Integrative Leadership:
Critical Conversations for Changing Times

Learn
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Association of
American Medical Colleges
October 23, 2009

Dear Colleagues –

I am pleased to present to you the report on the first meeting sponsored by the AAMC on Integrative Leadership and Health Care Reform, held in Washington, D.C., on September 15, 2009. Participants were selected to represent our differences in geography, institutional structure and size, and our organizational perspectives. Leaders from medical schools, teaching hospitals and health systems, and practice plans attended and shared their insights on how to lead in a time of unprecedented change for healthcare.

The goal of the meeting was to discuss how academic health centers can leverage our talents and create real institutional synergies. Traditionally we have bright lines of separation between hospitals, practice plans and medical schools, with each functioning fairly autonomously, ignoring their true interdependence.

I first became aware of this tension 15 years ago when I attended the new deans professional development program sponsored annually by the AAMC. I was a part of a group of relatively new deans discussing their shared conclusion that our structure was the problem. We took turns characterizing the academic departments, the health system, or the practice plan as impediments, rather than as vehicles we need to achieve our goals. I soon came to realize that dissolveing these structural units was not the answer. The solution was to put transcending, integrating processes in place that pulled those logical working units together to work in a functionally aligned manner.

What role should the AAMC play in the discussion on integrative leadership and the future alignment of academic medicine? The AAMC could, theoretically, do nothing and ignore the dissonance. We have chosen, however, to become more engaged in the debate because we feel that identifying and discussing examples of true leadership integration and organizational alignment will allow our members to more effectively leverage their own talent. There are risks in breaking down the barriers and silos that have existed for so long. However, healthcare reform will demand greater, not less integration. Creating the solutions will be up to us. This is not a process that anyone can do to us or for us. No one else can effectively move our delivery system towards a new model.

The strength of our institutions lies in creating powerful relationships between leaders at the top of our organizations, and between our practice plans, schools of medicine, and hospitals and health systems. This report shares perspectives about the qualities of leadership necessary to address the challenges of health care reform. To lower spending, improve quality, and create greater value requires us to reengineer our healthcare delivery system, and that in turn will require bold and innovative leadership.

I look forward to hearing from you on this important topic in the days ahead, and to further dynamic meetings of leaders from across our institutions so that together we can shape the leadership agenda for our community.

With best regards,

Darrell G. Kirch, M.D.
President and CEO
Association of American Medical Colleges
This report summarizes the discussions held during the AAMC’s September 15, 2009, Integrative Leadership and Health Care Reform meeting. During this meeting, leaders from 30 institutions gathered to share their perspectives on the leadership skills and team qualities needed during this time of health reform, and the challenges and opportunities for academic medicine to lead delivery system change for the country. This report includes the following:

**Critical Conversations with AMC Leaders**

Four AMC leaders each provided a perspective on their philosophy of leadership and management, how their institutions have addressed integrative leadership, and the values that enable them to embrace change even during times of great challenge. A common theme included the imperative to drive transparency and accountability. Results matter. Align your incentives to increase shared commitment (for instance, shared goals for Deans, CEOs, and management teams), and include the Chairs in the strategic incentive plan. Create appropriate measures of success for the new world. Focus on performance and achieving group practice levels of coordination. Integration as a theme extends beyond the medical school, hospitals, and practice plan to also include the other professional schools, the university, and increasingly, community partners.

**Respondent Panel**

Leaders from three institutions and Darrell Kirch, AAMC President, provided additional perspectives and reactions. Themes included establishing investment priorities, becoming highly efficient across our missions, delivering on the problem of clinical “systemness”, promoting talented leaders, and, finally, throughout all these imperatives, delivering on our promise to our faculty, to our patients, and to the boards and communities we serve. That promise includes providing leadership for improving population health so as to truly respond to public desire – and need – for vastly improved care delivery.

**Recommendations from Participants**

During the course of the afternoon session, the participants discussed several health care reform scenarios in break-out sessions. The AAMC’s mission leaders for Health Care, Research, and Education have summarized the results of these break-outs and also provide their own perspectives with resultant recommendations for leaders driving change in their institutions.

**Survey Results**

Prior to the meeting, participants completed a survey which broadly addressed the challenges faced by AMC leaders. The information gleaned from the survey results reveals that the top two issues keeping leaders up at night have to do with finances and, in some context, health care reform and the uncertainty it holds for AMC institutions. Almost every respondent also mentioned alignment and the accompanying challenges one encounters in attempting to align the various components of an academic medical center.
Integrative Leadership: Critical Conversations for Changing Times

Critical Conversations with AMC Leaders

In thinking about integrative leadership, I realize the real topic is this elusive term of integration of services and how we achieve it. Academic medicine has been very good at building silos. And, I think we probably perfected it better than any other organization. And, I think, in many ways, probably Johns Hopkins is the reason for it happening.

