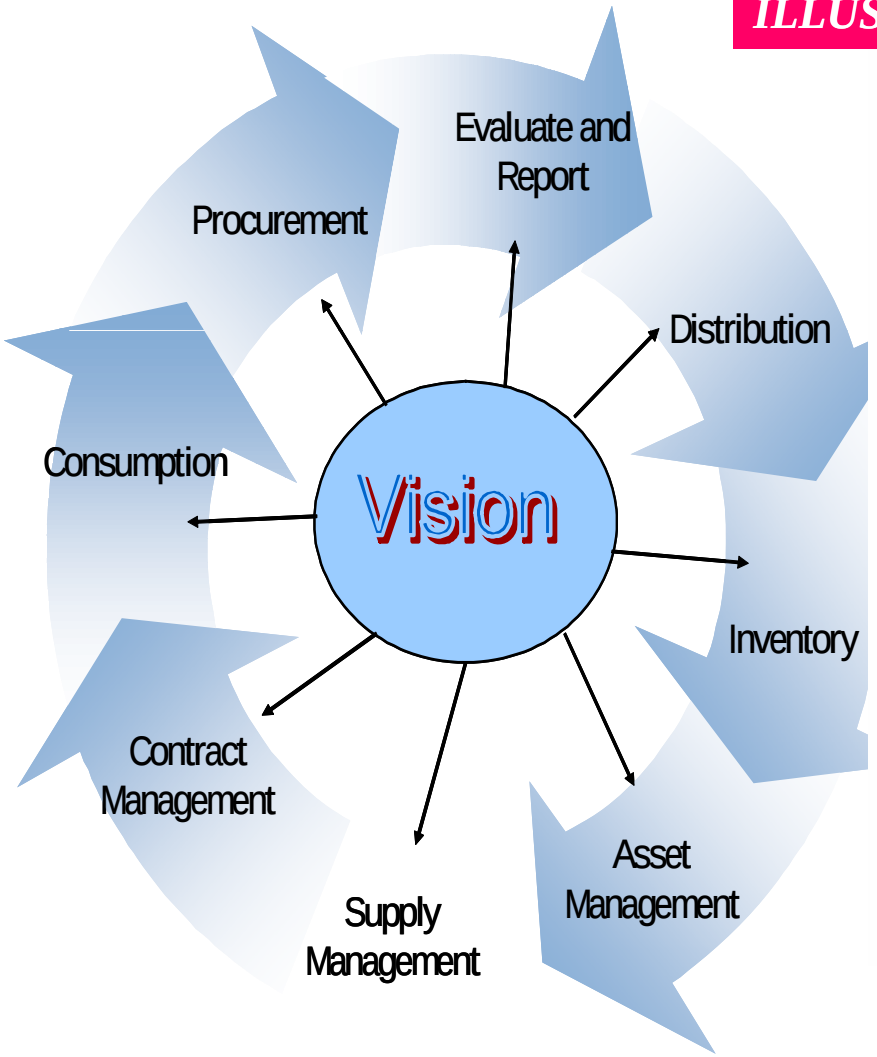
- $350M spend with $40M 3-year savings target

13. Integrate Education & Research

- $250M Grant Funding
- 300 Researchers
- 1300 Clinical Trials
- 650 Clinicians
- 720 Residents
- 400 Medical Students
- 400 Graduate Students

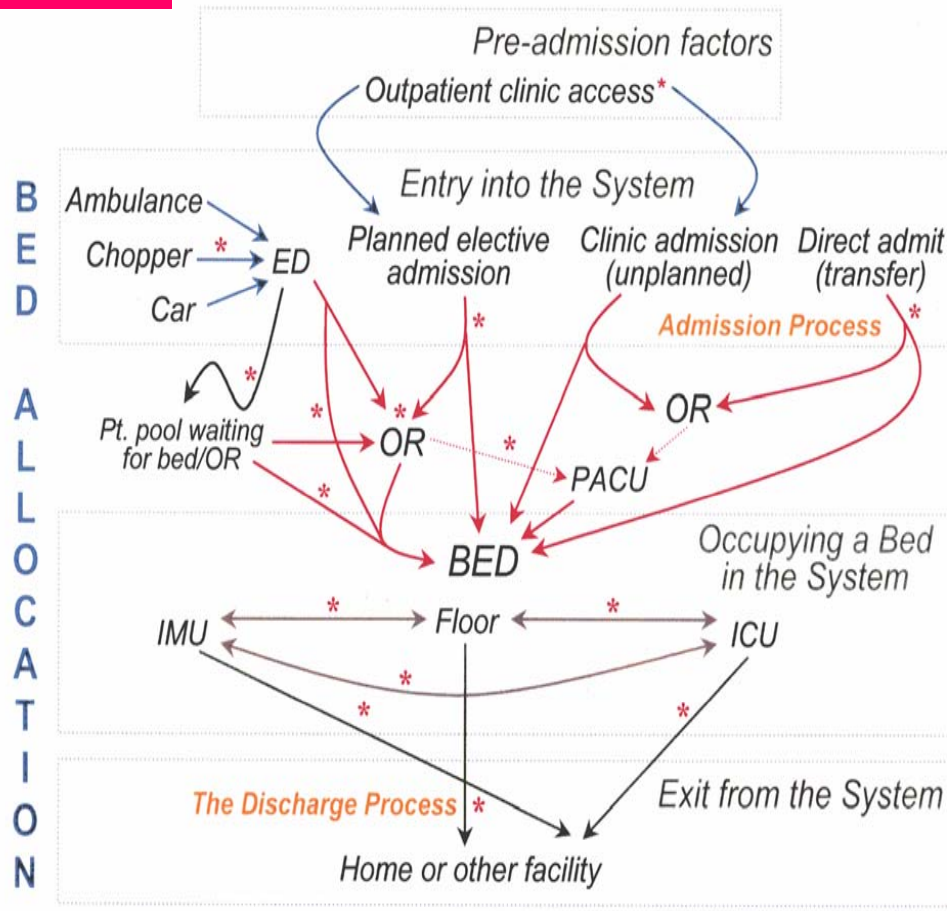
Process Redesign & Cost Reductions

Supply Chain



Throughput & Capacity

ILLUSTRATIVE



Process Redesign & Cost Reductions

Ambulatory Care

Central Call Center[1]

(One-stop shopping)

1-800-CALL-DOC or ASK- AMCC

~ 50% of current total appointment scheduling call volume

Appointment Scheduling
• Schedule basic appointments

Centralized Registration
• Register new patients/ update return patient information

Referring Physician Hotline
• Schedule basic appointments

Hubs

(Support 1 or more Clinical Centers)
(Direct line & dedicated line to Central Call Center)

connect calls ↔ **Neurosciences Hub**

connect calls ↔ **GI Center Hub**

connect calls ↔ **Women's/ Internal Medicine Hub**

Functions Performed within Hubs

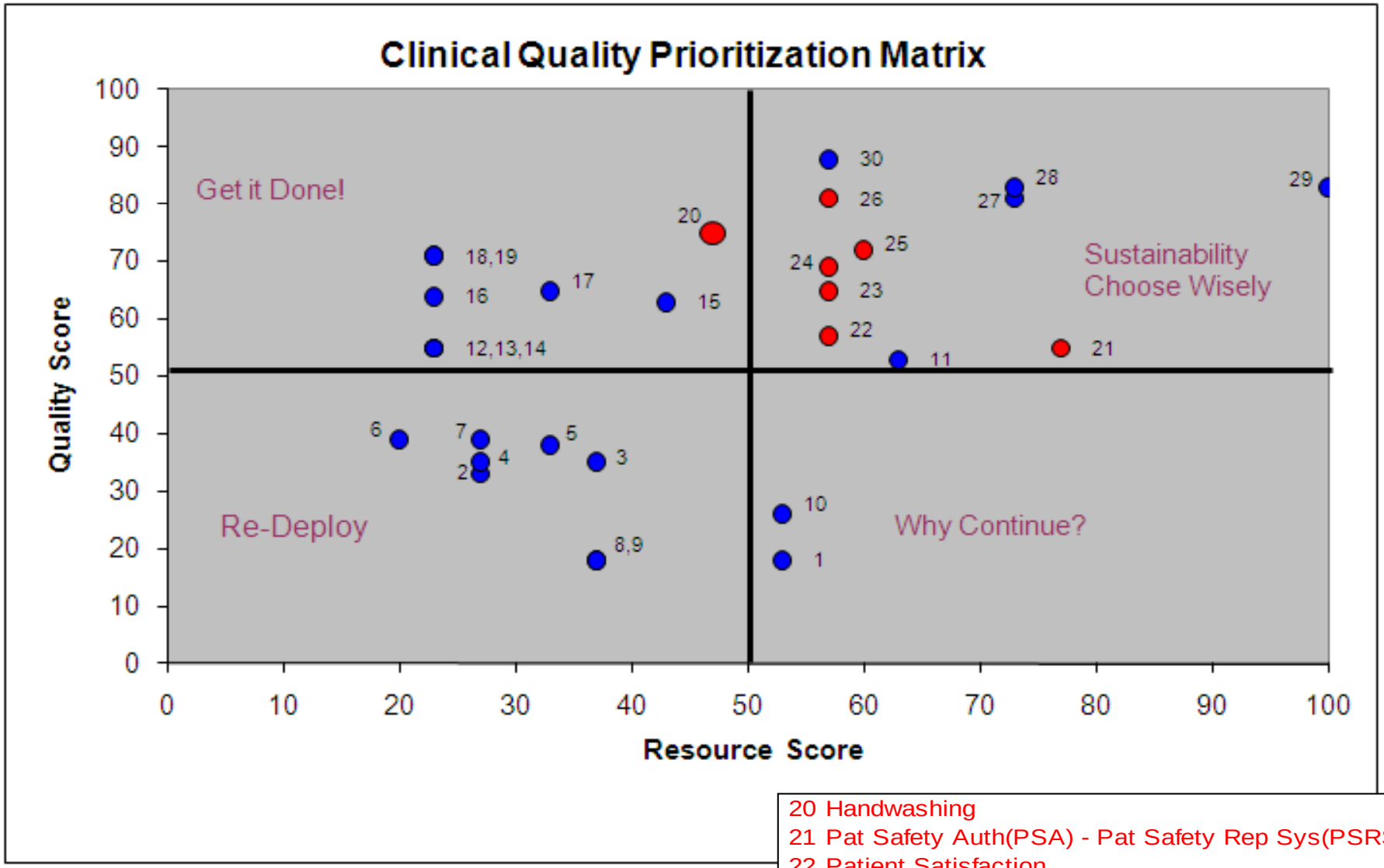
- **Schedule Levels all appointments for return patients in the center**
- **Triage & schedule complex appointments for new patients**
- **Handle appeals of dissatisfied customers**

ILLUSTRATIVE

Note: There will be approximately 10 hubs supporting the ambulatory operation

[1] Patients will be educated to contact the Central Call Center to schedule appointments

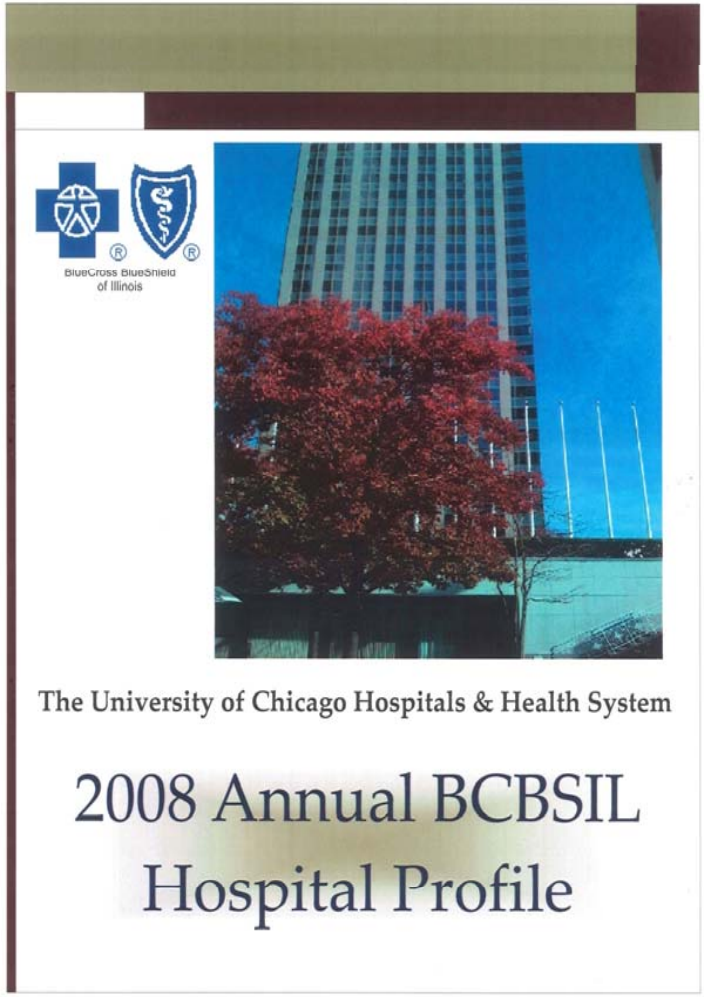
A Word About Quality



20 Handwashing
21 Pat Safety Auth(PSA) - Pat Safety Rep Sys(PSRS)
22 Patient Satisfaction
23 Patient Transport
24 Trauma Certification
25 Medication Reconciliation Guidelines
26 Quality Care Review + Centralized M&Ms

