



Tomorrow's Doctors, Tomorrow's Cures

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Learn

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Serve

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Lead

# Changing your Scope: Transformation of Chair to Institutional Leader

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# Common beliefs ...are they fact or fiction?

Healthcare is a complex adaptive system and is difficult to compare to other industries

Medical Schools, Academic Medical Centers and Teaching Hospitals have unique obstacles to effective collaboration

Our patients are not normal customers

Our structure gets in the way of effective integration

We are too big to fail

Others?

# Questions that keep all Teaching Hospital CEOs up at night

Looking for efficiencies as I prepare for

- decreased revenue from CHF, AMI, and pneumonia readmissions
- pressure from commercial insurers
- potential decreases in DGME and IME
- a medical school requesting additional support

How will expansion of Medicaid affect our institutions?

How can we infuse rigorous business planning across all missions...how can we manage necessary cross subsidies in research and education?

And....

# PPACA: Encouraging New Patient Care Models

- ESTABLISHED

- Centers for Medicare & Medicaid Innovation (§3021 and §10306)
- Medicare Shared Savings Program (§3022 and §10307)
- National Pilot Program on Payment Bundling (§3023 and §10308)

## COMMON THEMES:

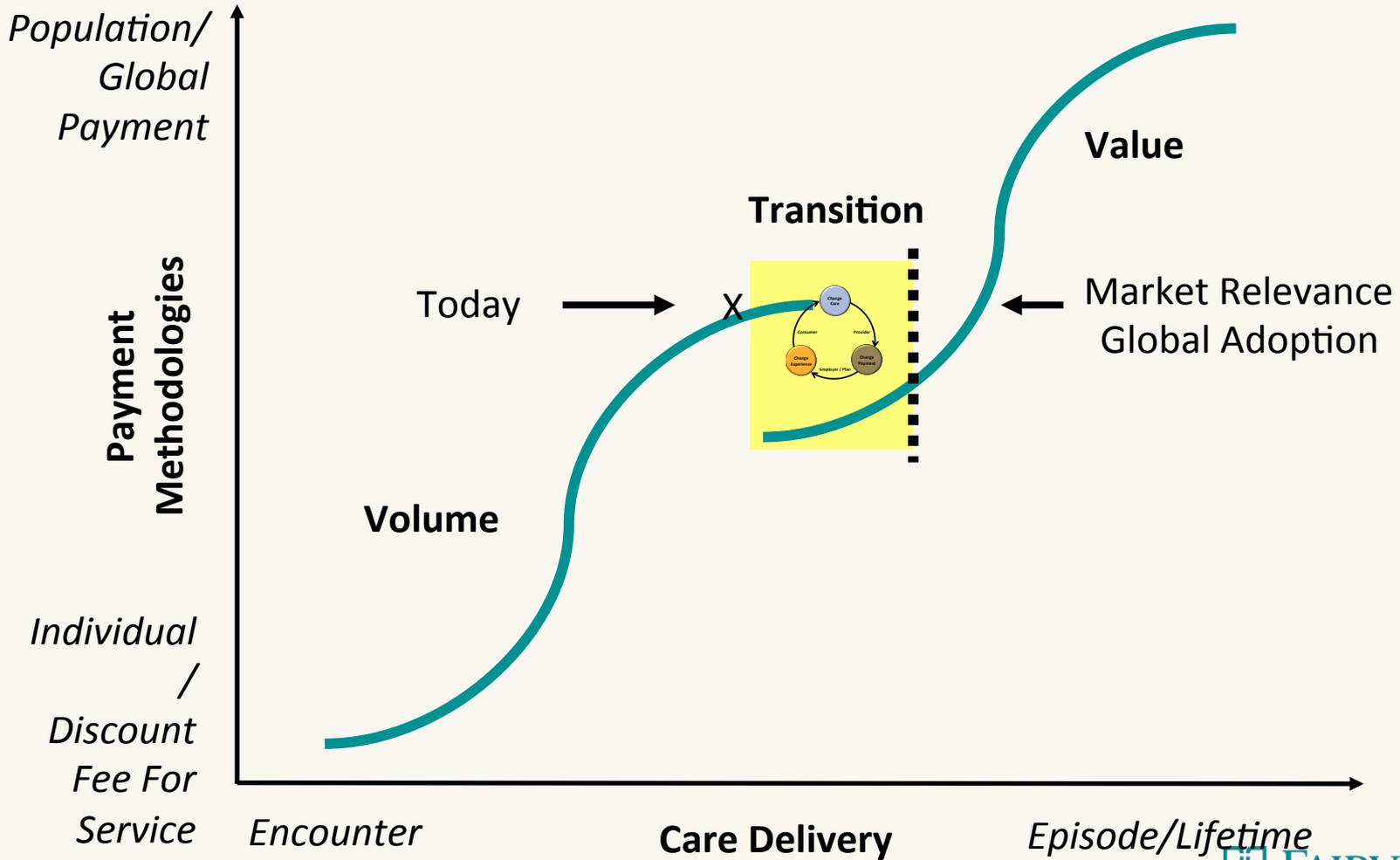
REQUIRE PHYSICIAN HOSPITAL INTEGRATION

IMPROVE COORDINATION

