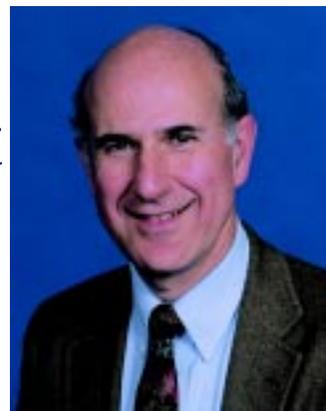


Message from the Executive Vice President for Medical Affairs



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.

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At a time of spectacular research breakthroughs in the life sciences and advances in medical care, all academic medical centers face serious financial stress due to employers' and governments' determination to control health care spending. Negative stereotypes are widespread among patients, payers, employers, referring physicians, and the media, who tend to describe university-affiliated medical centers and medical schools as aloof from their communities, too expensive, biased toward patients with less common diseases, and slow to change.

Our wake-up call came in 1996. Under pressure from employers and payers to reduce cost per case and facing a modest operating deficit, the hospital leadership stepped up quality improvement programs while eliminating 1050 positions and laying off 200 employees. Conflicts

between the hospital director and medical school dean about priorities, a gloomy outlook about NIH research funding, and insufficient sites for ambulatory teaching inspired new leaders of the medical school and the hospital to align more explicitly strategic, operational, and financial objectives of the faculty and the hospitals. A unified faculty group practice emerged from the "silos" of 15 department-based practices. The group practice, hospitals, and health centers were united in a clinical delivery system that would stimulate patient care and academic collaborations across departments and ensure joint attention to the overall bottom line.

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 ►

asking all staff to imagine themselves or their family members as the patients. Our progress in this regard has been quantified and benchmarked through participation in surveys of patients' perceptions of care throughout southeast Michigan. Gain-sharing programs were tied to improved satisfaction scores. Concerns about timely communication, expressed by a committee of referring physicians, were addressed by providing physicians with toll-free telephone, facsimile, and e-mail communication opportunities to keep them informed about treatment plans and necessary follow-up, all accomplished in real time. We are trying to look at ourselves as others see us.

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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 "rebasings" 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. The medical management/disease management capabilities have attracted other major employers and are being adapted by us for M-CARE, Medicaid, and Medicare populations. Academic medical centers need not be passive responders to the market.

Meanwhile, the health system and the medical school have increased investments on the academic side. We have combined

the recruitment, admissions, curricular, and mentoring aspects of 6 departmental and 5 interschool doctoral programs into a comprehensive program in biomedical sciences. We have launched a Center for Clinical Investigation and Therapeutics to make design and conduct of clinical research more efficient for busy clinical investigators. The center provides support in biostatistics, a patient registry, nurse coordinator and physician training, guidance in meeting institutional review board compliance requirements, and expertise in quality of life and pharmacoeconomics assessment. We have tripled our \$5 million investment in bioinformatics with foundation and corporate funding. We have created internal funds to support combined clinical and basic research proposals and for proof-of-concept studies of new technologies. We have 3 cohorts of 12 faculty members, each selected as "educational innovators," for a year-long program developing and implementing teaching modalities for biomedical advances, changes in medical practice, and meeting the needs of a multicultural society.

Following a special U of M Presidential Commission report, the university has committed \$200 million for a Life Sciences Institute; major involvement of the health system in this investment reflects confidence that advances in genetics, structural biology, cognitive neurosciences, bioinformatics, and biomedical engineering will transform medical care and enhance the health system's clinical competitiveness in concert with the academic mission. In parallel, the state has initiated a \$50 million per year, 20-year commitment for a collaborative Life Sciences Corridor among Michigan's research institutions and companies.

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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. We are confident that the U of M will be among those leaders preparing the next generation of health care professionals, advancing medical technology, attracting and serving patients, and improving the health of our communities.



Gilbert S. Omenn, M.D., Ph.D.
U-M Executive Vice President for Medical Affairs
and CEO, U-M Health System

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