THE UNIVERSITY OF CHICAGO MEDICAL CENTER & BIOLOGICAL SCIENCES

Quality: External Public Measures



30

2007 ★★★☆☆☆☆☆☆☆

2008 ★★★★★★☆☆☆☆

2009 ★★★★★★★☆☆☆

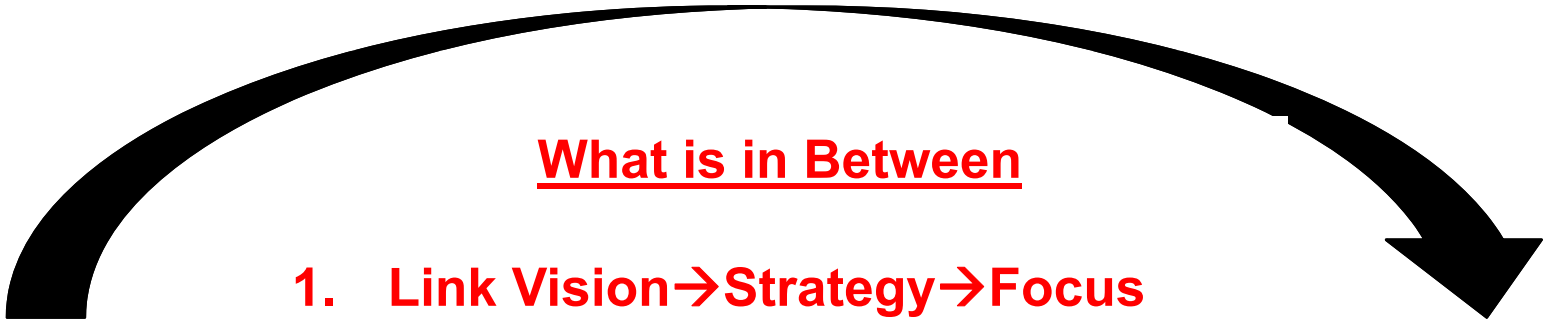
2010 ★★★★★★★★★☆

30

Future-Oriented CMO Implications

1. **Changing accountability and process**
   - MD Network – if referring physician calls, they talk to a faculty physician and admission/bed management simultaneously - NOT as easy as it sounds – and it is recorded for review if needed
2. **Changing workflow and structure**
   - "Form Follows Function" – LOS reductions; appropriate use; LWOTs
   - Working with College of Engineering – Penn State Center for Integrated Healthcare Delivery Systems – reworked entire ED flow – structure and process
3. **How will patients want to access our services and their personal data? – we will have to ask them! – and we will have to accommodate them**

Example #3



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Today

- FFS
- Volumes
- 'All Things to All People'

Tomorrow

- ACOs
- HIZs
- Populations
- Bundling
- Capitation

The Vision: Integrating the full spectrum of science[1]

AAMC will advance a bold medical science agenda focused on improving health through:

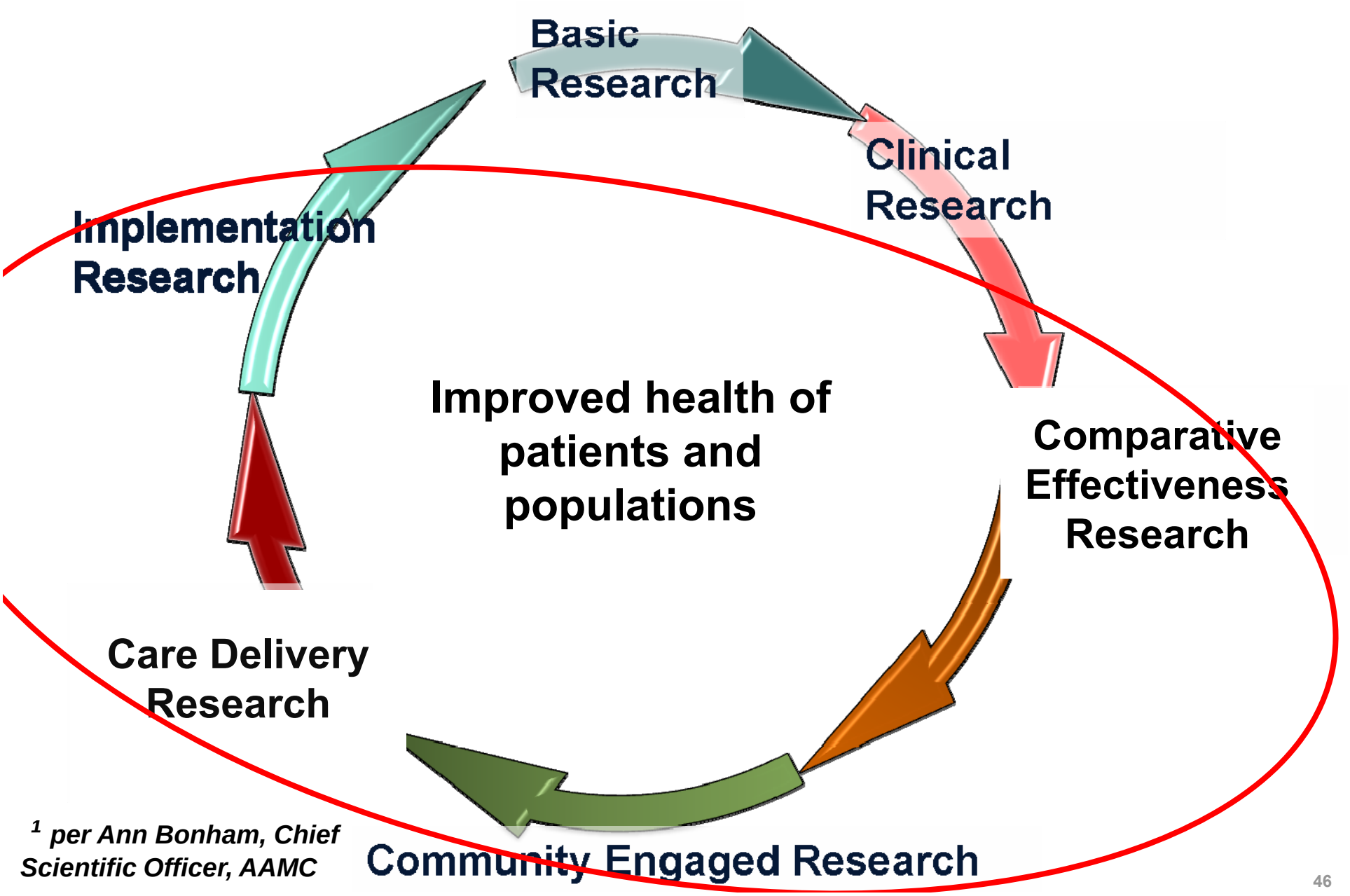
1. embracing the full spectrum of science;

2. fully integrating with the clinical care, education and diversity missions; and

3. anchored by a disciplined focus on quality in serving the patients and community.

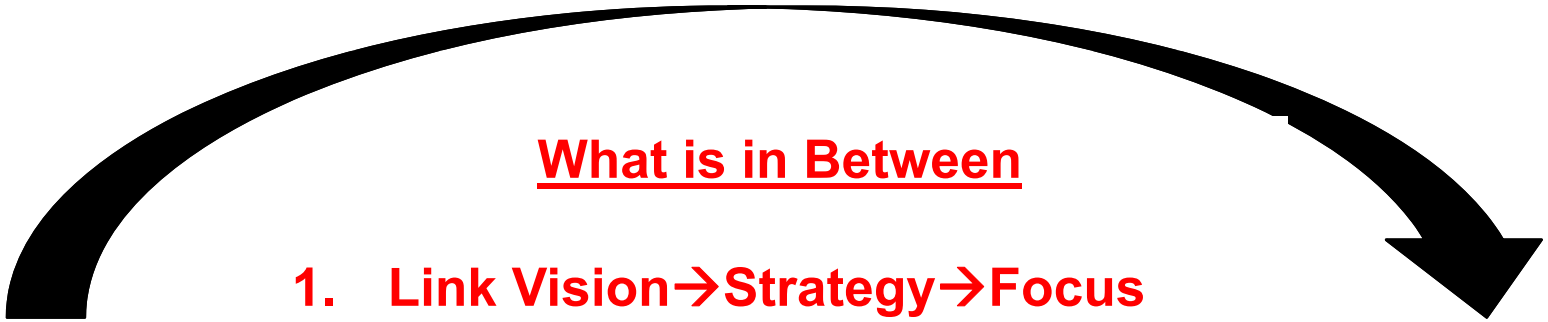
[1] per Ann Bonham, Chief Scientific Officer, AAMC

Integrating the Full Spectrum Of Science[1]



