Fulfilling the Promise and Potential of Our Academic Health Enterprises

Learn

Serve

Lead

MCG Health System
Annual Board Retreat
August 17, 2010

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

Association of
American Medical Colleges

Strategic Themes

1. **Context Setting**
2. **Funds Flow Redesign**
3. **Redesigning Processes**
4. **Aligning Management, Advice, and Engagement**
5. **"All Funds, All Missions" Integrated Budgeting & Accountability Mechanisms**
6. **Effectively Managing the Transition Process**
7. **Embedding Talent Management**
8. **Breakthrough Sustainable Results**
9. **(Re) Positioning for Health Reform**

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How We Can Work Together Today

- **Some Caveats and Thoughts**
  - Shortcomings of presentations – sequential, yet parallel & multi-dimensional ; themes build upon one another
  - Presentation is not based on a ‘case for action’ or health reform implications
  - Thinking from both your perspective and your colleague’s perspective
  - Respectful debate and dialogue, yet aligning on the MCG-specific points of view

- **New Language, Vocabulary, Distinctions, Themes**
  - Discuss alignment/collaboration/integration/”AHE”
  - Discuss approaches, processes, implications
  - Use actual lessons learned
  - Discuss what this means for:
    - the enterprise writ large
    - the people you directly lead
    - for you personally

- **The “Context is Decisive”**
  - “I”: numerology; geometry; alphabet; art; ect
  - Shifting from an “us versus them” to a “we”
  - Creating a Vision and Future for MCG, Augusta, Georgia, Nation

- **The Enterprise must free up 20% ($200M) of the operating base and redeploy it towards the strategic priorities across all missions and schools**
  - We recognize and appreciate that you have already taken ground; this will require even higher levels of alignment and integration than MCG has previously experienced

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Guiding Principles:

"In a real sense all life is inter-related. All men (people) are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly affects all indirectly.

I can never be what I ought to be until you are what you ought to be, and you can never be what you ought to be until I am what I ought to be.

This is the inter-related structure of reality."

--Martin Luther King, Jr.

"The world that we have made as a result of the level of thinking we have done thus far creates problems that we cannot solve at the same level we created them at."

— Albert Einstein

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A Breakthrough Roadmap for Managing Academic Health Enterprises

Key Distinctions & Underlying Principles: Strategy Bridged into Economic Reality; Transparency and Open Books; Peer Accountability; Recognizing the Interdependencies; Appreciating the Diversity; Maintaining the Collegiality & Collaboration; Instituting Financial Discipline; Providing Rewards & Consequences

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Potential Vision Themes

Ideally, MCG's Vision should leverage the full range of its academic and clinical capabilities to improve health care and achieve distinction

Potential Strategic Objectives Which Unify Academic and Clinical Capabilities:
Nationally recognized for its team based approach to health care delivery, education and research
Recognized internationally for interdisciplinary programs that bridge all elements of MCG and MCGHS
Unique in its participatory approach to managing the AHC and the extensive involvement of its faculty and staff in improving performance
Achieve significant health status improvements locally and statewide by using MCG's capabilities to study and address health disparities and other factors
Achieve a uniquely successful learning experience by understanding each student's learning approach and using MCG's resources to deliver the most effective approach
Establish a regional system of care that delivers superior outcomes and service to the area's residents

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A Breakthrough Roadmap for Managing Academic Health Enterprises

Key Distinctions & Underlying Principles: Asking and answering the question of "*should we be all things to all people?";* in an era of constrained resources, forced choices that are rank order and prioritized; iterative, multi-dimensional thinking

ILLUSTRATIVE

COMMUNITY
EDUCATION
CLINICAL
RESEARCH

Contribution to the Mission
H
L

Optimize
Invest and Grow
Redeploy
Fix Profitability
Fill Excess Capacity

Economic (or Tangible) Returns
L
H

Underlying Economic & Financial Plan

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Removing the Historical Barriers & Artifacts by Redesign Enterprise Funds Flow

Key Distinctions & Underlying Principles: The financial displays and metrics we often use for decision making are rife with historical artifact, noise, side deals, and distortions. In the absence of clearer data, the sense inside AHEs is that “someone else is certainly receiving a better deal than I am” and therefore organizational trust is weak which perpetuates the protectionist behaviors.