When Johns Hopkins died on Christmas Eve of 1873, he left money to start a hospital and a university: two separate entities that existed as silos for a long period of time. It took over one hundred years for the Board of Trustees of both the hospital and the health system and the Board of the university to decide that the system of separateness was not going to work any longer.

In the 1990s, Johns Hopkins Medicine was formed as a single entity to govern and manage both the hospital and the medical school. A new board was given a whole set of new responsibilities: overarching financial oversight, the responsibility for making decisions for the clinical practice, and for contracting for medical services.

I think the most important thing about this reorganization was many people were actively involved at each step of the way and these people started to look across departments, instead of just looking at themselves. When they took contracts, they understood, sometimes, it would hurt pediatrics, or it might hurt ophthalmology. But, they began to consider the total good that would result for Johns Hopkins Medicine.

One of the important things I have learned while serving as Dean and CEO for over 10 years is not only must people be involved actively at each step of decision making, but you must have the right people involved. I’ve learned the skill sets that are going to make a successful chair or chief. People skills matter. In the old days, 20 or 30 years ago, I guess the chief could say, “I’m king, I tell you what to do”. The faculty does not work that way anymore. The faculty wants to be involved in their practices. They want to be involved in decision making. And, the chief has to be able to listen to them, and listen to them politely, and be able to bring them together and move the organization forward.

Additionally, leadership must be transparent. When the office of Johns Hopkins Medicine meets, education, research, clinical care, and finances are all discussed while everybody is around the table. So, everybody sees a very transparent organization and they must view the organization with a long-term perspective. A decade ago, we put together a 10-year plan of what we needed, how much in loans we had to take, how many philanthropic dollars we had to raise, and how much state support we could get, if we could get any. And, importantly, we decided what we needed to get out of operations to make this all happen.

What this did is it dramatically changed the total process of budgeting for all the departments. In the old days, when I first got here, the departments sent up their wish list. The administration said no. Then we kind of came to some agreement after fighting for six months. With the 10-year plan, we just told the departments, this is what you need to do, because it’s in the 10-year plan. So, now we’re at the end of the 10-year plan and we’ve been able to do what we set out to do and everybody at the table is thinking very broadly about the overall needs of the institution.

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Edward Miller, M.D.
Dean and CEO
Johns Hopkins University School of Medicine
Where does the medical school piece fit in, in terms of education? That part has been, I think, one of the more fun things that has happened. When you have good chairs, and you have good boards of trustees, and people who want to make good things happen, well, good things happen: we’ve built new research, clinical, and educational facilities and we’re introducing a new curriculum, “Genes to Society,” a dramatic change that will train students to care for patients in a continuum, instead of distinct episodes of care.

The last thing I’ll mention is where we have evolved as a system. We’ve established a Center for Innovation in Patient Care that cuts through all the departments. Everybody gets to see the score card. So, everybody knows what’s happening in surgery or otolaryngology, or OB-GYN. It is a very transparent system. And, again, it’s done under the rubric of Johns Hopkins Medicine. It’s not a School of Medicine issue. It’s not a hospital health system issue. It’s a Johns Hopkins Medicine issue. So, people really do think that way, along that line.

We also decided in 2000 we would start an HMO, Priority Partners. In the first couple of years, it was a disaster; we were losing our shirt on it. But, after we started to get the data to understand what we could do, the data made us look at our patients in a very different way: from a continuum of health perspective. Where do we put services? How do we move the system forward? How do we put all of the pieces together? So, we now have about 200,000 people that we manage care for. And, I can tell you, it totally changes how our system works. And, that leads me to where I think we now need to go.

Specifically, in population health are these healthcare innovation zones that a number of us have been trying to push pretty hard on Congress. Fee-for-service is just not one of the ways to achieve what president Obama wants to achieve. We actually have proposed, and we think we have some ways to make things happen in the state of Maryland, to take care of a population of people, be slightly profitable, but do things that are very innovative: working with our School of Public Health to mine the data; offloading some ER visits to a for-profit start-up; and investing in new models for home care and primary care.

Overall, I think that what the trustees set up with Johns Hopkins Medicine has been incredibly important and it would not have occurred without their initiative. It is essential to engage the trustees - maybe the chairman of the Board, maybe the head of your finance committee - about some of these challenging financial and health reform issues that we’re all dealing with because the Board has a great ability to drive change and to support it.

We still have more to do. We’re well positioned to do population health management for a subset of patients. Yet we continue to do what everybody else is trying to do: to become more efficient, to get the costs out, and to make sure there’s no waste in the system. And, at the same time, we continue to think about how we’re going to provide and train the next workforce. These things are much easier said than done. But as a team, we continue to work on them.
National health care reform and the long-term consequences of the global economic contraction will undoubtedly pose challenges to academic medical centers (AMCs) for years to come. Meeting these tests, as well as continuing to deliver on our primary missions of patient care, education, and research, will require a re-examination of how we go about our business. Within this framework, I will argue that accomplishment is key and that structure and process are overrated.