[1] *per Ann Bonham, Chief Scientific Officer, AAMC*

Example #4



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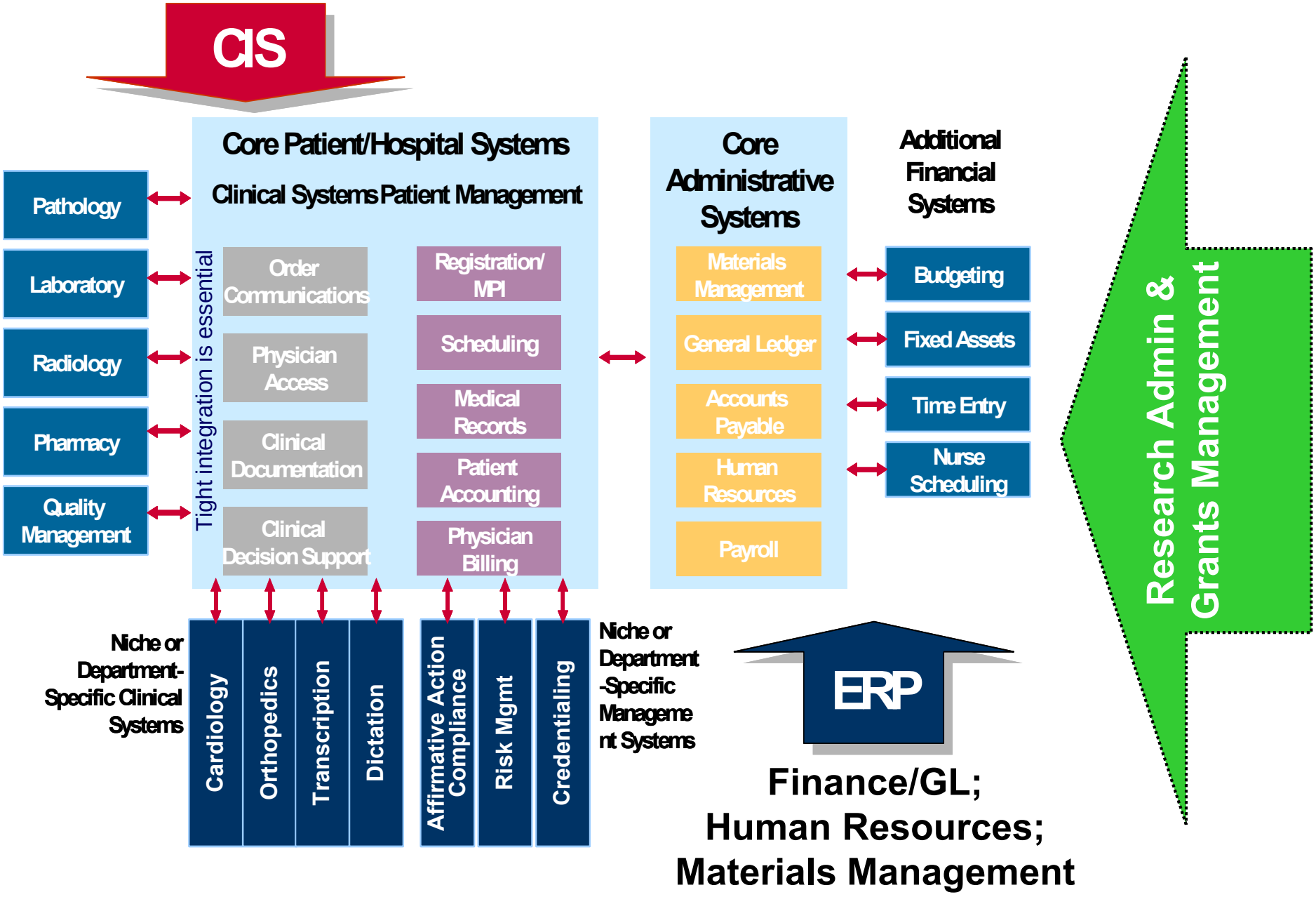
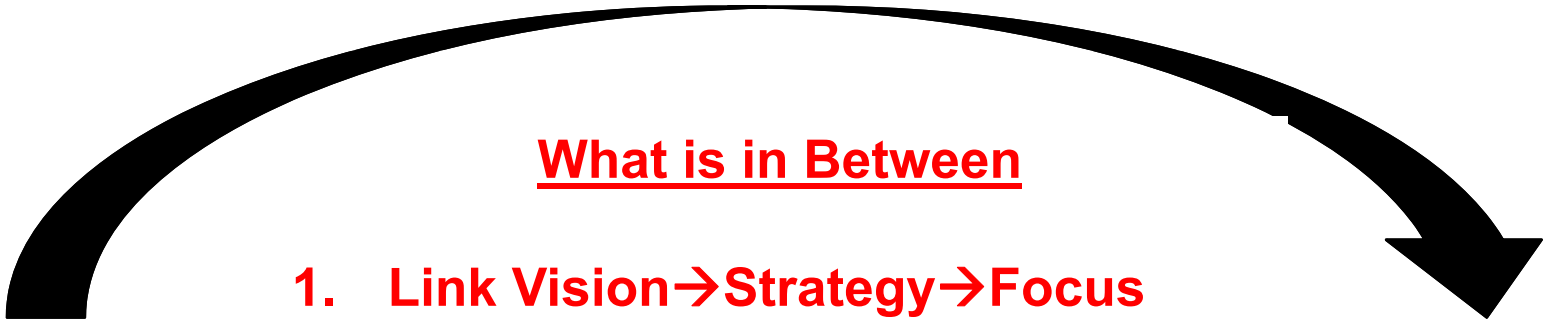
Sustaining Change with Technology Solutions…



Future-Oriented CMO Implications

1. **Meaningful use? – meaningful to whom?**
2. **Automating inpatient care was the easy part – CPOE, Pharmacy, Nursing Documentation, Progress Notes, etc – thank goodness for young, malleable minds and spirits!**
3. **Oh, you mean I will have to do that in my clinic?**
4. **Never forget – this is a clinical project, not an IT project! - (backfilling champions must hurt)**

Example #5



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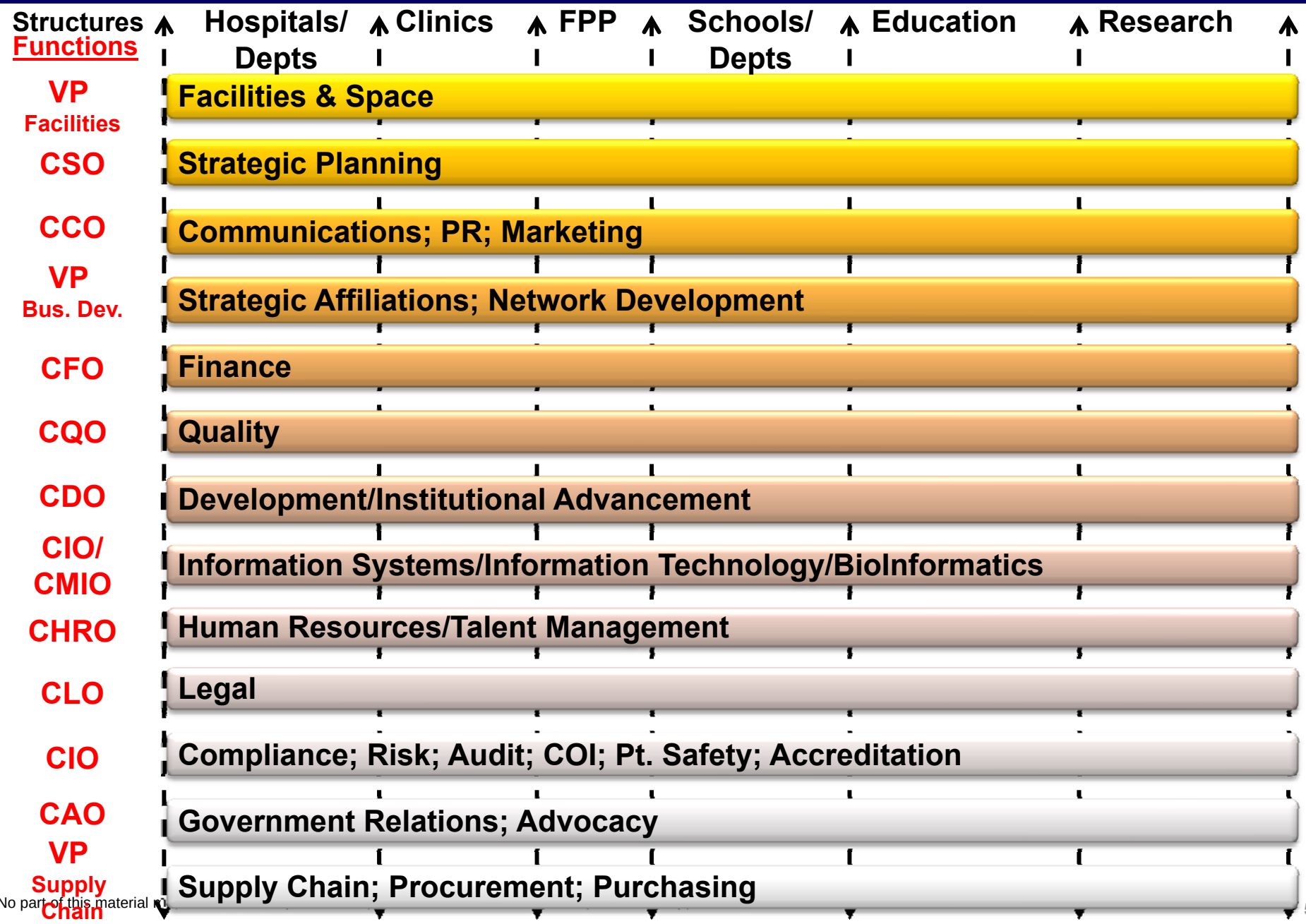
…Functional Integration in the Emerging Matrix and Team-Based Environment…



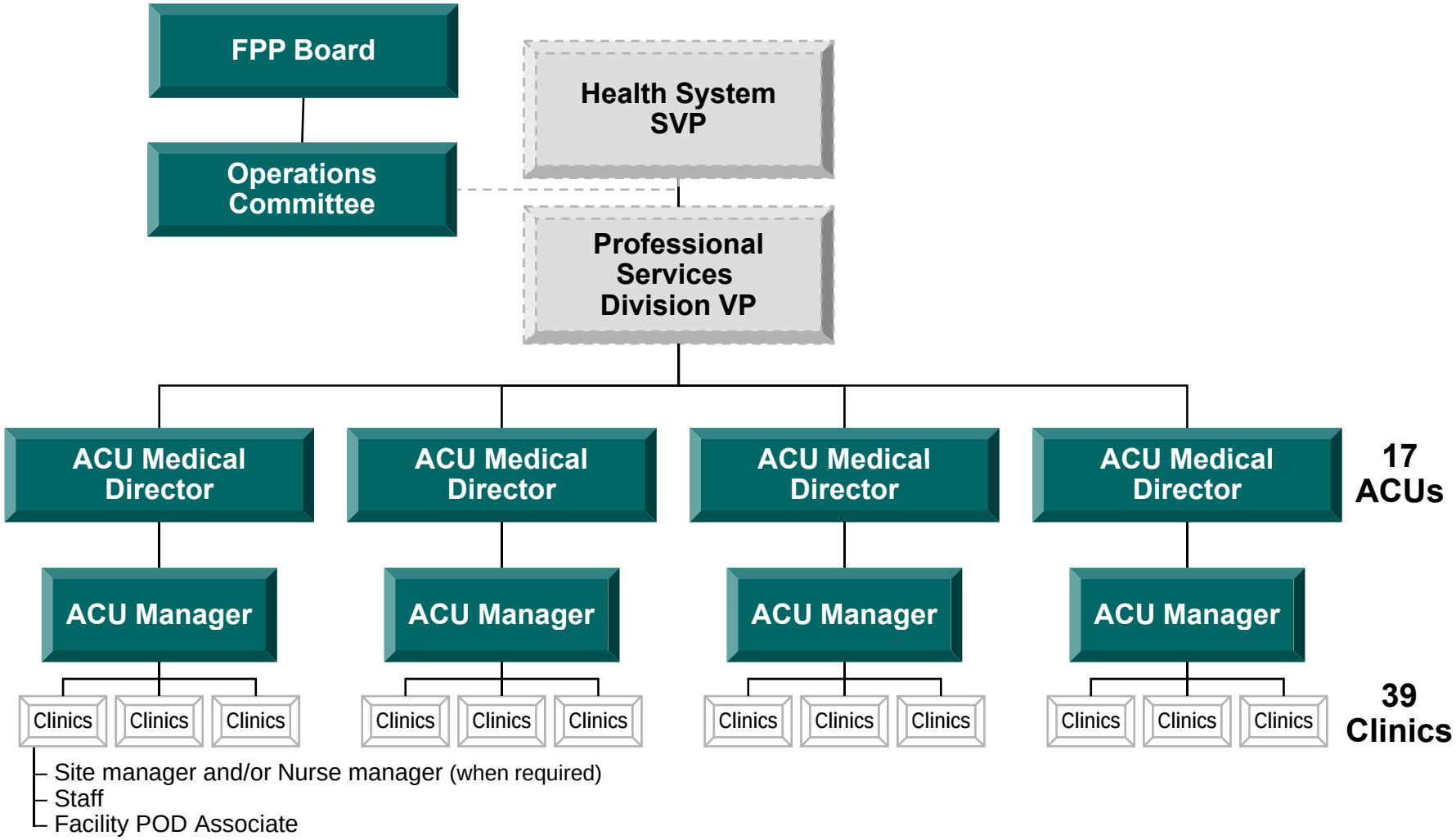
Effective Management in the Emerging Matrix and Team-Based Environment

Direct ("solid line") vs. Matrix ("dotted line")