PROMOTE ACCOUNTABILITY

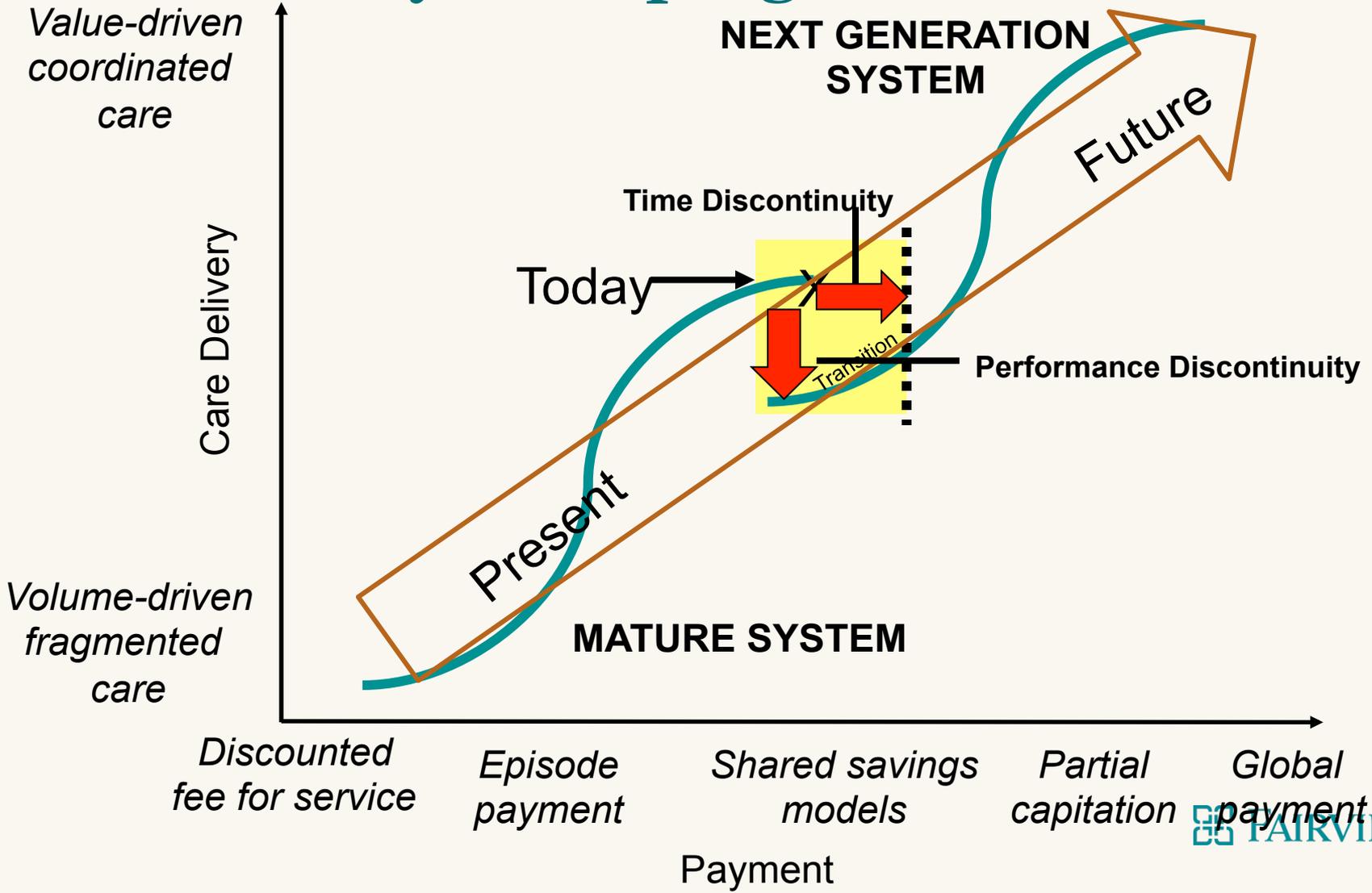


# The market is changing...





# Discontinuity: Jumping the S curve



# **How ready is the our leadership for the challenge of healthcare reform across the missions...what gets in the way of effective integration?**

**Do chairs have the skills to help move this institution forward?**

Are the medical school, practice plan and hospital working at cross purposes? What are our incentives to work together?

Are we engaging everyone in our organization around a common goal?

# Why is this so difficult?

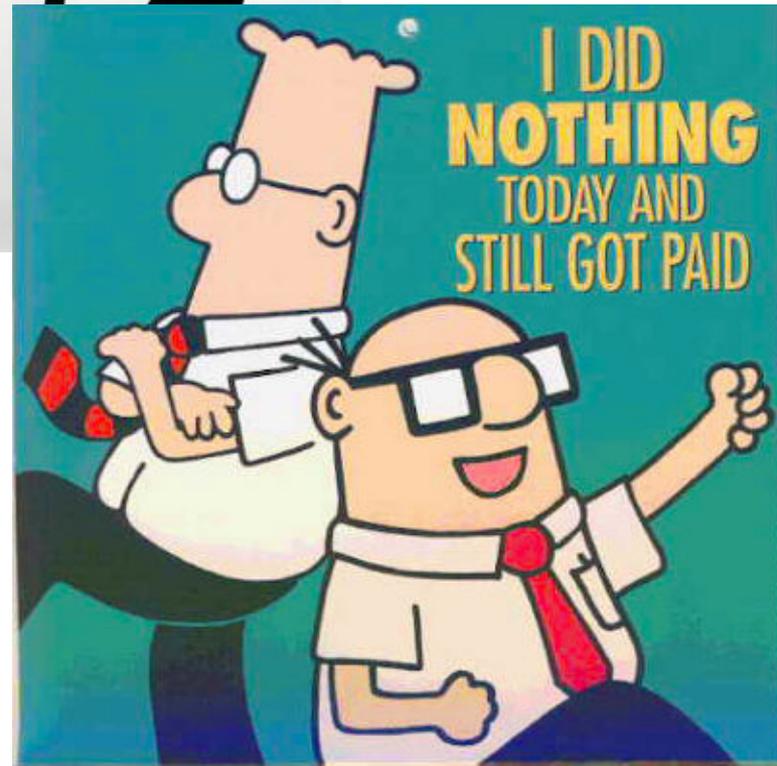
## Organizational Pathology

Tradition of physician autonomy

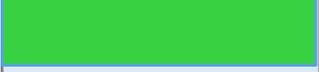
Reluctance to criticize colleagues

Resistance to teamwork

In the traditional medical world...we are physician centric rather than patient centric



# Readiness for Reform Phase I: Summary Results

|  | Low  | Med | High |
|--|--|-----|------|
| <b>Comparative Effectiveness Research</b>      |    |     |      |
| <b>Community &amp; Patient Engagement</b>      |    |     |      |
| <b>Access</b>                                  |    |     |      |
| <b>Payment Reform</b>                          |    |     |      |
| <b>Care Delivery Innovation (coordination)</b> |    |     |      |
| <b>Quality Reporting</b>                       |    |     |      |
| <b>Health Information Technology</b>           |   |     |      |
| <b>Training the Next Generation</b>            |  |     |      |
| <b>Organizing for Change</b>                   |  |     |      |