Ultimately, we will be judged by what we achieve. AMCs that pay excessive attention to the “right” process or the “right” structure will miss opportunities while running the risk of being bypassed by others who correctly home in on the only thing that matters: getting results.

Today AMCs find ourselves in largely unfamiliar circumstances: clinical margins are declining and the prospects of a further falling off are all too real. So in this new era of post-endowment growth, post-philanthropy boom, post-NIH “doubling,” and post-excellent clinical-mission margins of the recent past, what can we do to maintain fiscal strength? One answer: intensify our focus on improving outcomes.

My approach as CEO at UPHS is to be clear about what the organization is trying to accomplish and — equally critically — about the importance of measuring results so everyone knows exactly where they stand and how they can do better. To ensure both fairness and widespread comprehension of the institution’s goals, the process of reaching agreement on objectives and standards of measurement should be an open one that includes complete sharing of information. This means explaining previous results (both institution-wide and on an individual or departmental basis), what they’re tied to, whether they’re satisfactory, and, if not, where and how to improve them.

While this may appear reasonable in theory, practical challenges may arise. For example, not-for-profits such as AMCs lack a common way of measuring results, e.g. profit. Accordingly, we tend to fall back on saying things like “we produce great people.” But for a results-oriented focus such as the one I’m advocating, that’s not good enough. The primary question needs to be “How can we best measure performance?” Despite the absence of a bottom-line criterion, in truth AMCs have an abundance of options for determining success: NIH grants, publications in preferred journals, the competitiveness of our medical schools and hospitals in attracting students and faculty, the register of institutions at which our medical school graduates match as residents, and market share. All are instructive for gauging and improving performance across our educational, research, and patient-care missions.

An astute executive team will draw clear attention to indices such as these throughout every angle of the institution. For a results-oriented approach to succeed, it’s critical that alignment of interests and missions occur at all levels of the organization. It’s simply not enough for the dean and CEO to agree on what needs to be done (although a close connection of aims on their part is essential for wider buy-in of missions, goals, and objectives). Unity of perspective on the major points is also a must at the front lines of research, patient care, and education. It’s equally vital in the nursing units, ICU, OR, and medical school curriculum committee. In short, a focus on teamwork and alignment of objectives has to permeate the full organization.
So, how to get people to coordinate? One way is through funds-flow — channeling patient-care margins to research and education initiatives on a merit basis consistent with institutional goals. Another is through training. A third is through leadership selection. And it can always be generated through incentive plans. The important thing is to do it. At Penn we have set up common management plans for departmental chairs and members of the leadership team (including the dean and myself). As a result, we all have similar benchmarks of quality, finance, research, and education for which we are individually and collectively held accountable.

To achieve genuine integration of values and priorities, senior leaders of the clinical, education, and research arms should also have a role — and thus a stake — in the selection process for the organization’s leaders and department chairs. Levels of involvement will vary from institution to institution, and search committees and headhunters can do some of the leg work, but excluding your senior people will almost certainly be a blueprint for failure.

The kind of integration I’m talking about is not easy to achieve. Individuals and departments quite naturally have their own goals and views about what is important. This diffusion of interests can be compounded by the larger environment. For example, targeted science and specialized patient care are leading AMCs to become progressively splintered and differentiated. Agendas vary and priorities shift with rising regularity. Seeing the centrifugal nature of today’s medical world, government, regulators, and payers rightly conclude that they can’t hold every manager, doctor, or program in the country individually accountable. So they’re moving toward institutional accountability in the key realms of education, patient care, and research. Consequently, AMCs have to devote greater attention to how our health and business sides can work in harmony to set and realize institutional outcomes.

As do a number of our peers, we have an overarching entity — in our case, Penn Medicine — that serves as an umbrella for a comprehensive health system, medical school, clinical outpatient service, and off-campus satellites. Because clinical practices, research, training, and hospital administration are integrated under our structure, senior-system-leadership incentive plans and evaluation of clinical, education, and research outcomes are carried out in tandem. This arrangement provides a major advantage since administrators increasingly have responsibility for clinical, education, and research functions as well as more traditional fiscal obligations. At the same time, clinicians, researchers, and educators have to appreciate the business reality to understand what’s feasible in terms of their own goals. As always, problems may lurk. For example, care must be shown that integration doesn’t result in hidden cross-subsidies. Subsidies and cross-support are inevitable in widely heterogeneous structures such as AMCs, but they must be transparent so all parties can be fairly evaluated on results. Moreover, AMCs have to aggressively monitor — and address — asymmetrical internal cost relationships if it becomes necessary to decide which parts of the system to sustain and which to unwind.
Such complex efforts require a secure financial underpinning. As AMCs move into what I foresee as a financially taxing stage over the next five to seven years, we are going to have to pay even closer attention to which functions and individuals successfully address institutional priorities. Critical questions will need to be answered: Which faculty members should be renewed? Which aspects of patient care should be expanded? Which innovative facilities should be developed for the next generation? In forming answers, it may be worth bearing in mind the words of one of my former trustees in Chicago: “It’s not the money, but it’s the money.”