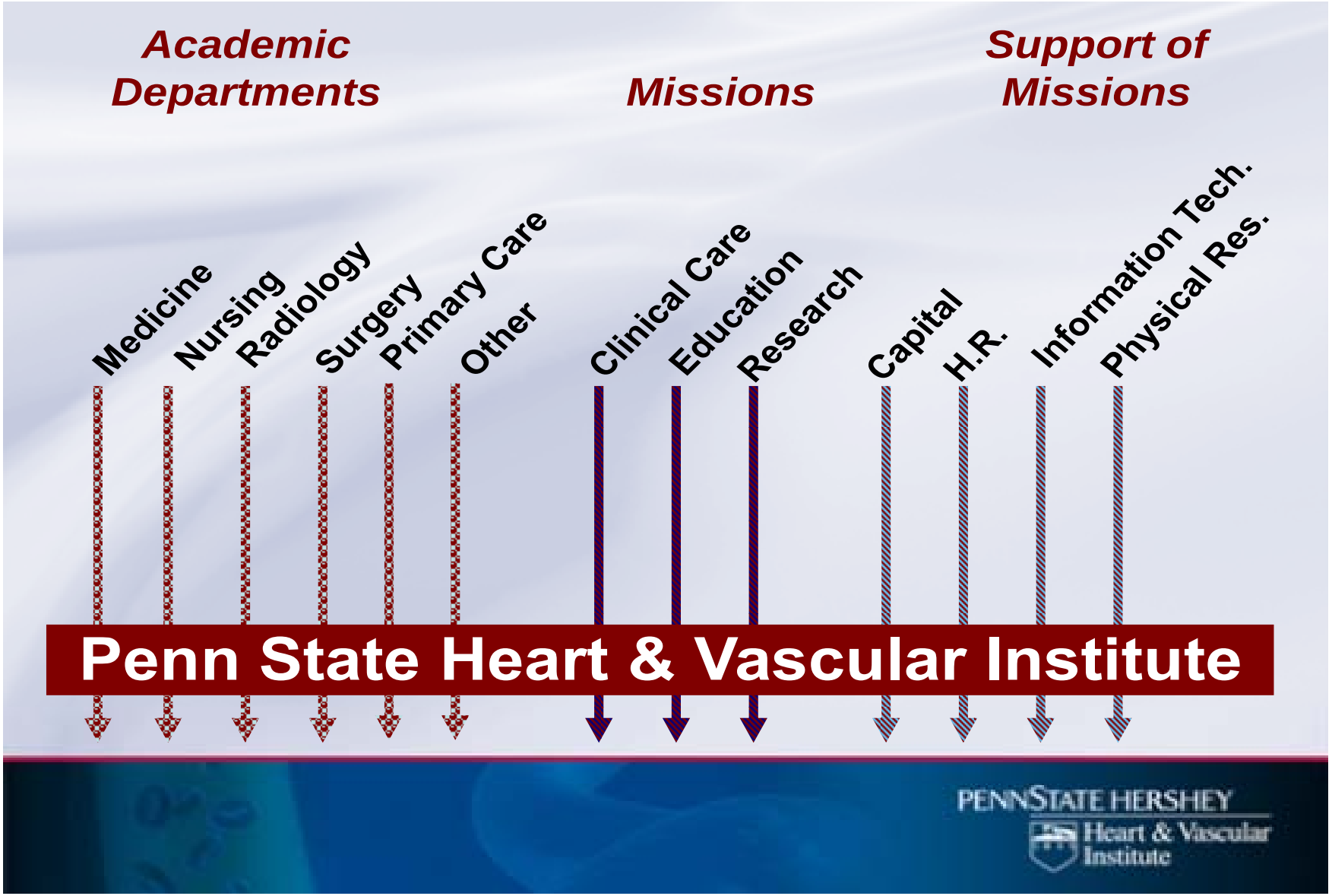
"Direct" Reporting Relationships	"Matrix" Reporting Relationships
• Hire/fire authority (for that particular accountability)	• Jointly establishes performance measures
• Determines base compensation	• Monitors performance measures with the expectation that they will be met or exceeded
• Determines and articulates expectations	• Input to performance evaluations
• Completes performance evaluations	• Input and recommendations for pay increases
• Determines pay increases and incentives	• Jointly determines bonus or incentive distributions
• Day-to-day management and supervision of activities	• If performance measures and/or expectations are consistently not met, then the "dotted line" can recommend/request/insist/demand the replacement or redeployment of the person to another function
• Career planning and development planning	

Ambulatory Care Matrix Management Model

ILLUSTRATIVE



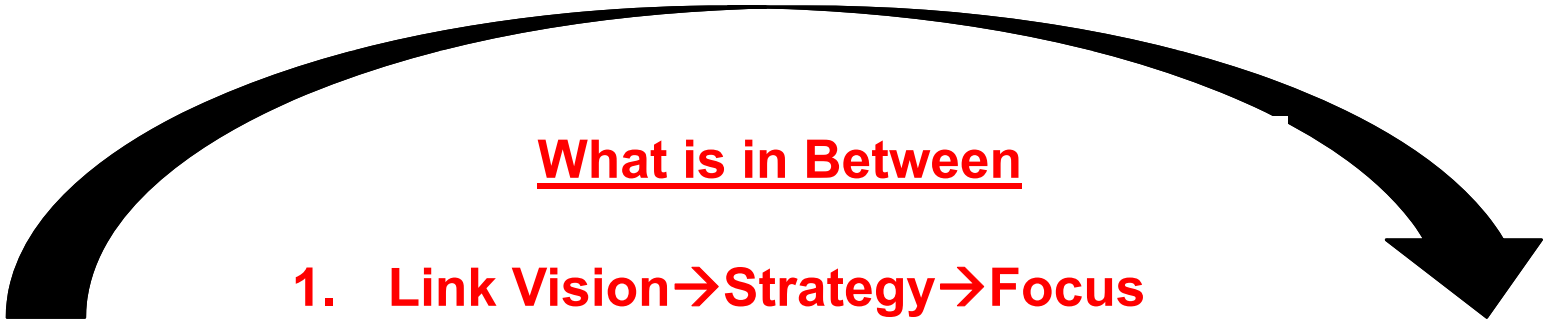
Institute Matrix Management Model



Future-Oriented CMO Implications

1. **Find a strong CNO partner – mutual admiration helps – unified front and transparency a must**
2. **Ibid: Interdisciplinary Centers and Institutes – PSHVI, PSCI, PSNS – are not as "natural" as a patient-centered, market-based "white paper" make it sound**
3. **Influence without ownership is a learned skill**
4. **When in doubt – bring data!**

Example #6



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Phenomena #1

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

Image: Simon Howden / FreeDigitalPhotos.net

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Phenomenon #2

What Americans want from the Healthcare system:*

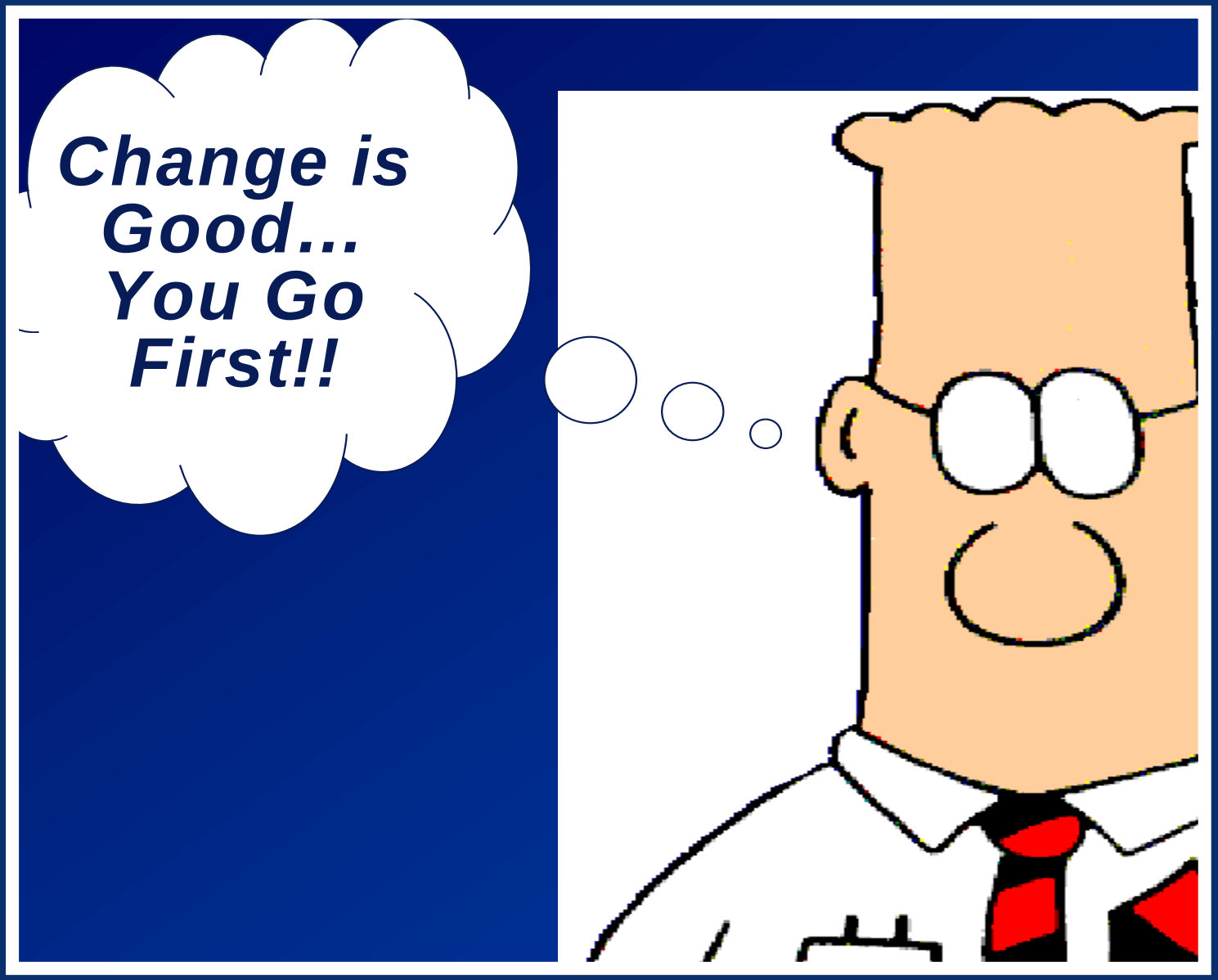
- We want the best care;
- We want it immediately;
- We want the most advanced drugs and technology;
- We want someone else to pay the bill; and…
- …if anything goes wrong, we want to sue someone.

AND

- We don't want to change any of our lifestyle choices and habits, even when we know our health suffers and costs rise because of them.
- We want to live as long as possible, regardless of the cost or the quality of the extended life we get.

*** Tom Gorrie , Johnson & Johnson**

Phenomenon #3



So What Are The Options?

Option 1: Continue an aggressive “whack-a-mole” strategy.

Option 2: Hold on until it’s someone else’s problem.

Option 3: When faced with a health benefits crisis, do what other industries do… outsource.

Option 4: Create a transformational initiative that meets the challenges simultaneously!