# Audience Response: Leadership Assessment Questions

***Clinical Effectiveness and Outcomes Research:*** Do you have a focus on leveraging institutional data to improve clinical effectiveness and outcomes? **Do you know your all cause and 15 day CHF, AMI, and CAP readmission rates?**

***Care Delivery Innovation:*** Are you engaged in investing in developing tools, techniques and processes to reduce the number of hospital acquired conditions: **Do you use CDC protocols for the placement of central lines in surgical patients? Do you use the surgical checklist?**

***Payment Reform:*** Are you participating in the development of alternative methods of payment? **Have you discussed how the physicians and hospital would divide a bundled payment?**

# **How ready is the our leadership for the challenge of healthcare reform across the missions...what gets in the way of effective integration?**

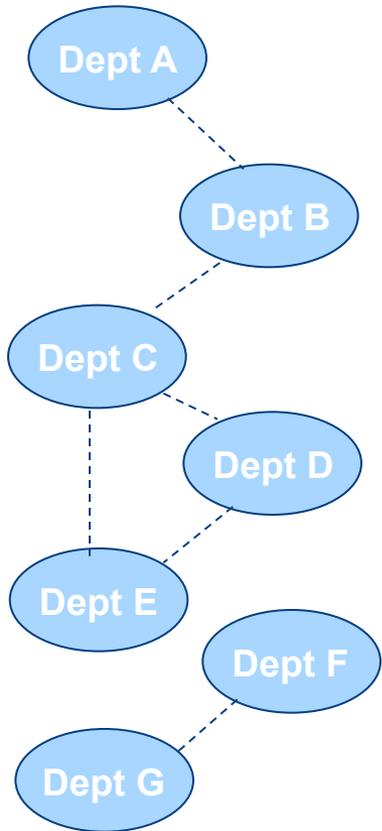
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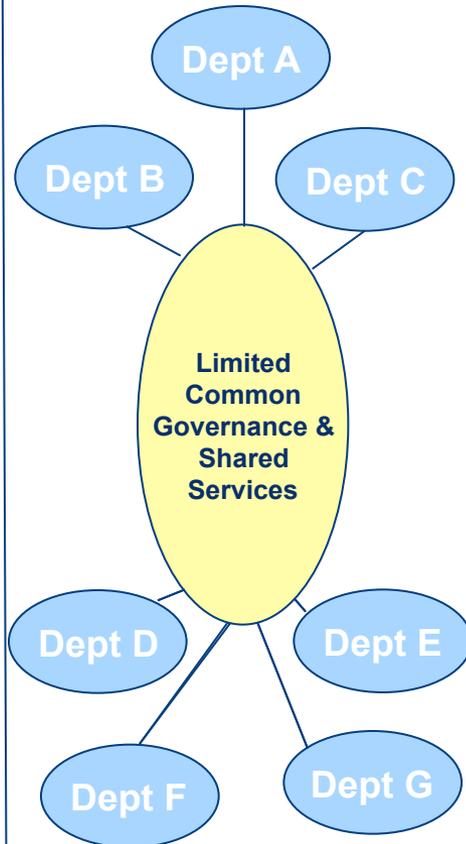
# Overview of FPP Models