A model for AMCs to consider is the traditional group practice, which places a premium on integration of aims across key fronts. A fully integrated system may be an idealized standard that can never be entirely met. But aiming for maximum feasible assimilation of goals and objectives, as group practices do, should be a touchstone. Through it, we can better secure the clinical and cost advantages of managing unnecessary readmissions, reducing bloodstream infections, coordinating care across the continuum, and a myriad of other worthy objectives. Integrated health systems with an insurance component, such as Kaiser and Geisinger, can take further advantage of clinical integration in ways that most AMCs (which don’t have an insurance product) can’t. I am certainly not recommending that AMCs move into the insurance business, as some attempted in the ’90s. But until fee-for-service payment is modified, our efforts to better manage care through integration will not be fully realized — which is why some insightful policy makers are promoting payment-policy changes that take providers’ full costs into account.

Beyond some of the challenges I’ve touched on here, opportunities will present themselves as well. For example, based on our outstanding track record of discovery, service, and innovation, we in academic medicine — including our professional associations, such as the AAMC and the University Healthsystem Consortium — can take an even larger lead in promoting community health — whether in East Baltimore, West Philadelphia, or the South Side of Chicago. As with our own individual institutions, such a mission will require a results-oriented approach predicated on integrated goals, objectives, and measurements of success. I for one am confident that a micro/macro connection between what works best within our own walls and within our communities is possible. Success, after all, breeds success.
In Massachusetts, we already have health care reform:

In Massachusetts, we’re not preparing for health care financing reform; we actually have had it for a few years. The good news is that the vast majority of Massachusetts’s residents are now covered. Nevertheless unintended consequences include higher costs because of pent up need. People who previously had no medical care now have access to care and seek care. We also discovered we had insufficient primary care physicians to meet this demand. Reimbursement is slow and relatively low. Everyone is not yet covered. Some people get waivers, and, because the fine for lack of coverage is modest, some have opted out. Funding for undocumented internationals, even those who have lived in the area for years, is also problematic.

Obviously, Massachusetts is trying to pay for this plan; the state is going to be about a billion dollars in debt in the next year. On the horizon are new Rand recommendations for the state, which advocate paying the same reimbursement rate for primary care for both AMCs and community hospitals, not recognizing that maintaining tertiary services and residency training increase costs.

Costs are also increased in our particular case, as Boston’s safety net hospital, because our patients are poor. Variations in Medicare costs and the Dartmouth data have been targeted as evidence of unnecessary care, but recent analysis shows that the variation also reflects the impact of poverty. Medicare is more expensive for people who have had inadequate medical care prior to getting on Medicare. They have developed chronic disease and have pent up needs for care. In a new analysis corrected for poverty and residency training, New York City and Boston are actually below the mean for Medicare costs.

Multidisciplinary teams: Multidisciplinary care and teams are critical in this era of constrained resources. For certain disciplines in medicine, such as oncology, multidisciplinary or team-based care is already considered the optimal model. In oncology, these teams include surgical, medical and radiation oncologists and a pathologist. Certainly complex cardiovascular or GI patients also need coordinated multidisciplinary care. Faculty and administrators often tell me that to provide interdisciplinary care, we need a quarterback (often suggesting themselves for the role). I believe we need a basketball team of interdisciplinary physicians who develop tight and predictable working relationships, stay abreast of the latest study results, and adjust their recommendations to the needs of the patient. After working together over time, they can almost predict what their colleagues will recommend. To stick with the basketball analogy, they know where their colleague will be when they make the pass. Organizations then need to figure out how to reward these teams, as opposed to always rewarding single leaders.

Partnerships: In terms of integrating relationships, we need new out-of-the-box partnerships. The insurance industry likely has many of the same goals as AMCs in that we both want to know what works. In Europe, insurance companies actually fund clinical trials. This has not happened to date in the US, although CMS has done a few pilot studies (and got a fair amount of push back). Medical schools can certainly access the expertise of other schools within their University. Expertise from their School of Management can result in adoption of “best practices”. According to management experts, a committee of 8-13 people from different backgrounds will generally make

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Karen Antman, M.D.
Dean
Boston University School of Medicine
the best decisions. Thus, a diverse workforce is key to realizing creative solutions. Diversity within the group making decisions provides a broader range of options. We can leverage existing resources across the university to support and sustain innovative activities. For example, we established, with the law school, a Refugee Clinic for people seeking asylum in Boston. We manage patient’s care, and the lawyers handle their visa requirements.