(particularly if you are a large self-insured employer, who is also a provider, a researcher, and an educator)

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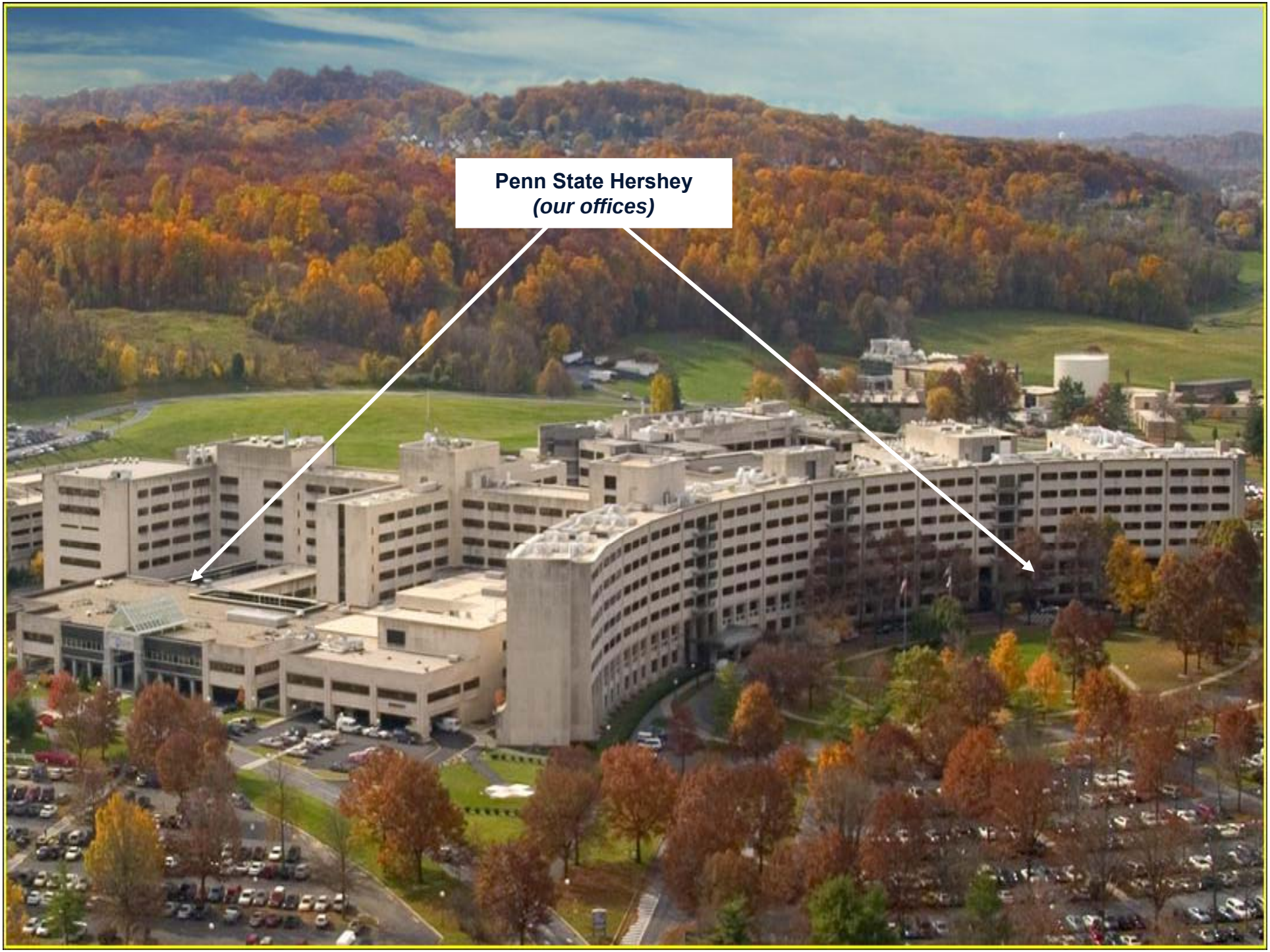
Penn State Hershey
(our offices)

“Rather than telling the rest of the world they need to change, how about we transform healthcare for ourselves?”

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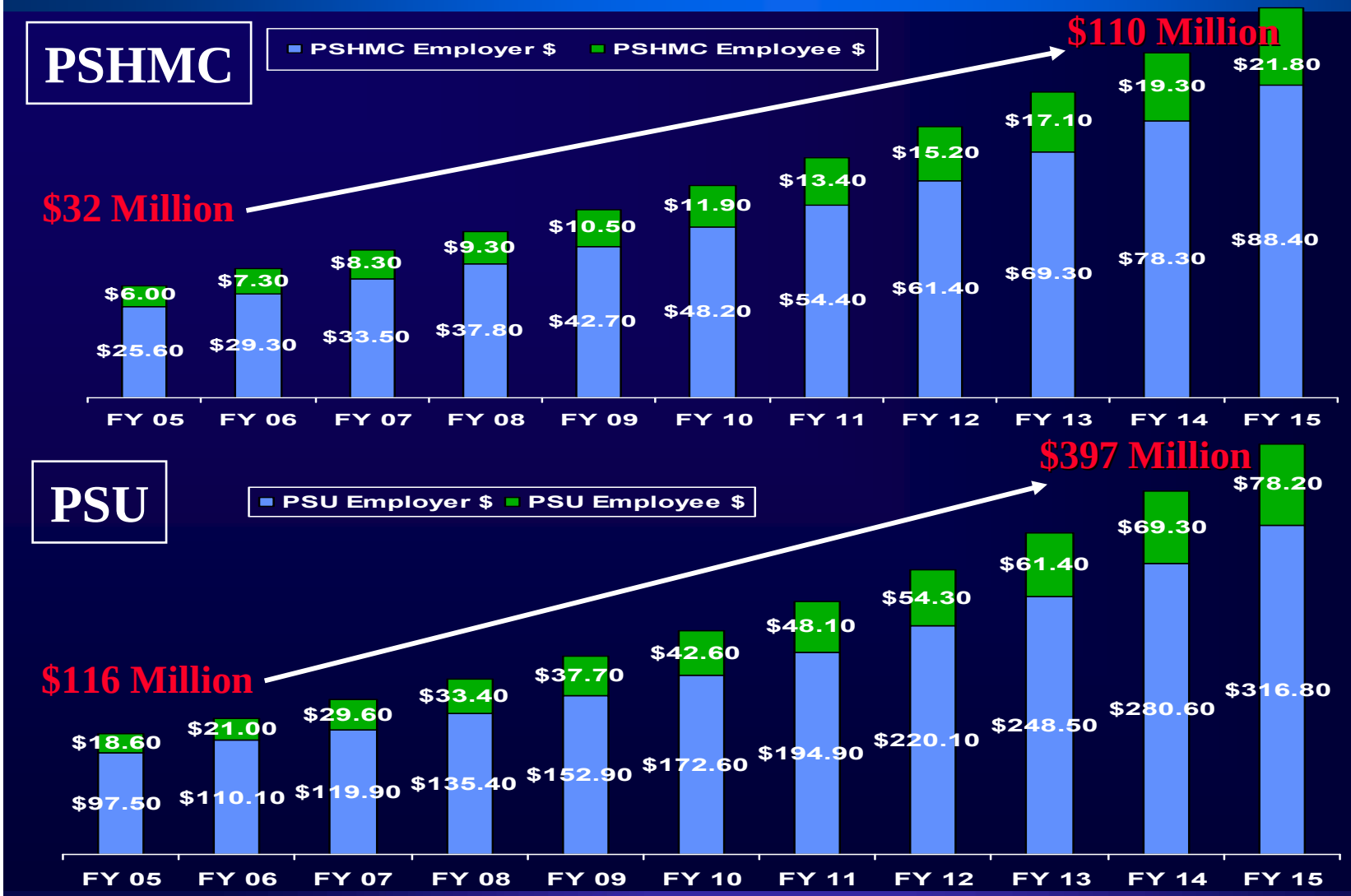
The Future . . .if we do nothing



10 Yr Total

$700 Million

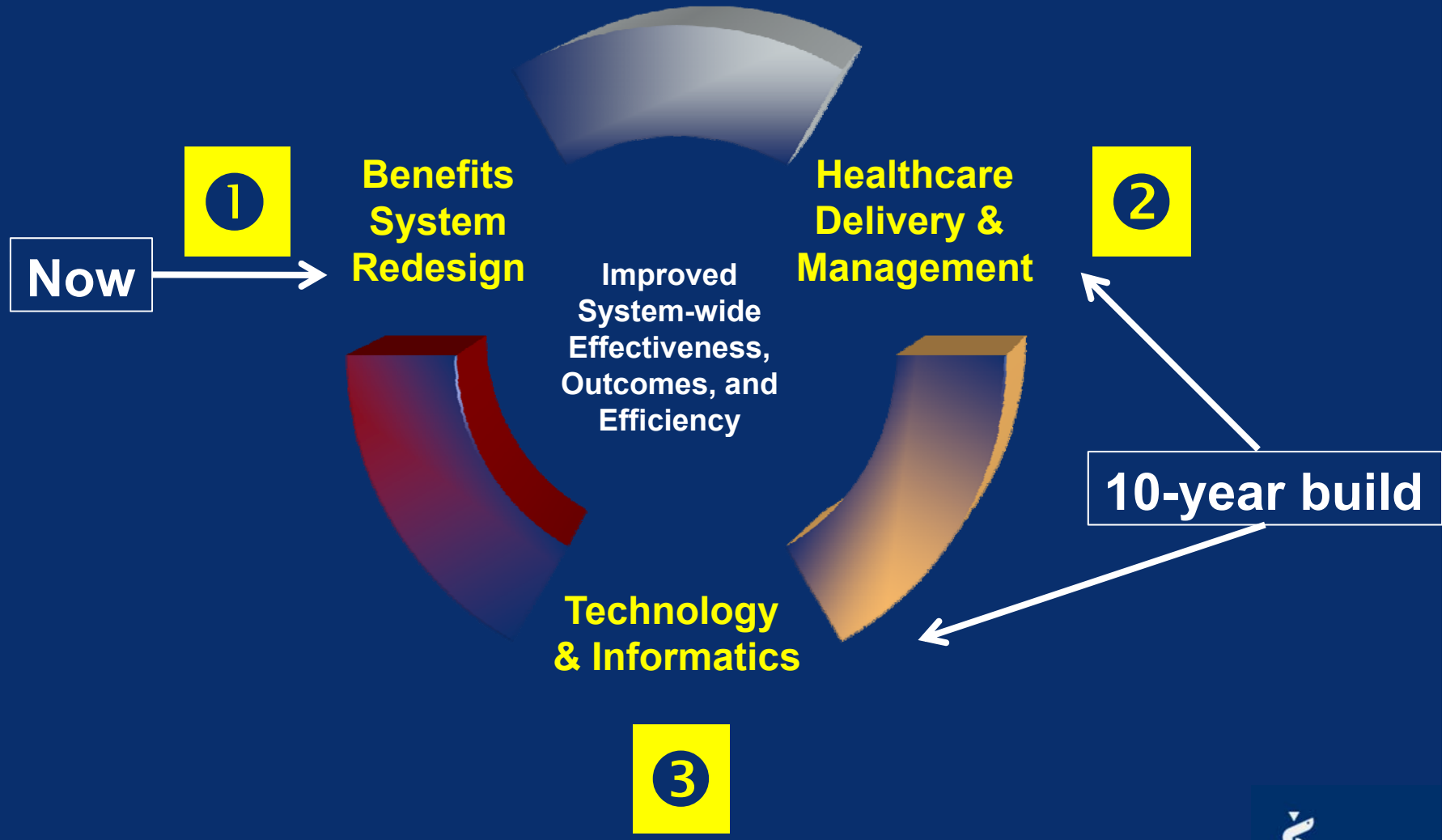
10 Yr Total (in billions)

$2.4 Billion

$3.1 Billion

PENNSTATE
Milton S. Hershey Medical Center
College of Medicine

New Healthcare Model for Central PA



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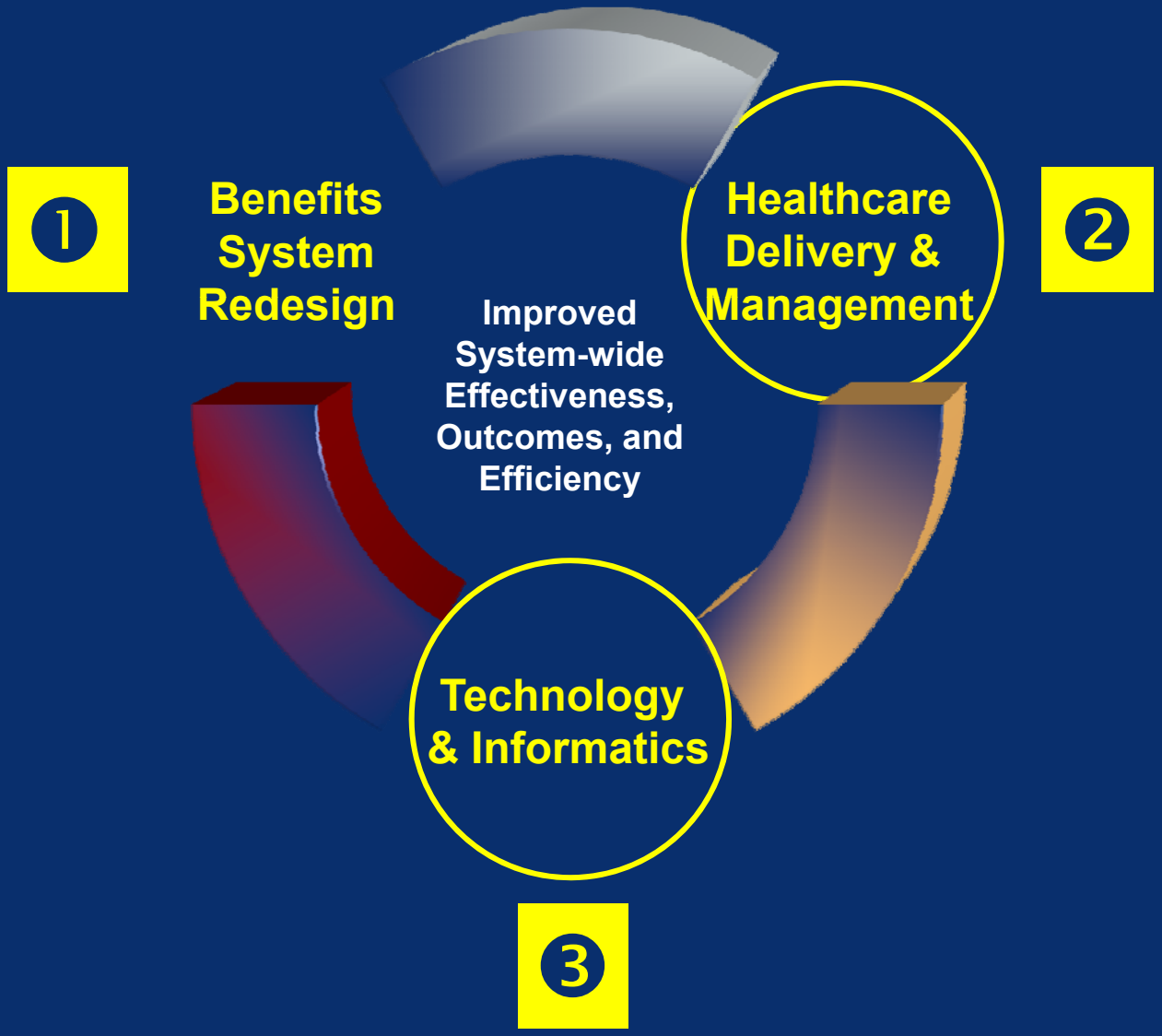