## Departmental Model



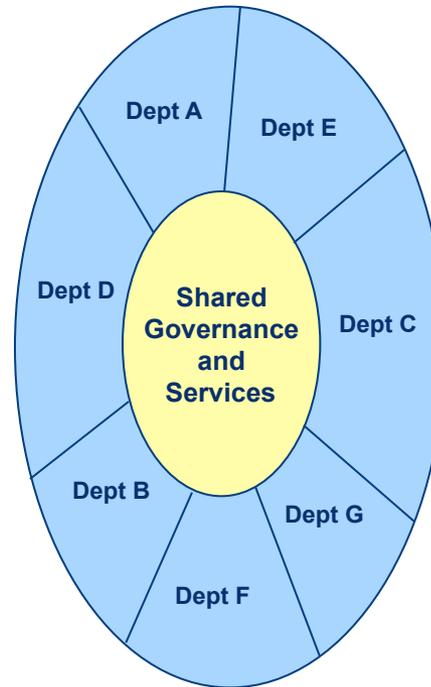
*Ad Hoc Integration*

## Federated Model



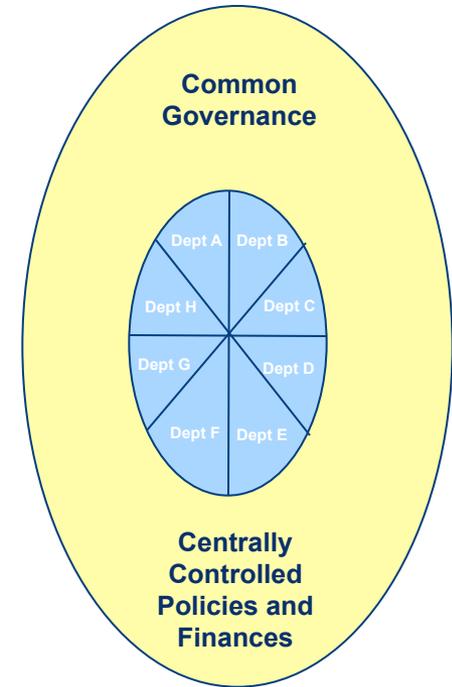
*Limited Central Governance and Mgmt*

## Integrated Model



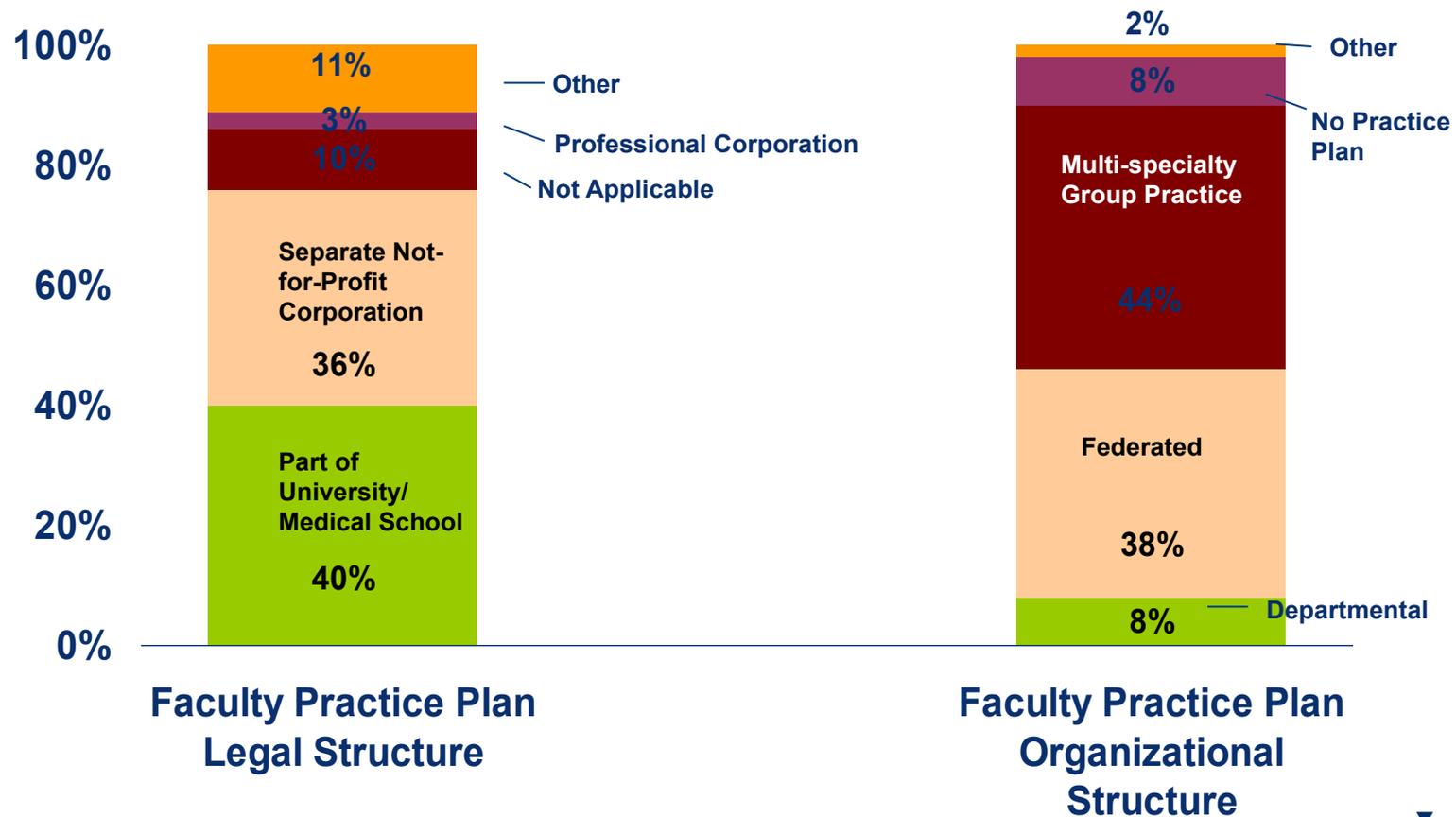
*Strong Central Governance and Mgmt*

## Multi-specialty Model



*Common Governance, Mgmt & Finances*

# Faculty Practice Plans Have Evolved Toward Separate Not-for-Profit Legal Status and Multi-specialty Group Practices



Source: LCME (2007 data)

# **What are the incentives...**

Shared incentives between Practice plan, School of Medicine and Hospital?

Faculty incentives?

Resident incentives?

**Audience Response:**

**Do your hospital and medical school leaders share the same incentive goals?**

# **New innovative approaches**

**Incentivizing Residents to achieve specific quality and utilization goals: Robert Baron M.D. Associate Dean for GME and CME, UCSF**

Residents were eligible for up to \$1200 in incentives for hitting performance goals in 3 areas...institution wide areas and program specific

Avg resident earned approx \$750

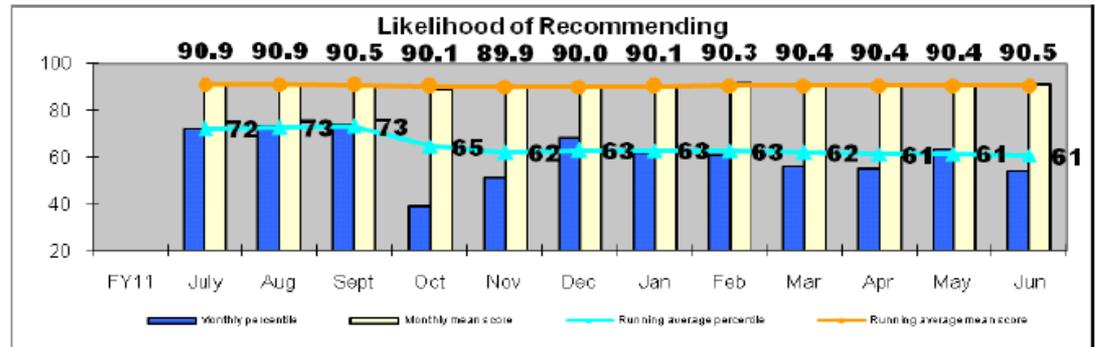
<http://www.medschool.ucsf.edu/gme/residents/incentives.html>

### CLINICAL HOUSESTAFF INCENTIVE GOALS SCORECARD: Q4 FY2010-2011

● Immediate Attention (> 5% below target) ● Warning (< 5% below target) ● On Target (meets or exceeds target)

