I want to share with you the following commentary, which I co-authored with Dean Allen Lichter, Hospitals Executive Director Larry Warren, and U-M President Lee Bollinger. This article appears in the February 16, 2000, issue of the Journal of the American Medical Association. Entitled “Shaping a Positive Future for Academic Medicine at Michigan,” it highlights challenges we have faced and met as an academic health system, including important new initiatives in the Medical School. It is one of seven peer-reviewed original articles to appear in the issue by U-M Medical School authors, along with a wonderful historical piece by Howard Markel, who organized the special issue.

The University of Michigan (U of M) is proud to celebrate a splendid legacy of innovation and service at the 150th anniversary of its medical school. Some notable achievements in our history include the establishment of the first university-owned teaching hospital in 1869, enrollment of women and African American medical students in the 1870s, development of iodized table salt as a goiter preventive, early advances in electrocardiography, the first thoracic surgery section and introduction of thoracoplasty for tuberculosis, the development and progressive application of extracorporeal life support, discovery of the gene for cystic fibrosis, investigation of gene therapies for cardiovascular diseases and muscular dystrophies, and new forms of managed care. However, we cannot rest on our laurels.

Instead of considering our academic mission a costly burden on patient care, we reaffirmed our commitment to integrating medical practice with education and research. In 1997, the medical center was renamed the University of Michigan Health System to highlight the geographic reach of 32 ambulatory health care centers, various strategic affiliations, and the central role of the medical school. Through grant-supported programs to train residents in managed care and through overall system investments in medical management, disease management, and pharmacy practices, we are also gaining synergies from our own health maintenance organization, the 190,000-member M-CARE health plan. Proposals for separating the hospital from the rest of the university and for mergers with other provider systems were rejected at the U of M; it was our belief that such actions would undermine our academic mission, force the integration of different provider cultures, and create a situation of incompatible governance. Attention was focused instead on better service to patients and to referring physicians; credible measures of patient satisfaction, productivity, quality, and cost-competitiveness; instructional innovations; and an improved research infrastructure. We have seen a growth in clinical volumes with positive operating margins.

In concert with the organizational changes, we have made a sustained effort to change the culture. The hospitals and health centers adopted the theme “Putting Patients and Families First.” Under this banner, professionals and support staff were brought together with common goals; many commented that service to patients was their initial motivation for pursuing a career in health care. Essentially, the theme reflects the approach of...
We are trying to look at ourselves as others see us.

Although control of costs remains challenging, we have reduced cost per case 20% through clinical unit redesign, volume purchasing, and spreading fixed costs over increased inpatient admissions and outpatient visits. We have sought innovative ways to control costs. For example, the General Motors "PICOS" (a Spanish term for peaks of mountains) team of system engineers helped us assess operating room and postoperative procedures: average cardiac surgery duration of about 5 hours was reduced by 72 minutes. Consultants from the Ritz-Carlton Hotel Company guided the department of dermatology with suggestions to improve customer service, empower staff, and improve patient flow, resulting in increased patient satisfaction and decreased staff turnover. For fiscal year 2000, every hospital and ambulatory unit is accountable for 4% downward “rebasing” of budgets, adjusted for volumes.

A special test of our capacity for change occurred in late 1997, when the Ford Motor Company challenged the U of M to develop a proposal for a new health care plan with the company. Physicians, hospital administrators, and M-CARE staff were given 5 working days to prepare a presentation; four days after the proposal was submitted, Ford announced Michigan as its partner. The company knew that 18% of its workforce accounted for 86% of its health care costs and wanted to cooperatively design a disease management program. After months of analysis and negotiation, the plan called “Partnership Health” emerged. This plan features systematic disease management for all enrollees in 5 initial diagnostic categories (congestive heart failure, coronary artery disease, asthma, diabetes, depression); a key role for patient advocates called “health navigators”; and opportunities for enrollees to name their own personal physicians, who are accepted into the University of Michigan Health System/Ford Partnership Health network if they agree to practice under Partnership Health guidelines. The plan is exceeding expectations. Physicians, hospital administrators, and M-CARE staff turned their attention to control costs. For example, the General Motors “PICOS” (a Spanish term for peaks of mountains) team of system engineers guided the department of dermatology with suggestions to improve customer service, empower staff, and improve patient flow, resulting in increased patient satisfaction and decreased staff turnover. For fiscal year 2000, every hospital and ambulatory unit is accountable for 4% downward “rebasing” of budgets, adjusted for volumes.

It is certain that the pace of change in medicine will accelerate in the years leading toward our bicentennial. Institutions that can respond to those changes while remaining focused on service, productivity, and market leadership will shape a positive future for academic medicine.

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