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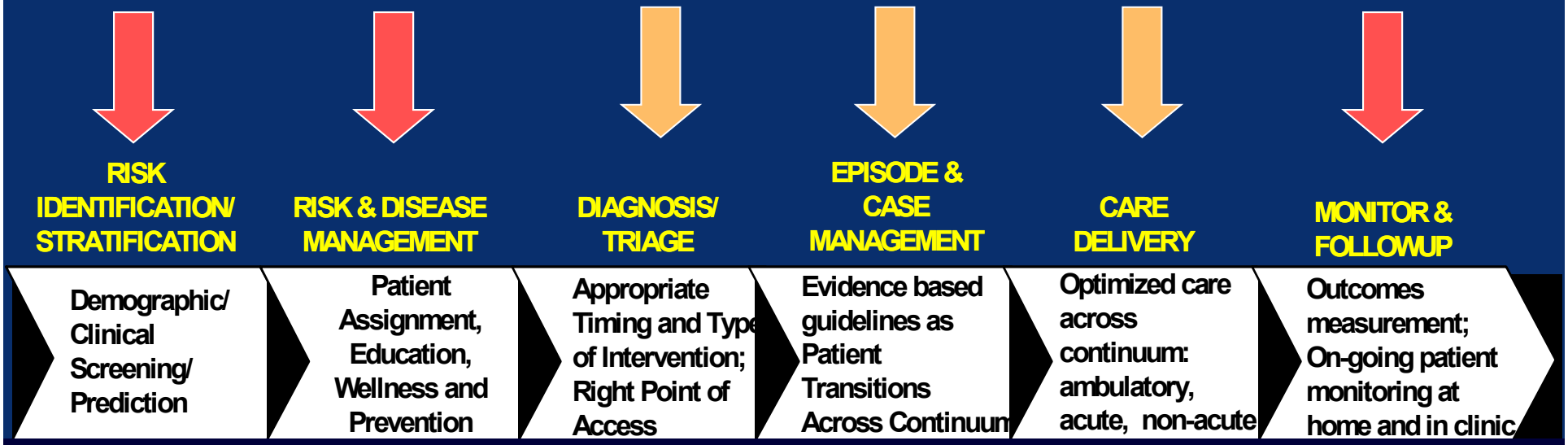
A New Care Delivery Model



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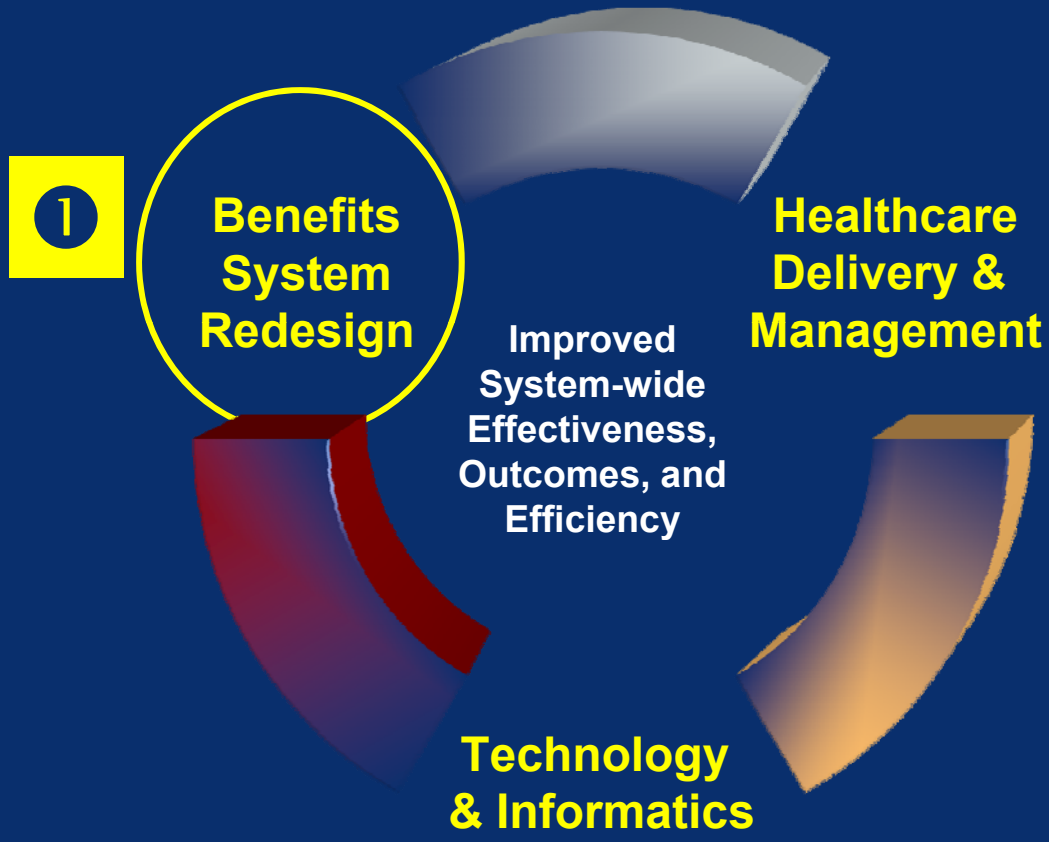

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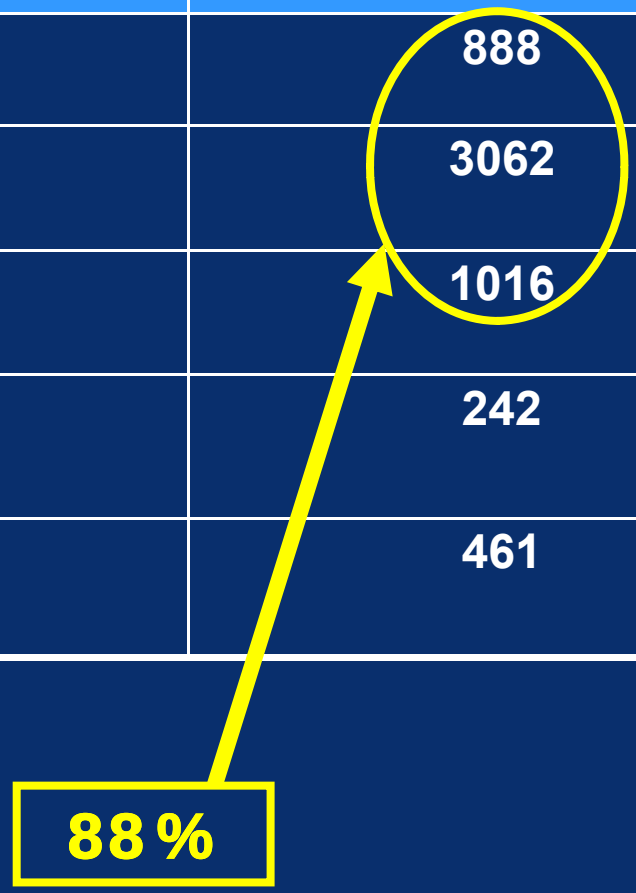
Healthcare Benefits Pop Quiz !!

1. My monthly or yearly premium deduction is….?
2. What % of my salary does premium represent?
3. The monthly or yearly premium portion that the Medical Center pays is…?
4. My annual deductible is….?
5. My co-pay for primary care visits is…? specialty visits is…?
6. My annual "out of pocket maximum" is…?
7. I know what a Health Reimbursement Account (HRA) is…?
8. I have read and have signed an:
   - organ donor card?
   - advance directive and living will?
9. I know both what "BMI" is and I know what my BMI is?
10. I know the greatest risk(s) to my long –term health?

Medical Center Employees by Salary Level

Salary Range	# of Employees
< $25,000	888
25,000 to $49,999	3062
$50,000 to $74, 999	1016
$75,000 to $99,999	242
> $100,000+	461



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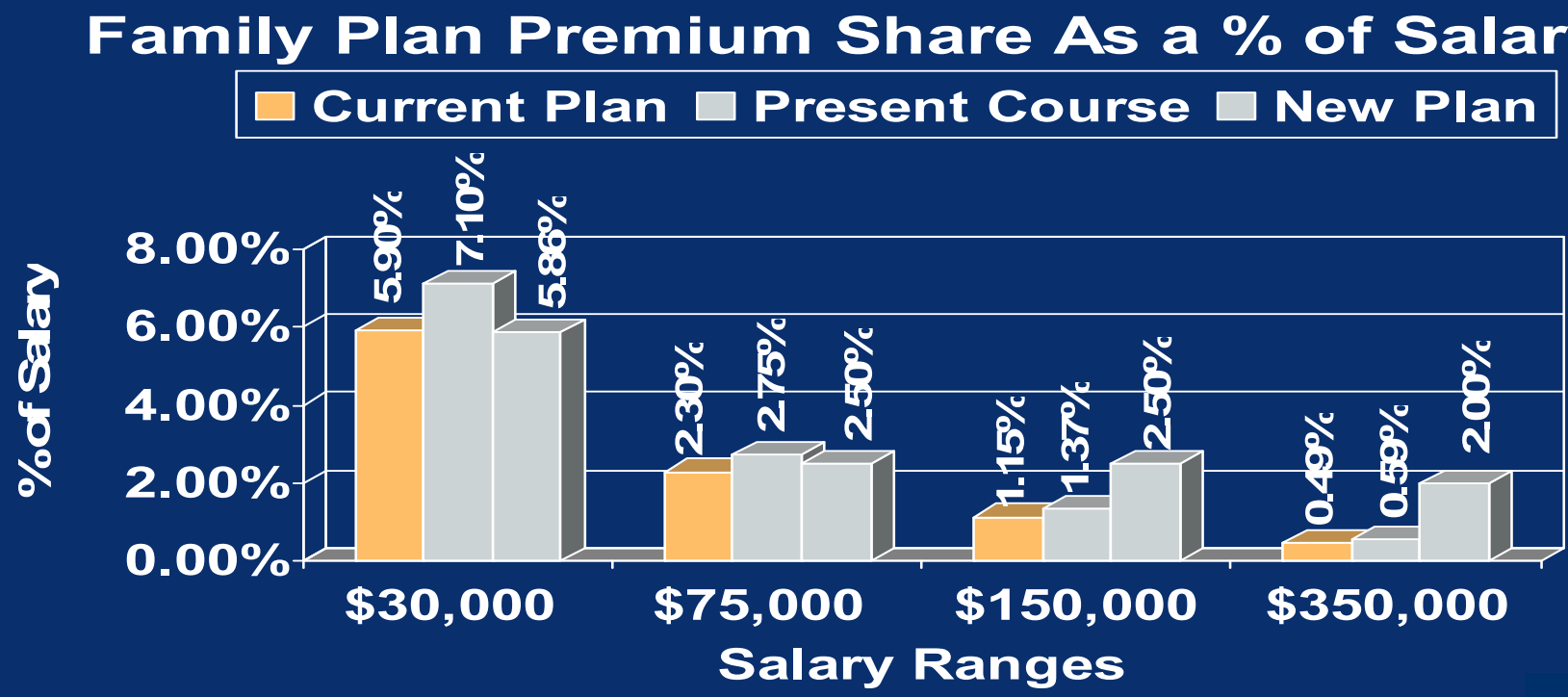
Employee Share of Healthcare Premium