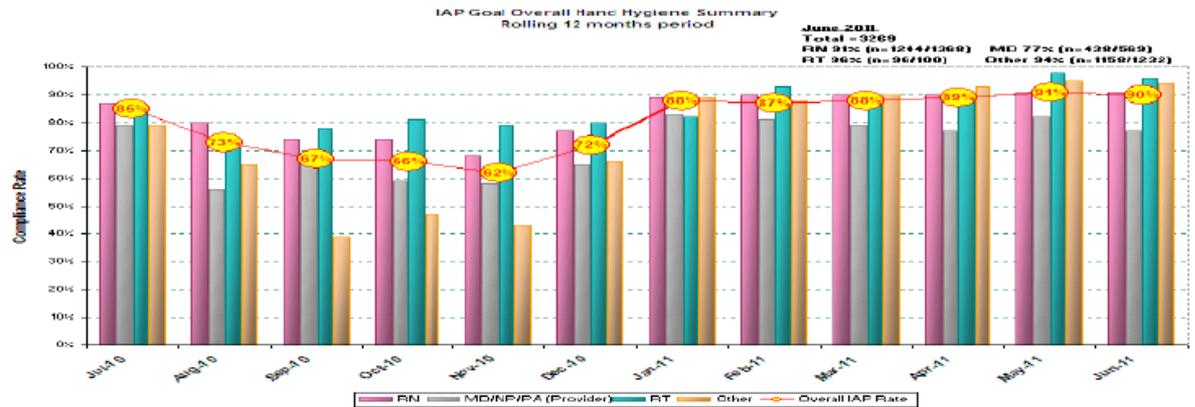
**PATIENT SATISFACTION:**

For the period of June 2010-July 2011, on the patient satisfaction survey likelihood of recommending question, maintain an annual average mean score of 90.5.



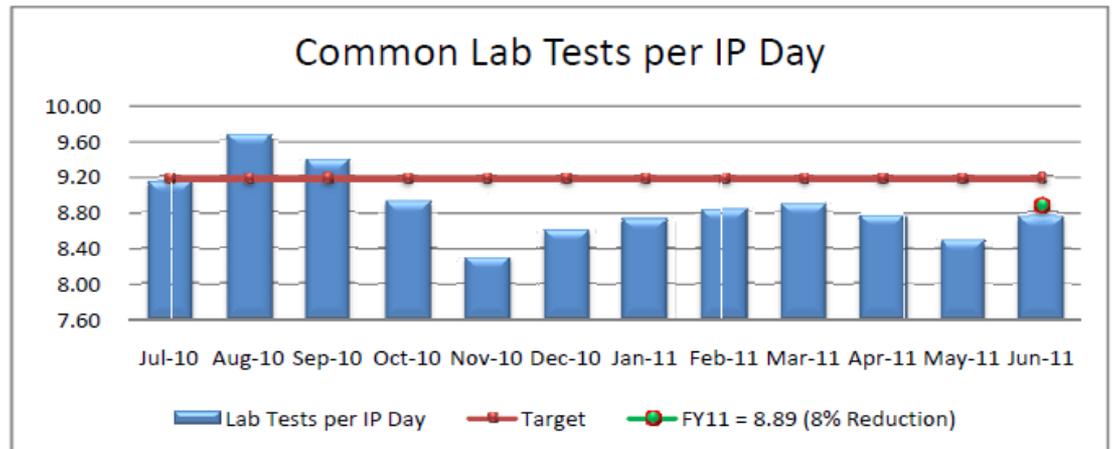
**PATIENT SAFETY AND QUALITY:**

For the period of July 2010-June 2011, achieve 85% hand hygiene compliance for at least six of twelve months.



**LAB UTILIZATION:**

By June 2011 residents will decrease by 5% the aggregated utilization of common laboratory tests (defined as tests/inpatient day). Common tests will include, CBC, CBC with differential, electrolytes (Na, K, Cl, CO2, HCO3, Mg, Ca, Phos), BUN, Cr, AST, ALT, total bilirubin, alkaline phosphatase and albumin.



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# The Power of Alignment: How Great Companies Stay Centered and Accomplish Extraordinary Things