Sequential, linear changes to the various funding streams are problematic and often doomed with the first change effort. Therefore, leadership must establish the overarching principles and corresponding arithmetical algorithms, recast the financials, and then manage the key stakeholders and managers to the new bottomline margins and expectations.

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Removing the Historical Barriers & Artifacts by Redesign Enterprise Funds Flow

PACK YOUR BAGS - - WE ARE HEADED FOR LAS VEGAS !!

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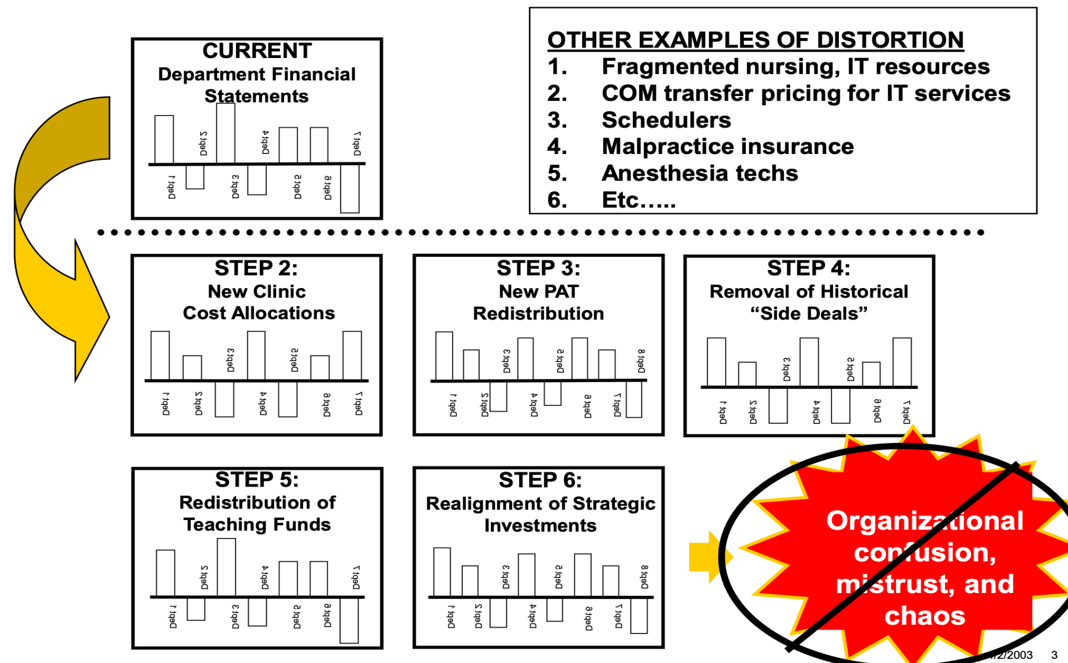

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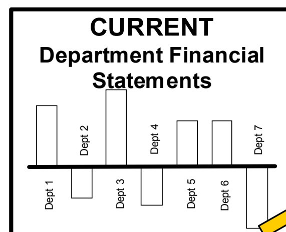
Removing the Historical Barriers & Artifacts by Redesign Enterprise Funds Flow

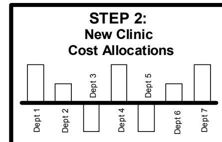
THE COMPREHENSIVE FUNDS FLOW APPROACH

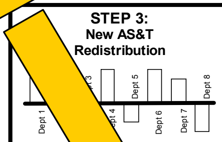
Illustrative

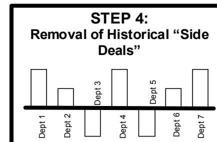


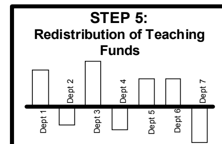
Other Non-Financial Views

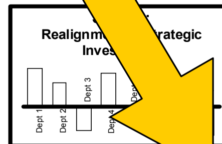
1. Clinical productivity metrics
2. Mission contributions (research & teaching)
3. Strategic importance
4. National reputation
5. Etc.…