	Biweekly	Monthly
Individual	$27.03	$58.57
Family	$66.37	$143.80



Redesign of Employer's Health Benefits

- Only one plan was offered
- Introduced high deductibles
  (e.g., $3,000 family)
- Premiums reverse indexed by income
  (e.g., low income = $2,000/yr; high income = $7,000/yr)
- Employer-funded HRA component seeded against the deductible reverse indexed by income
  (e.g., low income = $2,250; high income = $400)
- Evidence-based, preventative care services, covered-in-full
- Incentives:
  - $0 co-pay for using employer facilities for expensive testing, procedures, hospitalization, specialty care
  - $200 for engaging in weight loss and 'stop smoking' initiatives
  - $100 for educating yourself in advance directives & arbitration
- Unspent HRA balances rolled forward each January 1 with new HRA investment added

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Redesign of Employer's Health Benefits

Annual Salary →	*< $70,000 Employee*	*>$289,000 Employee*
Annual Deductible	$3,000	$3,000
Annual HRA Contribution	$2,250	$400
Annual Premium	$2,000	$6,000

AAMC

Redesign of Employer's Health Benefits: *Campaign Mode*

- Town Hall meetings with 4,500 employees, staff, and faculty
- Trained up 200 managers to answer FAQs
- Extended longer, hands-on, open enrollment period
- Transparent pricing and comparison shopping
  - Comparison data for assessing our new plan against external plans
  - Intranet website for internal price comparators for procedures & visits
  - HR Help Line to answer employee's questions
  - Clinic "cheatsheets" and physician education to answer employee's questions
- Forged an exclusive, long term, single payer agreement for low cost ASO and web portal services; incentive terms for maintaining top quartile cost & real quality outcomes

Redesign of Employer's Health Benefits: *Results*

- **First year results**
  - Garnered SEIU and Teamster support
  - Highest ever enrollment (96%)
  - 25% reduction against predicted budget
  - 13% reduction against prior year actuals
  - 40% of seeded HRA dollars savings rolled over
- **Multi-year trend**
  - Removed over $6M of costs per year from the projected course and speed
  - Employee satisfaction results equal or better

AAMC

Redesign of Employer's Health Benefits: *Physician Engagement & Impacts…*

- **As Care Givers…**
  - Discomfort of employee's questioning the need for testing
  - Exposed the knowledge gap between 'value' and 'cost'
  - Established real preventative services that matter

- **As Leaders…**
  - A shift from the sidelines into the actual field of play
  - Employee engagement in real time decisions and choices

- **As Individuals…**
  - Exposed the philosophical clashes
    - *Democratic & Republican leanings*
    - *Leading reform & funding one's back pocket*

AAMC

Redesign of Employer's Health Benefits: *Yet to be Accomplished*

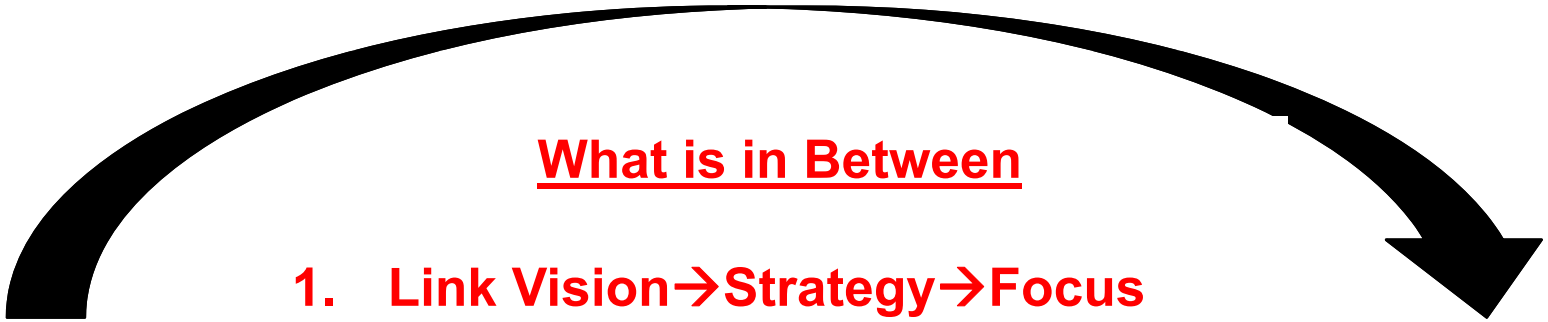
- Crack the code on chronic disease
- Resolve whether punitive measures are required
- Find other leading-edge employers to implement with

AAMC

Future-Oriented CMO Implications

1. **You can never communicate too much**
2. **And even that may not be enough to avoid conflict and pushback**
3. **The journey to improve the health of Penn State lives and dependents will be a long one**

Example #7



What is in Between

1. Link Vision→Strategy→Focus
2. Multi-mission integrated budgets
3. Funds flow redesign
4. Core process redesign & reduce cost base by 20%
5. Care management capabilities
6. Continuum-of-care linkages
7. Multi-mission education redesign
8. Rebalancing research mission
9. Functional integration across AHE
10. IT-enablement
11. Leadership development
12. Comp & incentive redesign
13. Employee health redesign
14. Etc; etc; etc….

Today

- FFS
- Volumes
- 'All Things to All People'

Tomorrow

- ACOs
- HIZs
- Populations
- Bundling
- Capitation

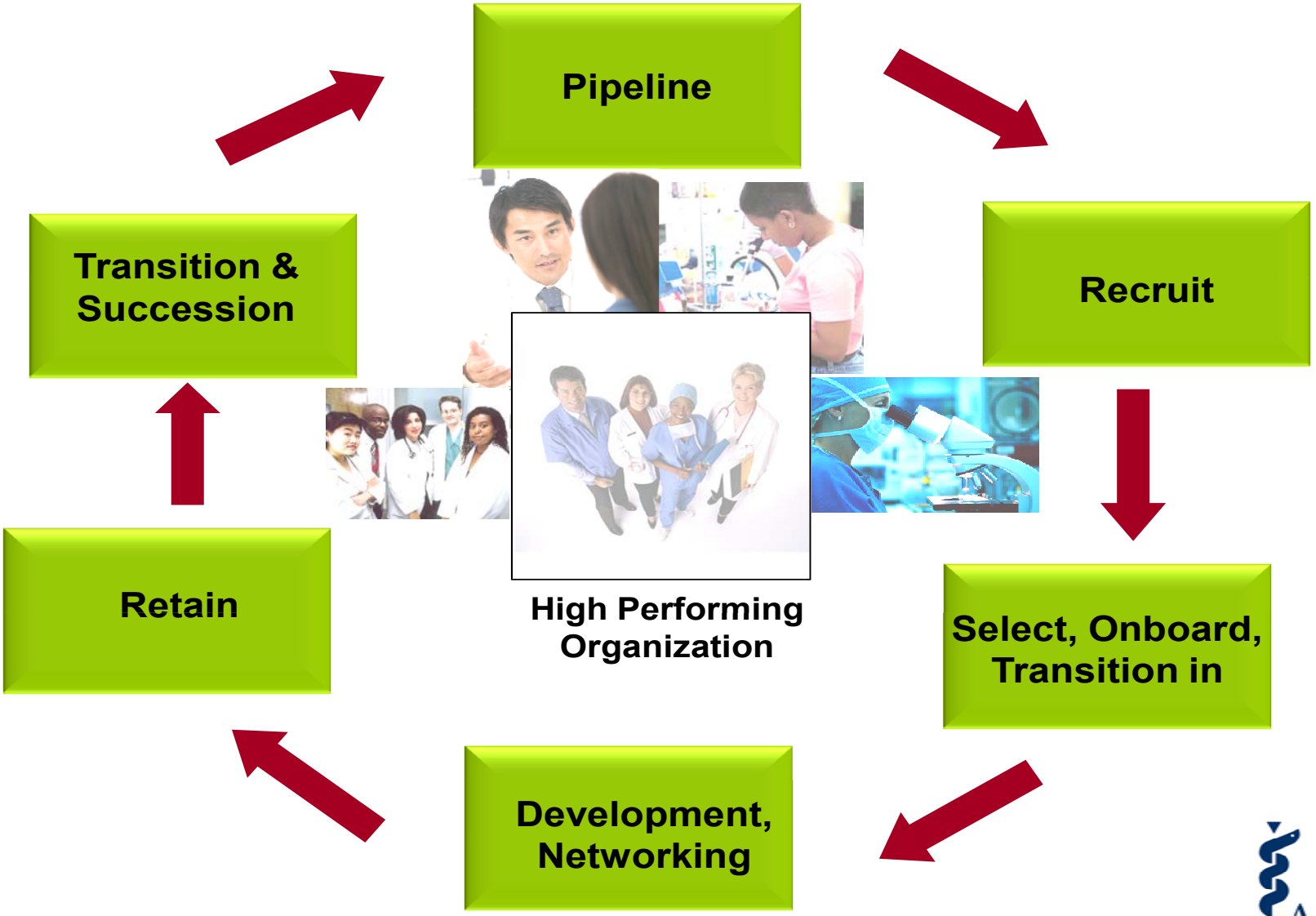
AAMC

Tomorrow's Doctors, Tomorrow's Cures®

Integrative Leadership:
Critical Conversations for Changing Times

Learn
Serve
Lead

Talent Management & Leadership Development



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State Change for Chairs

The Past…

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

The Future…

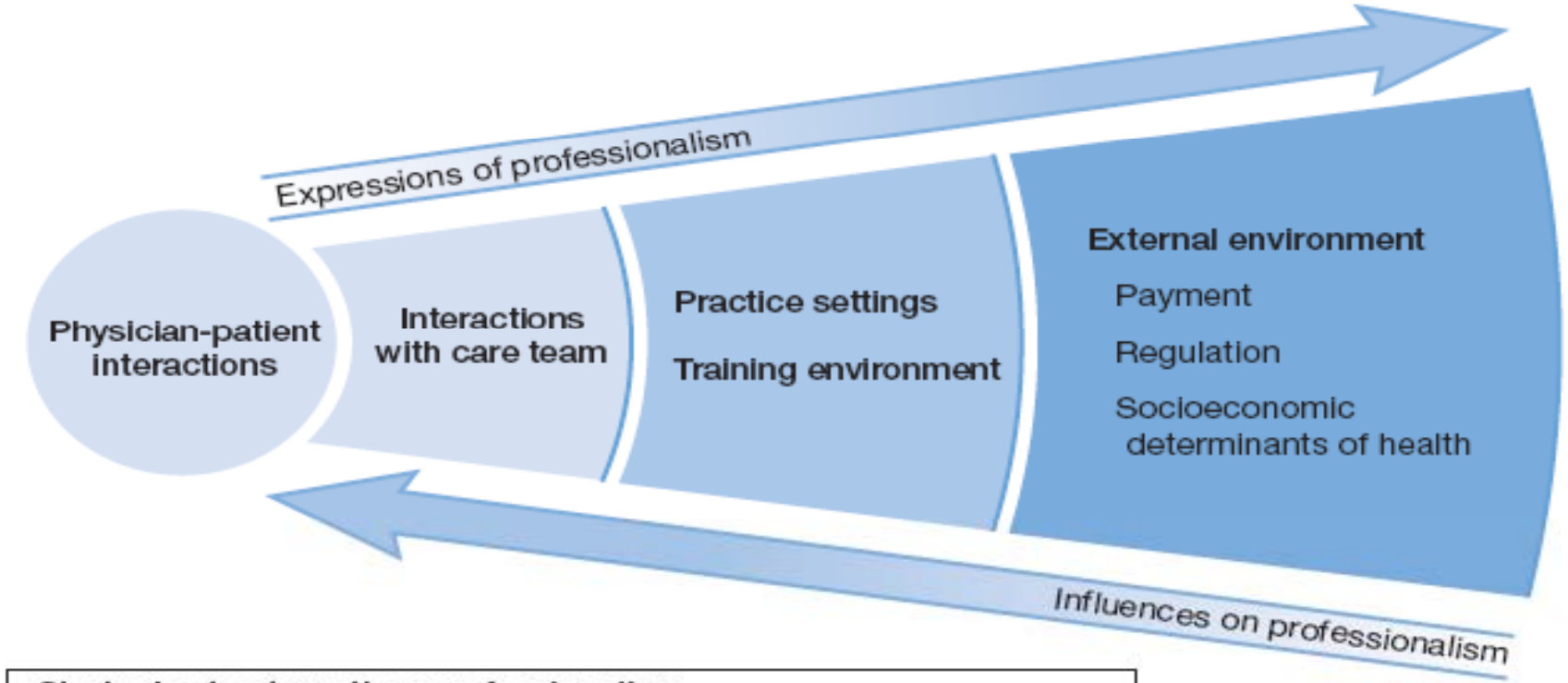
1. Successes and failures more visible
2. Deep understanding of, and engagement in, the success of the entire enterprise
3. Frank dialogue and mentoring with each faculty member
4. Change agent
5. Work collaboratively with peers, while holding peers accountable for results

"Professionalism may not be sufficient to drive the profound and far-reaching changes needed in the US health care system, but without it, the health care enterprise is lost."