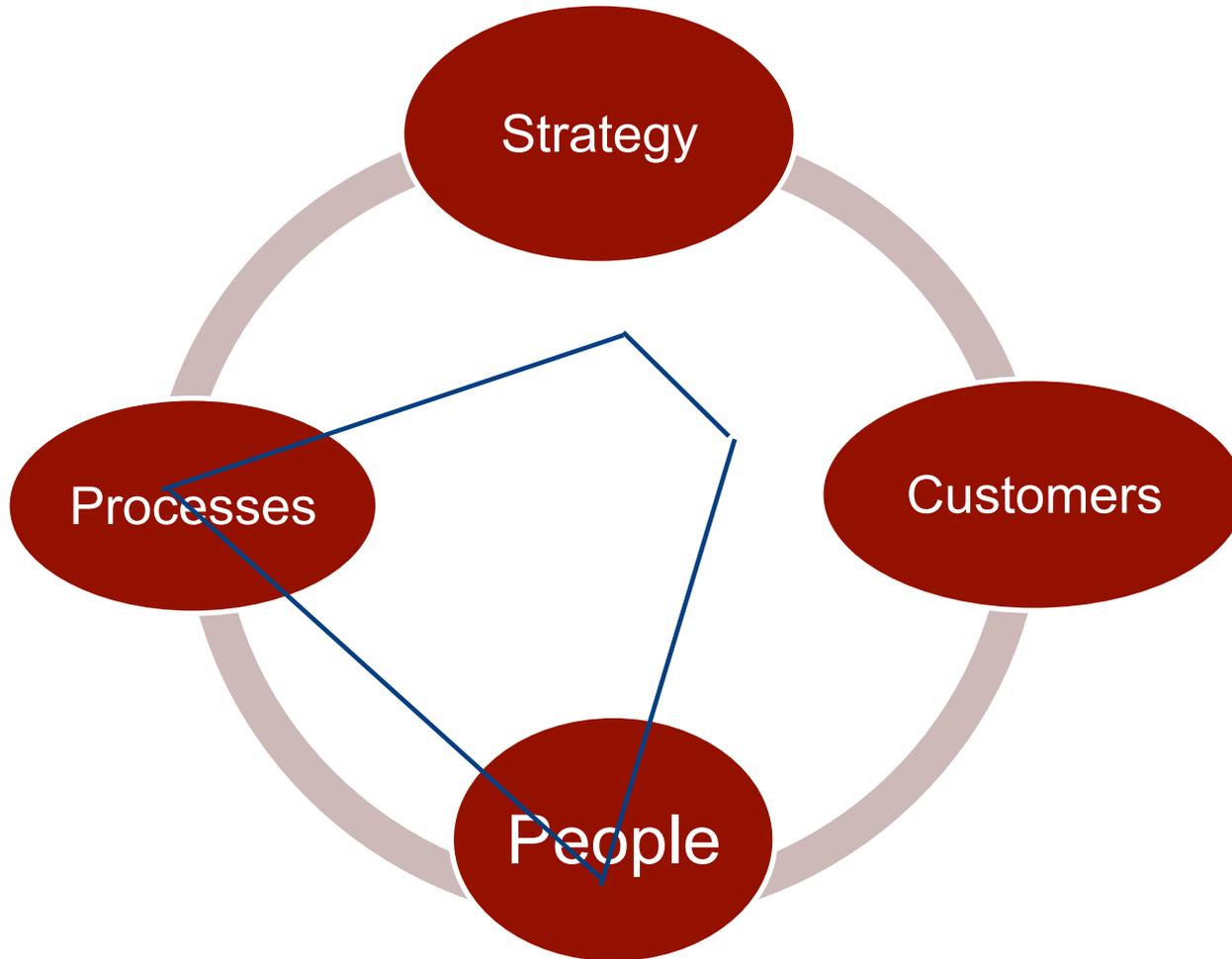
G. Labovitz and V. Rosansky

Which model  
are you?



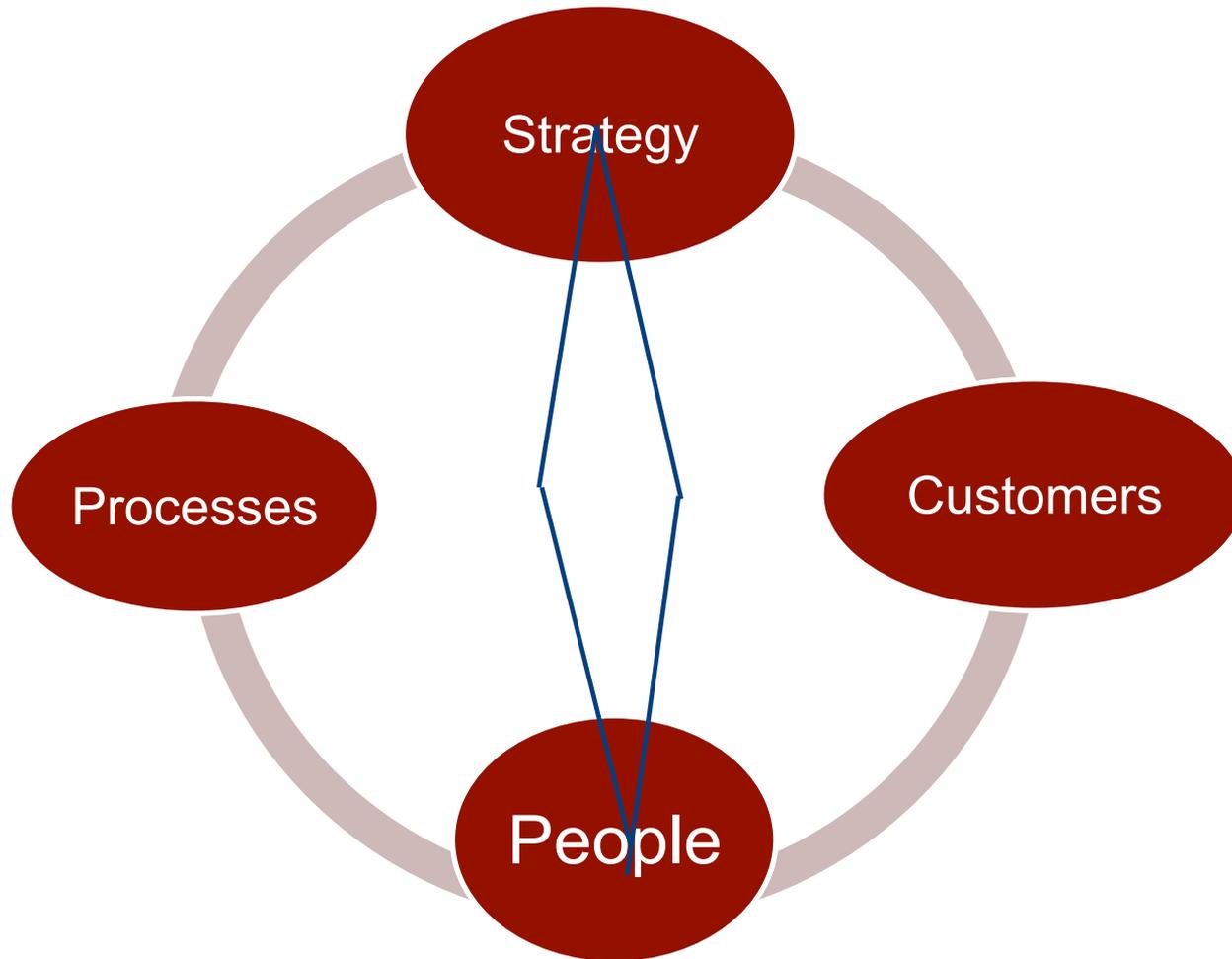
# Tyranny of One:

Each group did the best job from their own perspective but never connected it to the customer experience or overall strategy