**Change**: How can academic health centers support and sustain innovation in this era of constrained resources? First, “never waste a good crisis”. The faculty expects change in a crisis, so it can be the best time to innovate.

We may need to refocus on our core missions of research, care and education. We might experiment with new educational models, such as three-year MD programs for students with advanced standing, to help them get through with less debt, and conduct research on effective medical education strategies. We know that in lectures students get about 10% of the data. If they interact more, they actually remember up to 50% of the data. Using new strategies, such as simulation and web-based learning, can be more effective than traditional lectures.

**Revenue streams in health education**: AMCs need to consider new revenue streams in health education. We can fulfill our educational mission and support faculty salaries by teaching the public, our university’s undergraduates and the health care workforce. Undergraduate students need education in diet, substance abuse, particularly alcohol, and mental health. Similarly, public education is another revenue source that can be supported by employers or insurance companies. When WebMD did a module on breast cancer, 16,000 people paid for the course. Finally, we can educate the health care workforce. The public is looking for professional degrees in areas like MedTech, imaging, emergency crisis management, and mental health counseling. Expanding your educational programs will help keep your faculty, who need an alternate source of income, funded. The basic sciences call our professional masters program their “practice plan”.

**The institutional costs of research**: Another current issue that increases deans’ anxiety levels is the increasing fraction of institutional funding of research. The Federal government increasingly looks to “cost sharing” or “institutional support”. AMCs currently must find the funds to pay 5-20% of the research budget from institutional income. This funding can come from tuition, clinical income or philanthropy, but these are not reliable long-term sources. Given the student debt burden, raising tuition to cover research costs is ethically problematic. A related issue is recruiting new junior faculty, who are now a median of age 45 when they get their first grant and therefore need to be supported for a much longer period before they establish their careers.

So, how can academic health centers’ research resources address the health paradigm challenges? First, we have to expand the definition of research. We’re all very familiar with the paradigm of bench to bedside. Much research occurs between bench and bedside. We certainly recognize translational lab-to-clinic and clinic-to-public health, but we also have implementation translational research, how new clinical research results get adopted as standard care. Health services research, comparative effectiveness research, outcomes research, and behavioral research are increasingly respected research components with targeted NIH funding.

Electronic medical records and more robust databases can support this research and helps us learn more about patient preferences, behaviors, and outcomes. There also might be an opportunity to use academic health care networks, via the AAMC or CTSA or other groups, to form trials consortia that improve the efficiency of our research.

We might work more closely to reduce overhead expenses by using centralizing IRBs and standardizing pharma research agreements. The Howard Hughes med to grad program is also an interesting model facilitating translational research by PhDs in clinical departments.
The University of Chicago Hospitals and the Pritzker School of Medicine, for all practical purposes, are an integrated organization, and it works very well, most of the time. Financially, we are integrated. We have a single financial statement, a single bottom line. We understand where our streams of revenue are coming from. We understand what is profitable and not profitable. But, we also think of it as a common bottom line and common investments going forward, among the school, the practice plan, and the hospital, and the clinics. Functionally, we are integrated. Many of us go across the organization in our management functions. Our executive administrators for some departments take responsibility for hospital functions. For instance, our surgery administrator is responsible for all hospital perioperative functions. The medicine administrator takes responsibility for all hospital perioperative functions. The medicine administrator takes responsibility for ambulatory care throughout the enterprise.

Integration is not without a price, though; it has its perils. I think that turbulent economic times test the mettle of an integrated organization. It’s not so hard to be integrated in good times. It gets a little bit harder in tough economic times, and leadership really has to step up and think, do we actually operate as a single entity, or do we go back to our separate silos? We all believe that through consistent reassessment, we’re going to be successful. A case in point- we operate under the name of Chicago Biology and Medicine. Last year we called ourselves Chicago Biomedicine. That turned out to be not very attractive to the scientists. At the University of Chicago, we have kind of a unique structure, where basic sciences are not just microbiology and physiology, but they are also paleontology and plant science and ecology. Scientists who don’t see themselves as aligned with medicine as others do really have been very active this year in voicing some of their unhappiness about our integration. That has resulted in a few changes. One has been a change of the name to now have that focus on biology and medicine, not just medicine.

As I look towards the future, I believe the faculty practice organization is going to be dually impacted by an increased need for access and a move away from traditional fee-for-service towards shared payment models. I don’t think most of us are very proud of our access, particularly, in some of our subspecialties. As more lives are covered and health care becomes more affordable for patients, many of them are going to be at our doors, and I don’t know that we are actually ready for them. Many of us have moved away from primary care, because of the low reimbursement, to much more highly specialized care. To meet this access challenge, we may have to really reconsider either staffing up ourselves, or more important, partnering with community hospital groups and physician groups.