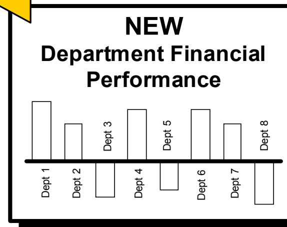












Transition the implementation (1 – 2 years) with Chairs accountable for a new redistributed bottom line

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Principles for Redesigning Enterprise-wide Funds Flows

1. Reflects reality, unburdened by past rules, allocations, deals, etc
2. Supports the three-part mission, serving our patients and community, educating future physicians and advancing medical knowledge
3. Takes into account our financial performance and market conditions
4. Supports the stated strategic initiatives
5. Recasts all historical anomalies (AS&T, mission-critical investments, IT services, side deals, etc)
6. Acknowledges interdependencies of primary/specialty care & basic science/clinical
7. Establishes an expectation that every Department and Unit optimizes their resources and improves their performance over time (e.g., productivity, costs, efficiencies, etc)
8. Correlates faculty effort & output to faculty compensation
9. Enables Department & Unit economic and financial changes through a transition period
10. Demands that management reports are open and transparent for inspection
11. Ensures that every function is managed by <u>someone</u> against promised, measurable outcomes
12. Requires that leadership is held accountable for the outcomes, with <u>real consequences and rewards</u>
13. Insists that the mechanisms that drive the plan are "implementable"

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Optimizing Every Core Process Provides a Sustainable Competitive Advantage (SCA)

Key Distinctions & Underlying Principles: Freeing up and redeploying 20% of the economic base ($200M); removing waste, duplication, redundancies, inefficiencies, and unnecessary variations; redesign processes and hand-offs from an end-to-end point of view;

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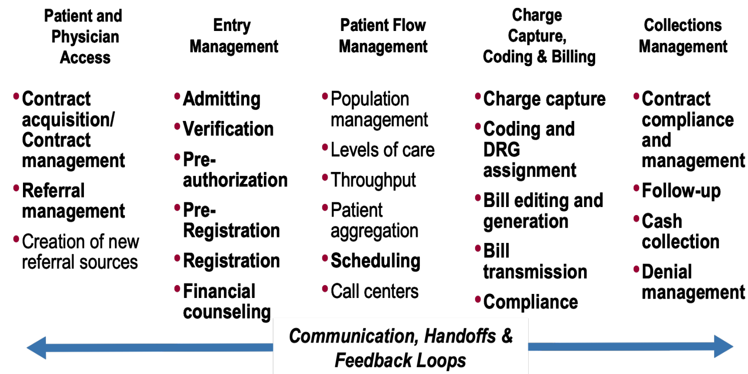
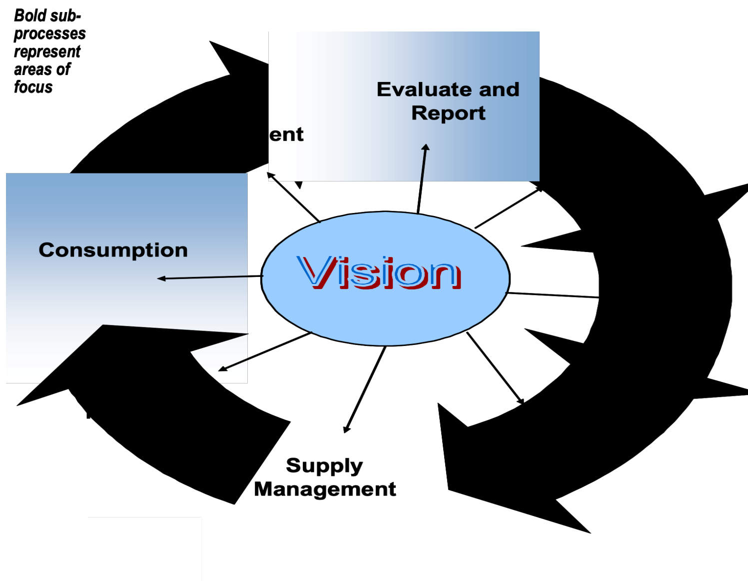
Optimizing Every Core Process Provides a Sustainable Competitive Advantage (SCA)