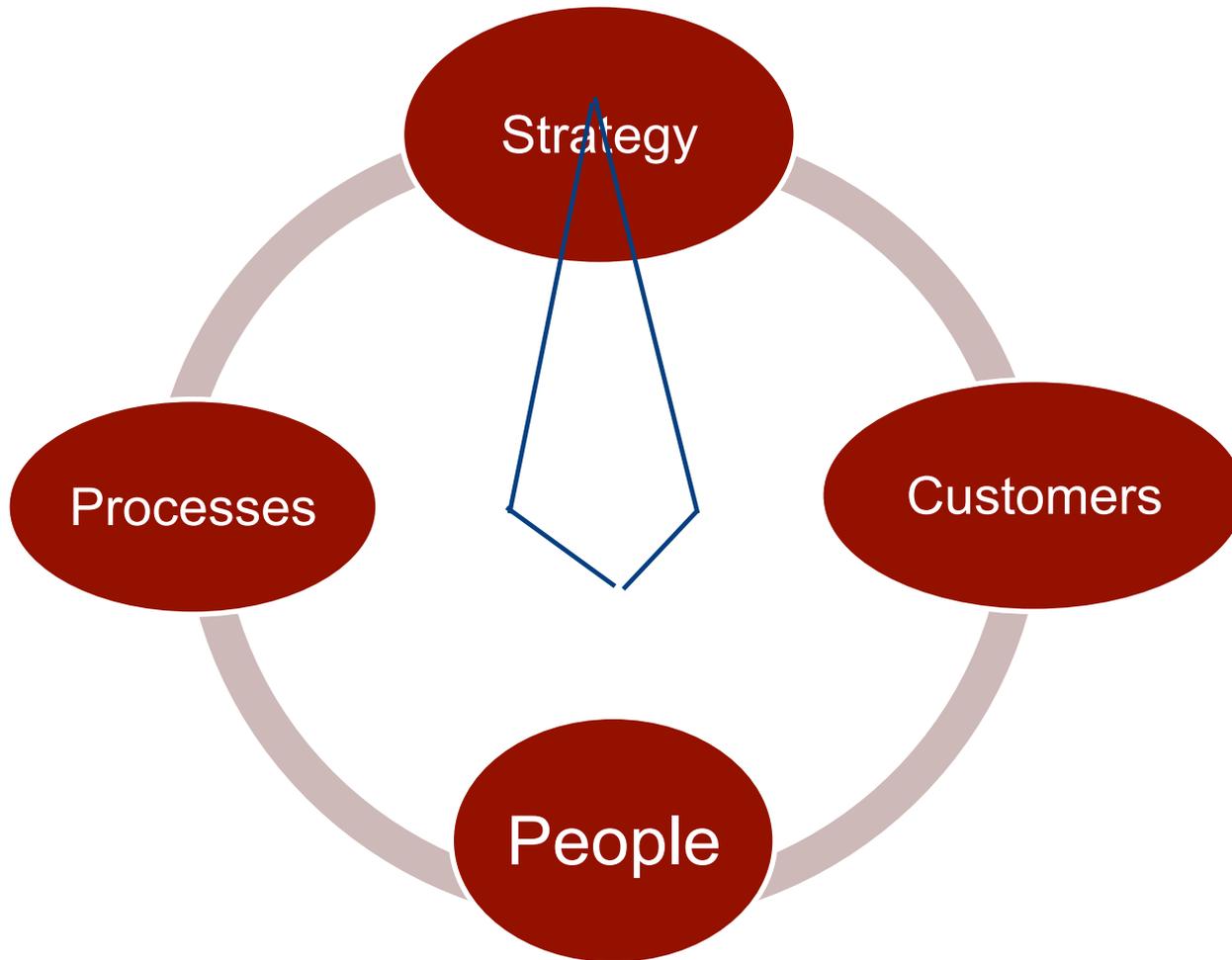
# Strategy Interruptus:

Strategy is an intellectual exercise ...no one ever asks what it takes to execute it.



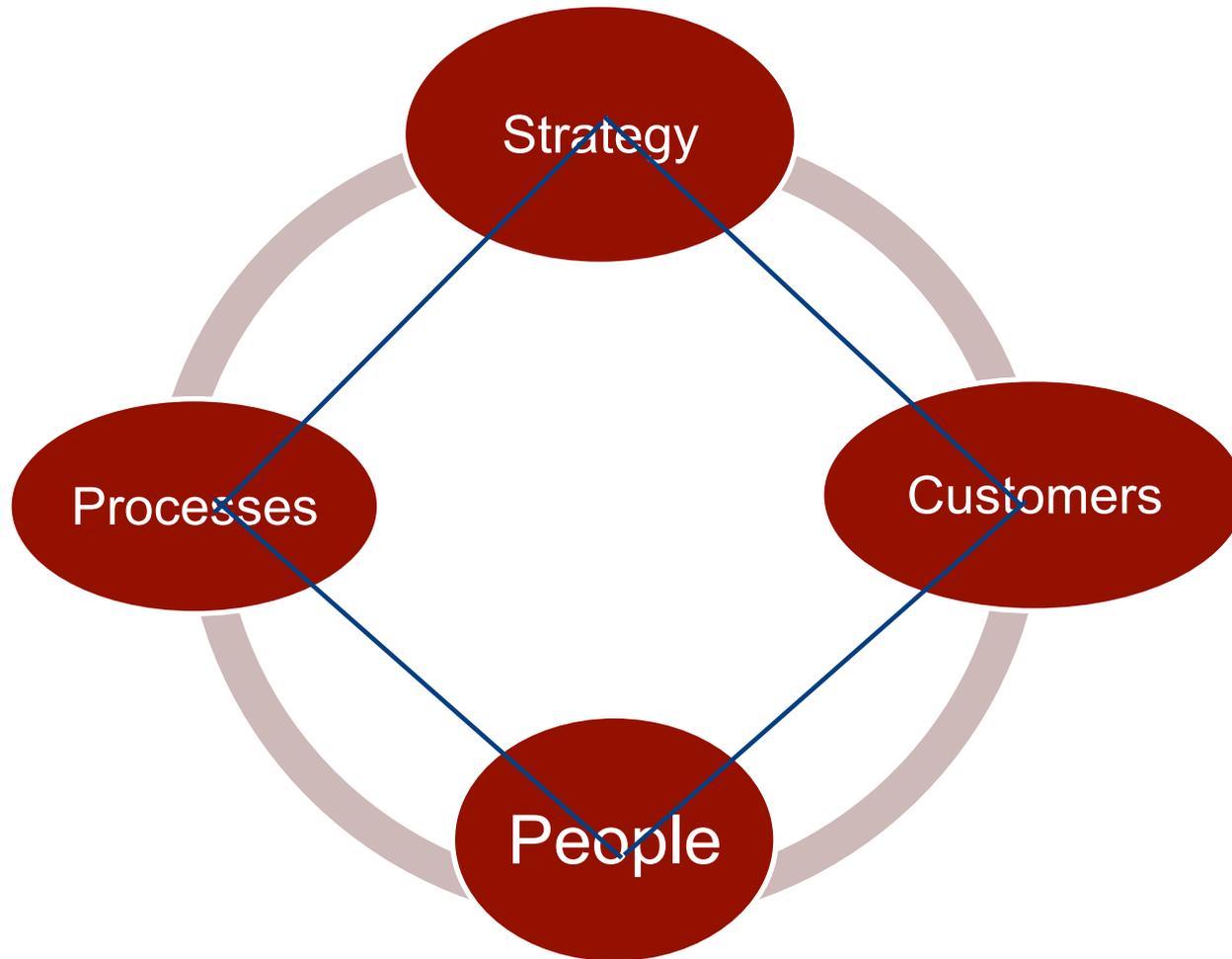
# Market Myopia:

Blind to market changes



# Dead Man Walking:

Living in the past...lost sight of the competitive environment and needs of customers



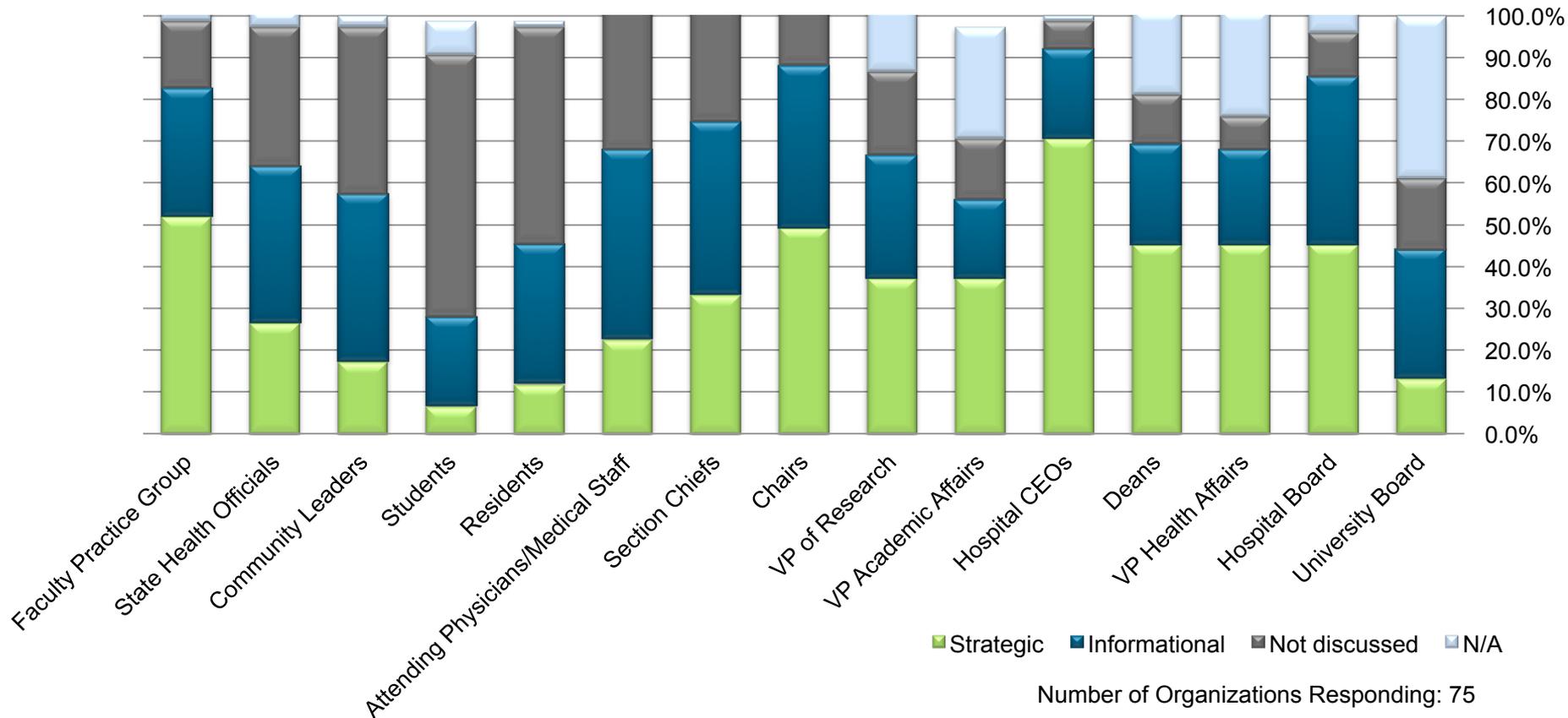
# **Audience Response:** **What model fits your organization?**



1. High Alignment
2. Tyranny of One
3. Strategy Interruptus
4. Market Myopia
5. Dead Man Walking

# Wrap Up – Organization & Communications

Strategic discussion of health reform has not permeated throughout all the constituencies that will be affected and that will be integral to institutional success:



**Question 2:** At what level and with which constituents have formal interactions occurred regarding the challenges and changes likely to occur due to health care reform?

# R4R – Organizing for Change

|  | % Agreed but not Implemented Yet | % Implemented/ In Place |
|--|----------------------------------|-------------------------|
| <i>Tactical plan across the clinical enterprise</i>                  | <b>25%</b>                       | <b>4%</b>               |
| <i>Decision process across the clinical enterprise</i>               | <b>14%</b>                       | <b>22%</b>              |
| <i>Designation of a point person to organize &amp; orchestrate</i>   | <b>13%</b>                       | <b>27%</b>              |
| <i>Designation of a task force to organize &amp; orchestrate</i>     | <b>14%</b>                       | <b>30%</b>              |
| <i>Designation of investments necessary to address health reform</i> | <b>12%</b>                       | <b>8%</b>               |
| <i>Clarity of expectations of all leaders across all missions</i>    | <b>9%</b>                        | <b>8%</b>               |

# Summary

We are facing challenges to our business model

We can learn from other industries

Leadership that can integrate effort across silos is a critical success factor

There are both internal and external organizational alignment characteristics

There are many leadership myths...but many more leadership models

Just start.....

The greater the  
obstacle, the more glory  
in overcoming it

*Moliere*

The man who insists  
upon seeing with perfect  
clearness before he  
decides, never decides

*Henri Frederic Amiel*





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