The discrepancy between primary care and specialty care fee-for-service is going to erode over time. Shared models, like bundled payments and accountable care organizations, are going to put more pressure on that notion. So far, I haven’t seen much sharing of fees within faculty group practices. We’ve sustained departmental models where everyone sits on their own fees, and boards dominated by surgeons who pronounce that they’re bringing in the most money.

“As more lives are covered and health care becomes more affordable for patients, many of them are going to be at our doors, and I don’t know that we are actually ready for them.”
Moving forward, we’re going to have to think hard about how we share the wealth. As we are forced to count on each other more and more around these issues, you may see some shifts in where the power centers are. It’s very easy for a practice board, or a group of clinical chairs, or even a group of basic science chairs, to think only about me, my department, my section, my specialty. I think we’re really going to have to ensure people move away from that model. In an integrated organization, you’re going to be in a much better situation to really address those questions.

Faculty practice leaders have a real obligation to lead change within their own organizations. We’ve traditionally focused on the financial metrics, but we need to encourage physicians, whether they are lay leaders or physician leaders, to measure ourselves against those external, clinical standards by which we are going to be measured over time. It’s not so easy in a faculty driven organization to hold each other accountable. In an integrated system, fostering teamwork across boundaries to create environments of shared responsibility and accountability is key. We need to build the understanding for the work of management. As things change quickly, good, experienced managers who have a vision of integrated or well coordinated systems are those who are going to be able to lead effective changes.

Faculty group practices are going to need to shift the focus from the individual physician and the individual physician specialty, and working around that physician, to working around the needs of the patient and working around the needs of the enterprise. The natural affinity of faculty group practices really is the hospital, because we are in the same business of delivering care to patients. One of the basic issues between the faculty practice and the hospital is revenue. The sooner that we can get together with the hospitals around the care of patients, the more successful we’re going to be. We are already fully aligned with our medical schools, in most cases, around the education of students and new physicians. To bring it all together is really the trick. We are uniquely qualified in academic health centers to do that, we just often don’t choose to do it, because integration is hard, it’s painful, and some people lose their jobs. The right model with the right people in the right environment usually will lead to success. This is a model that needs to go forward; it’s a dynamic that needs to continue even in tough economic times. It’s not the time to backslide.
Respondent Panel

Steven M. Safyer, M.D.
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Claire Pomeroy, M.D., M.B.A.
Vice Chancellor and Dean
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Thomas Heckler, M.B.A.
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Darrell G. Kirch, M.D.
President and Chief Executive Officer/American Association of Medical Colleges

During the respondent panel, four panelists discussed integrative leadership, what the term means to them and at their institution, and how integrative leadership is or is not practiced at their institution. The respondents also shared their recommendations for how and why integration must occur within AMCs. The major themes discussed are summarized below.

Panel Synopsis

Medical school faculty members often comment that they feel as if they’re caught between the tectonic plates of the hospital CEO and medical school dean “grinding away” at each other. In some institutions, deans perceive hospital CEOs to be insensitive to the academic mission while hospital CEOs perceive deans to lack the management and financial experience needed to work in the “real world” business of health care. This tug-of-war amongst leaders can fracture leadership, faculty, and staff and prevent people from working together to achieve the AMC tripartite mission of education, patient care, and research. And there is a very pervasive, powerful conventional belief that the fragmentation in AMCs is somehow part of their inherent nature, and that those institutions – such as Hopkins and Penn and Montefiore here today as well as many others – that have achieved real integration are somehow exceptions.

The tug-of-wars must end and the disparate parts of AMCs must be aligned; new business models need to be created and implemented. In order for this to occur, the components of the AMC must function together and AMC leaders must recognize that their individual success depends on helping others to succeed. This only can be achieved by integration. The various leaders of an AMC must have a common vision and common goal. However, integration may exist in many forms and no one form is ideal for every AMC. In some institutions, the hospital, medical school, and faculty practice plan will be integrated legally as a single organization. In other AMCs, the components may be virtually integrated but the components will co-invest, co-fundraise, and co-identify future goals and opportunities. Distinct corporate entities can still clearly delineate shared responsibilities and goals. It is the outcome that matters, not the underlying management or legal structure. And the first ingredient to achieving a good outcome is starting with good people.

Much can be accomplished with good people and good will. Each person-to-person interaction builds upon the next and the past leads to the future. Stability and civility amongst colleagues is very important; animus between leaders and co-workers is not productive and it must be bridged. By tightly collaborating and designing common reward structures, leadership teams can foster integration from the top-down and from the bottom-up. This includes fostering integration from the board level down to the management team, faculty, and staff and from the faculty and staff level up to the
management team and board. Everyone within the AMC must share a common vision and common goal.

Academic medical centers need to be mindful that integration within an AMC may begin with the hospital CEO, practice plan leader, and medical school dean, but this is merely the first step. The schools of nursing, pharmacy, graduate studies, etc., also must be integrated and the entire system must share a common vision and goal. And of equal, if not greater importance, integration must occur between the AMC and the community which it serves.