Bold sub-processes represent areas of focus



Revenue Cycle Redesign

Supply Chain Redesign

Throughput, Capacity, and PeriOp Redesign

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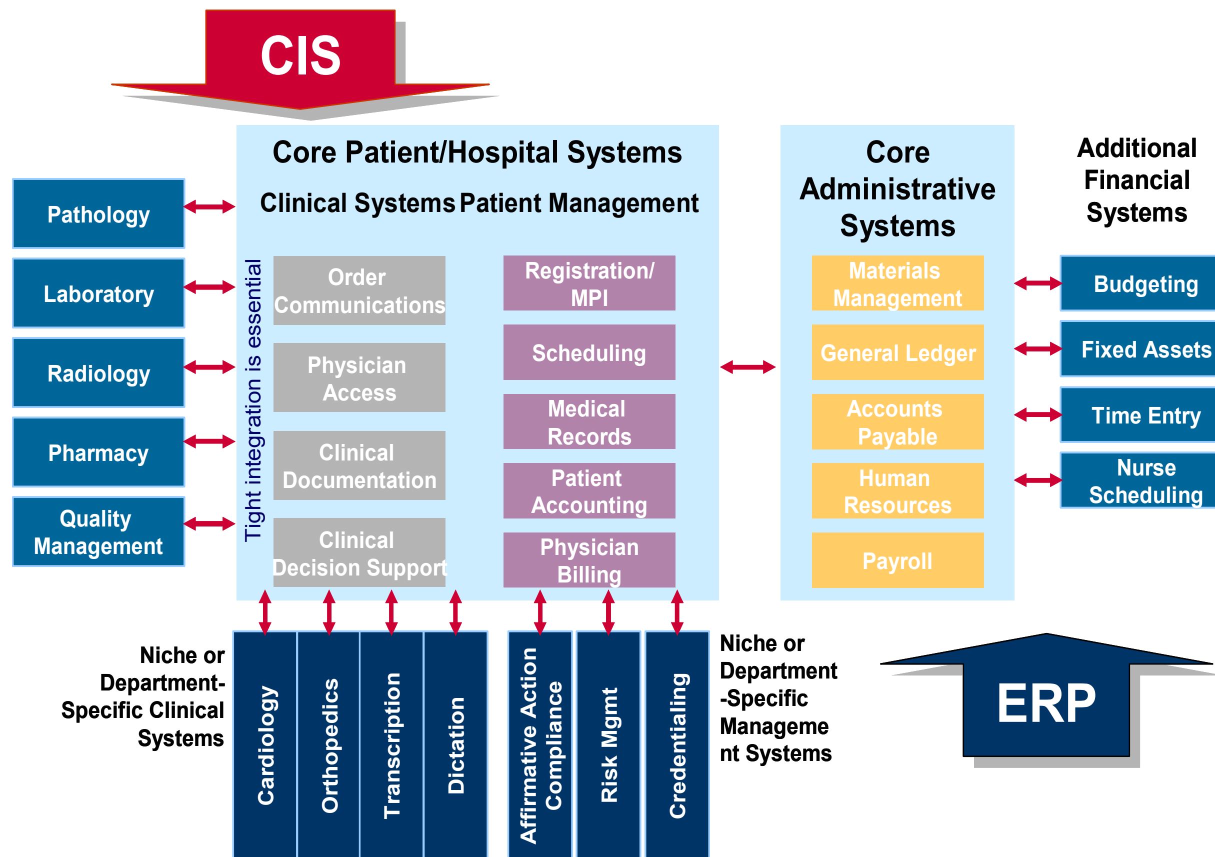
Re-enforcing these Redesigned Processes with Technology Solutions…

Key Distinctions & Underlying Principles: To assure changes are embedded into the new operating practices across all missions, IS must be integrated into the daily workflow. New ERP, CIS/EHR, Grants Management & Research Administration systems require investment and an rigorous implementation discipline. These multi-year campaigns must be led by the end users in partnership with the IT/IS department.