Lesser CS, Lucey CR, et al. A Behavioral and Systems View of Professionalism. JAMA. 2010;304(24):2732-2737

A BEHAVIORAL AND SYSTEMS VIEW OF PROFESSIONALISM

Figure. Systems View of Professionalism



Lesser CS, Lucey CR, et al. *A Behavioral and Systems View of Professionalism.* ***JAMA.*** **2010;304(24):2732-2737**

A Behavioral and Systems View of Professionalism

- Move beyond viewing professionalism as static, abstract, idealized, principal-based or innate attribute of individuals

- Rather see professionalism as a set of competency-driven, measurable and learned behaviors of individuals and "systems" that can be taught, refined and evolved over time

Lesser CS, Lucey CR, et al. *A Behavioral and Systems View of Professionalism.* ***JAMA*****. 2010;304(24):2732-2737**

Table 1. Framework for Conceptualizing Professionalism—Individual Physician Behaviors in Interactions With Patients and Family Members and Other Health Care Professionals

Values	Examples of Individual Physician Behaviors: Interactions With Patients and Family Members	Examples of Individual Physician Behaviors: Interactions With Colleagues and Other Members of the Health Care Team
Compassionate, respectful, and collaborative orientation, "in service" of the patient	Provide patient-centered care, demonstrating empathy, compassion, and actively working to build rapport Promote autonomy of the patient; eliciting and respecting patient preferences, and including patient in decision making Be accessible to patients to ensure timely access to care and continuity of providers Act to benefit the patient when a conflict of interest exists	Work collaboratively with other members of the care team to facilitate effective service to the patient Demonstrate respect for other team members in all interactions
Integrity and accountability	Maintain patient confidentiality Maintain appropriate relationships with patients Promptly disclose medical errors; take responsibility for and steps to remedy mistakes Actively manage conflicts of interest and publicly disclose any relationships that may affect the physician's recommendations related to diagnosis and treatment (eg, part ownership of surgery center)	Report impaired or incompetent colleagues Participate in peer-review and 360-degree evaluations of team Specify standards and procedures for handoffs across settings of care to ensure coordination and continuity of care
Pursuit of excellence	Adhere to nationally recognized evidence-based guidelines (eg, guidelines issued by Agency for Healthcare Research and Quality or US Preventive Services Task Force), individualizing as needed for particular patients but conforming with guidelines for the majority of patients Engage in lifelong learning and professional development Apply system-level continuous quality improvement to patient care	Participate in collaborative efforts to improve system-level factors contributing to quality of care
Fair and ethical stewardship of health care resources	Do no harm; do not provide unnecessary or unwarranted care Commit to deliver care equitably, respecting the different needs and preferences of subpopulations, and to provide emergent care without regard to insurance status or ability to pay Deliver care in a culturally competent and resource-conscious manner	Establish mechanisms for feedback from peers on resource use and appropriateness of care Work with clinical and nonclinical staff to continuously improve efficiency of care delivery process and ensure that all members of the care team are optimizing their contributions to care delivery and administration Actively work with colleagues to coordinate care, avoid redundant testing, and maximize prudent resource use across settings

Lesser CS, Lucey CR, et al. *A Behavioral and Systems View of Professionalism.* ***JAMA.*** **2010;304(24):2732-2737**

Values	Examples of Organizational Behaviors: Practice Settings (ie, Hospitals, Health Systems, Physician Organizations)	Examples of Organizational Behaviors: Physician Advocacy and Professional Organizations
Compassionate, respectful, and collaborative "in service" of the patient	Support ongoing development of communication skills and cultural competency to foster effective interactions with patients, families, and care team members Invest in shared decision-making supports and actively encourage patient engagement in care decisions Establish mechanisms to engage representatives of patients and family caregivers in organizational management and governance Adopt policies and practices that support timely access to patients' providers of choice Foster creation of a physical environment that promotes healing	Advocate payment policy that supports clinician time with patients to build rapport, engage in shared decision making, and be accessible to patients to provide timely care Actively promote ongoing development of competencies related to patient engagement and teamwork
Integrity and accountability	Provide peer and organizational support for disclosure of medical errors and reporting impaired or incompetent clinicians Adopt clear and stringent policies regarding conflict of interest and maintaining patient confidentiality Provide performance feedback to care team and hold the team accountable for results for a defined population, eg, via compensation, public reporting, or both Discourage provision of services without an evidence base to support value to the patient	Develop and encourage organizational strategies to foster a "culture of professionalism" Participate in development of professional standards and establish mechanisms for remediation and discipline of members who fail to meet those standards Commit to disclosure of meaningful performance information Encourage development of systems to report and analyze medical mistakes to inform prevention and improvement strategies Develop conflict of interest policies Use benefit to patients as the metric to guide resolution of conflicts of interest
Pursuit of excellence	Invest in system-level supports for organization-wide quality improvement, eg, electronic health records, registries Establish clear targets for improvement and continuously monitor and raise the bar for performance	Develop and encourage use of meaningful measures of clinical quality of care and sound guidelines for clinical practice Establish ambitious targets and support actions to achieve significant and rapid system-wide improvements in quality of care Advance scientific knowledge
Fair and ethical stewardship of health care resources	Encourage judicious use of resources to care for a patient population, eg, by providing information on system-level costs and outcomes Implement mechanisms for supporting cultural competency and continuous quality improvement focused on reducing disparities in care	Advocate for development and adoption of tools to support cost-effective care and judicious use of health care resources Promote public health and advocate on behalf of societal interests with respect to health and health care, without concern for the self-interest of the individual physician or the profession Advocate for payment policies that drive a focus on total cost of care rather than discrete encounters and individual clinician inputs Support development of tools to facilitate reflection on disparities in care and drive down unwarranted variation in quality and resource use

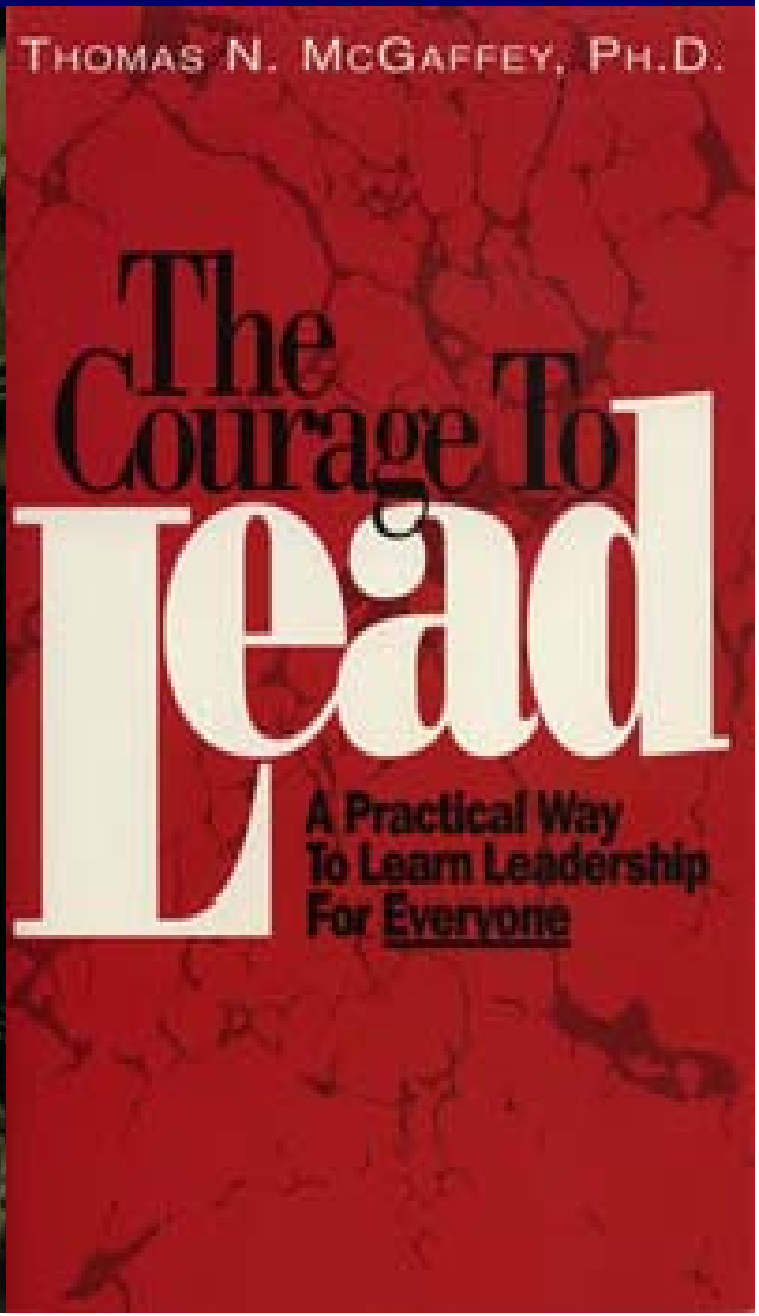
Lesser CS, Lucey CR, et al. *A Behavioral and Systems View of Professionalism.* ***JAMA.*** **2010;304(24):2732-2737**

Mistrust


Hospitals & Clinics
Faculty Practice Plan
"Us vs Them"
Allied Health & Health Professions & Public Health
Clinical & Basic Science Departments

Dissolving Mistrust

Generating the Courage to Lead



Back to Our Pondering

- **Administrators (and physician executives) do not see patients, teach medicine, or perform research – yet expensive overhead for all academic health centers**
  - New levels of complexity coming at us – business assumptions, business models, new actual and "virtual" integrative relationships, etc

- **Why are Chairs and Center-Directors critical?**
  - They are the trusted relationship with the faculty – and faculty generate the $$s (tuition, grants, patient care)
  - Will remain the field generals with the greatest opportunity to directly lead the troops doing the increasingly tough work of the organization across missions

- **Why are future-oriented CMOs critical?**
  - Servant leadership
  - Keeper of the big picture and "true north"
  - Trusted advisor, mentor, catalyst, referee, and honest broker to the generals and the C-Suite

Questions to Consider

1. From my personal point of view, how long is the ‘runway’?
2. What aspect(s) are most relevant to us and what and what requires greater clarification?
3. What would we need to do to achieve the enterprise-wide & system-wide level of understanding and engagement needed to successfully implement this kind of strategy?
4. What would the implications be for reaching this level of understanding and engagement for:
    - My AHE writ large?
    - my School? my Hospitals? my Departments?
    - my staff? my faculty?
    - me personally?

DISCUSSION


N896LL
Life Lion
PENNSTATE
Milton S. Hershey Medical Center
College of Medicine