Most academic medical centers remain hospital-centric and they have evolved and stayed this way in order to generate and use hospital revenues to pay for academic missions. Many decisions within an AMC are made for the good of the AMC and for preserving the status quo and the health needs of the community are not always at the forefront. This will change in the future. When health care reform is discussed, what really is being talked about is payment reform. And the anticipated payment methodologies for the future ultimately will be structured around delivery system responsibility for ensuring the well-being and overall health of a large population.

Integrating with the community and its existing providers can be accomplished in many ways. Again, structure is not the key; the outcome is the key. Integrating with the community does not mean the AMC needs to develop and control and own the primary and secondary care in its community. What it means is medical care needs to be integrated across the community so the citizens are provided with quality services at all levels of care, from primary care to burn and trauma care. Participation in a RHIO (Regional Health Information Organization) can be part of this. Thinking and acting regionally will also provide AMCs with opportunities to develop new methods for partnering with others to deliver education to students, existing providers, and the community at large. New research opportunities will also be presented and these must be explored.

AMCs should not focus solely on preserving or optimizing their current business models. AMCs also should lead the redefinition of what health care and health is going to look like in the future. This means moving from a hospital-centric AMC model to a population/community-based model. AMCs must drill down to identify what the special needs of their communities are and then determine how the AMC will help the community to meet these needs. How the AMC manages the transition from the current operating model – which optimizes the clinical margins short term to subsidize our missions – to a new population centric model will define who we are.
In summary, most leaders in academic medicine believe there is great benefit in becoming more integrated and establishing an inter-dependent kind of culture within their institution and between their institution and their community. While there is consensus on what the key tools are that leaders must use to pursue integration, the application of these tools will vary and must be tailored to the needs of specific AMCs and the communities in which they are located. Institutions must involve people at all levels of their organization, including their governance, in integrating the various components of their AMC. This will be a key to transitioning from a hospital-centric business model to a community-centric model.

Integration involves talking about things honestly and having shared accountability based on very clear goals and measures of progress towards those goals. Leaders both at the institutional level and the national level must act to ensure integration occurs and that stability and civility are practiced during their tenures. To accomplish this, many AMCs will need leaders who have different qualities and abilities than those that have been sought in the past. The only thing certain about the future is it will present change and opportunities for change. AMCs should seize this opportunity to implement the integrative changes that will enable them to continue to pursue their missions of education, patient care and research.

The day was intense and the audience engaged. The following are a list of attendee recommendations which should help others to develop powerful aligned leadership at teaching hospitals and medical schools:

- AMC leaders should discuss and commit to cross organizational values. They should develop a common mission and vision. Leaders should collaborate and partner to add value in the clinical, educational and research enterprise. The leadership team should think strategically with a long term view and also remain adaptable. The entire clinical and educational team should focus relentlessly on their goals because results matter.

- AMC leaders should make transparency and accountability priorities. They should create a culture of transparency and accountability using improved mission funds flow and public reporting of quality and safety outcomes.

- AMC leaders should re-engineer incentives to increase shared commitment (e.g., commit to identical goals for Deans and CEOs to improve alignment). Leaders should make an effort to include the chairpersons in incentive plans that reward success in hitting strategic milestones (such as quality, efficiency and patient safety) rather than just volume of work or collections.

- AMC leadership should look to search firms to provide honest analysis of the leadership skills an organization needs in order to be successful.

- Integrative leaders should have an inclusive “what is the right size for our organization” discussion. AMCs should ask themselves if growth is still a goal they actively should incentivize.
Integrative Leadership:
Critical Conversations for Changing Times

• AMC leaders need to have critical conversations with their Boards of Directors/Trustees about health care reform and the need for transformation in care delivery. Institutional leaders also need to have the same conversations with departmental chairpersons – the people who will be doing the heavy lifting of implementation.

• AMC leaders need to make improved patient access and population health priorities.

• AMC leaders need to look at their team(s) critically and ask themselves who cannot weather the organizational transformation. Successful organizations will transform from both the bottom up and the top down.

• Successful AMC leaders need to determine what their organizations do best and not try to be all things to all people. Leaders need to be certain their strategy accurately identifies the resources required for success and tempers expectations downstream and upstream.

• AMC leaders need to communicate endlessly.

AAMC’s Role in Fostering Integrative Leadership

There are many ways in which the AAMC can support our members in these initiatives. We will continue these discussions with stakeholders. We will develop sessions that will include board chairs and finance subcommittee chairs. We will focus on engaging new chairs and associate deans in meaningful ways, helping to fill the leadership pipeline. We have committed to working with willing institutions to develop a transparent scorecard, where we would combine both hospital and medical school information so the best decisions can be made with all of the relevant data required. We will continue to discuss how to identify internal and external future leaders to ensure we have medical school and hospital leaders who are strong and strategic and have the requisite skill sets to be powerful partners.