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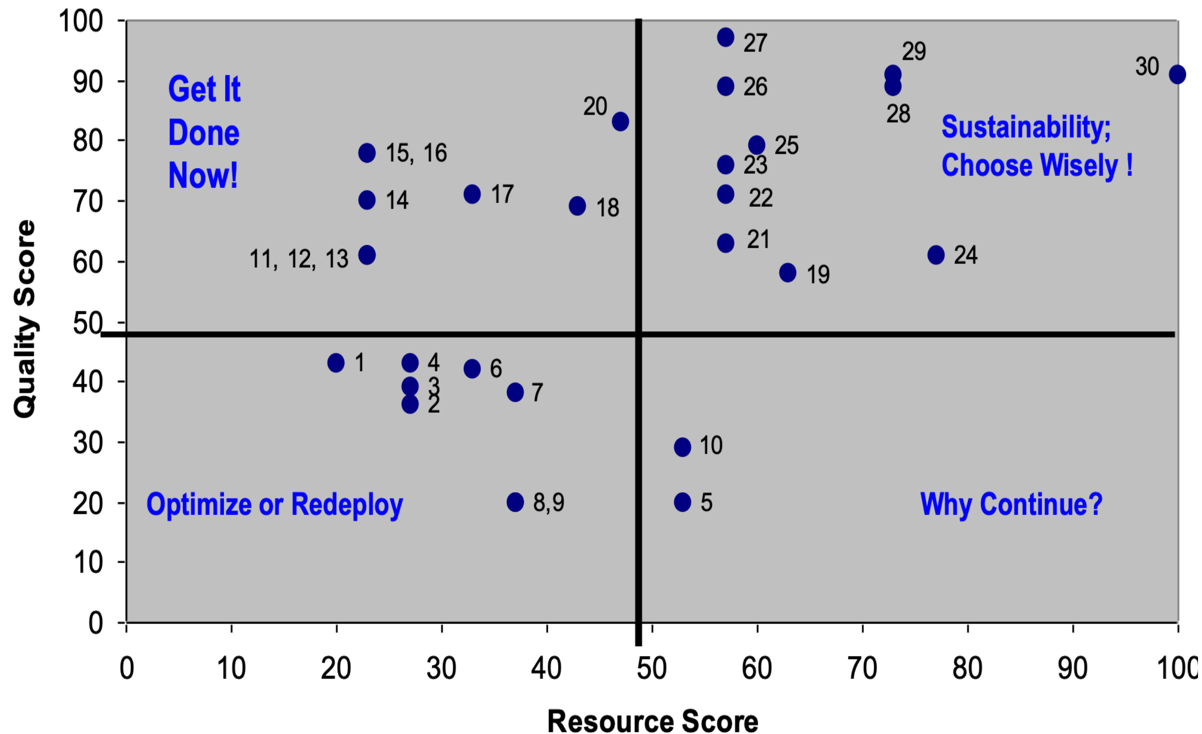
… rethinking and redefining "Quality"

Key Distinctions & Underlying Principles: Creating a new culture of "Quality" requires hundreds of micro- and macro- approaches. The enterprise should engage in a rank order prioritization process that aligns the actions of all faculty and staff for understanding what aspects are being addressed over what period of time and in what order of priority.



1 NCQA - Outpatient Primary Care Clinics
2 CMS
3 CARF Accreditation (Rehab)
4 Department of Health
5 PHC4 - Healthcare Acquired Infections (HAI) Initiative
6 UHC Benchmarking
7 JCAHO Accreditation Survey Lab
8 PHC4
9 UHC Participation
10 JCAHO Accreditation Survey Hospital
11 Surgical Antibiotic Prophylaxis
12 Ventilator Pneumonia Prevention
13 Catheter-related Infection Prevention
14 IHI Campaign
15 AMI Care
16 Public "Quality Measures"
17 Code Blue
18 Informed Consent
19 Magnet Certification
20 Handwashing
21 Patient Satisfaction
22 Patient Transport
23 Trauma Certification
23 Trauma Certification
24 Patient Safety
25 Medication Reconciliation Guidelines
26 Quality Care Review + M&Ms
27 JCAHO Safety Goals + Protocols
28 Medication Safety
29 Culture of Safety
30 Connected

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Effective Management in the Emerging Matrix and Team-Based Environment

Key Distinctions & Underlying Principles: Aligning the complex multi-mission academic health enterprise inherently requires management of functions and accountabilities across traditional silos. Expanding one's span-of-control & 'double-hatting' key leaders becomes an imperative. Being clear about these matrix-management expectations will increase understanding and productivity.