Survey Results

Prior to the meeting, attendees were asked to complete a six question web-based survey designed to inform the AAMC about challenges being raised for our members by health care reform, and to help AAMC develop and refine tools that can assess the gap between institutions’ “current state” and “optimum readiness” to prepare for health care reform. The survey was completed by 22 individuals: eight representing the Council of Deans (COD), eight representing the Group on Faculty Practice (GFP), and six representing the Council of Teaching Hospitals and Health Systems (COTH). Respondents were not identified and the data summary presented below is without attribution to specific individuals or institutions.

What are the top 2 concerns that keep you up at night?

Virtually every answer related to finances and, in some context, health care reform, particularly the uncertainty health care reform currently presents to academic medical center leaders. There also were several answers mentioning other academic concerns such as faculty relations, inter-hospital relationships, and caring for the uninsured, but the overwhelming majority of answers related to financial challenges and health care reform.
What currently consumes your day-to-day attention and focus?

Currently consuming respondents’ day-to-day attention and focus are the responsibilities academic medical center leaders typically hold: attending numerous meetings, communicating goals and information throughout the institution, keeping programs alive, financing buildings and programs, etc. It was interesting to note representatives from each council or group responding to the survey also frequently mentioned “alignment” and in particular, the challenges leaders face in attempting to align the various parts comprising their academic medical center.

In response to this question, an intriguing quote was submitted by one respondent. It read,

“Every day is different and many of our priorities and efforts are driven by people and events outside of my control or influence.”

A key challenge consuming the day-to-day attention of many academic medical center leaders continues to be aligning the numerous levels of management within a center in order to have them all strive towards a common goal.

What is your individual and institutional state of readiness for health care reform?

The intent of this question was to assess individual and institutional ability to speak with a single voice, whether it’s in leading and aligning the institution towards a common goal or whether an institution assigns to one individual or group the responsibility for making key decisions regarding quality, financing, and coordination of medical care. Although we were aware there is a scale of readiness that might be determined, we asked respondents to answer yes or no to indicate if their:

- organization plans and acts with one voice
- organization delegates responsibility and authority to a single leader or team to manage economic risk and quality of care
- board thinks, acts, and executes with one voice
- physician leadership is aligned
- AMC budgets, allocates resources, and employs incentives across the AMC

Overall, approximately 50% of respondents indicated they thought their institution was able to act as one voice, delegate responsibility, and align physicians and resources through the efforts of one person or a small group of people. The other 50% of respondents thought their institution was not at this level of readiness for reform. The only distinction between the different groups of respondents is individuals representing COD and COTH were more likely to indicate they thought their respective institutions were at the aforementioned state of readiness while the respondents representing GFP were less likely to think their respective institutions were prepared for reform. While these are not true quantitative or statistically significant data, they did suggest that leaders of faculty practice plans may view their institutions differently than do deans or hospital leaders.
An additional subset of this question asked for respondents’ opinions regarding their institutions’ preparedness for Safe Harbor protection for non-owned practices. 75% of respondents indicated they thought their institution was well-versed in the legal aspects of safe harbor regulations and they were prepared for this potential aspect of health care reform.

What challenges do you anticipate addressing over the next 2-5 years?

Although addressing health care reform and financial issues dominated the responses to this question, virtually every respondent also mentioned the word “change” in some context. Respondents anticipate significant change soon will occur at their institution, whether it’s within their educational model, how they are paid, or their system’s willingness and need to adapt a change. Several respondents also anticipate having to deal with and adapt to anticipated change in leadership at their institutions.

How are you bridging the gap?

Institutional leaders indicated they are bridging the gap between where their institution is now and where they need to be in the future in order to adapt to health care reform, by placing emphasis on collaboration, reducing costs, increasing productivity, prioritizing their efforts and goals, and aligning the components that comprise their institution.

What do you believe will be required of your institution in order to be successful in this new paradigm?

Regardless of what the new paradigm presented by health care reform will be, in order to prepare for it, respondents indicated their institution would be introducing new care delivery and business models, placing a greater emphasis on coordination of care, and integrating and aligning the disparate parts of their institution.

The survey data presentation concluded with the sharing of a comment submitted by one respondent:

“…there is relatively good alignment at the highest leadership levels between the University Hospital CEO, practice plan CEO, and Dean. Where we fail or stumble is in execution. To actually function in a seamless, coordinated fashion on a daily basis requires alignment of all of the executive and middle level management staffs…the tactics and execution of the strategy resides at those levels of the organization. We need to find better ways of communicating and mobilizing all staff and faculty to a common goal and plan of action.”

This quote eloquently summarized the need for integrative leadership in academic medical centers and it was referred to frequently throughout the remainder of the meeting.
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