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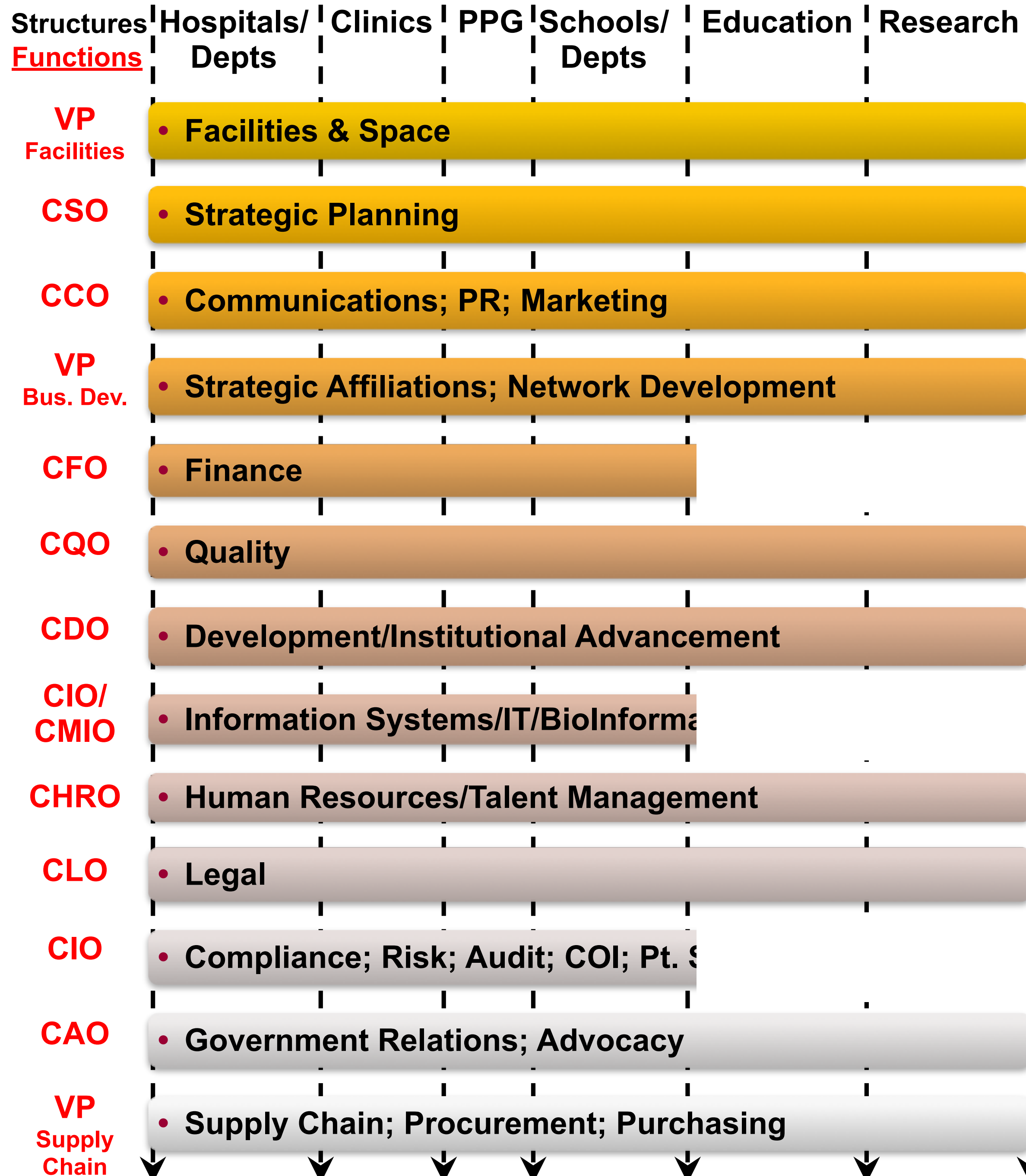
Integrative Leadership:
Critical Conversations for Changing Times

Learn
Serve
Lead

Functional Integration in the Emerging Matrix and Team-Based Environment

ILLUSTRATIVE



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

"Direct" Reporting Relationships	"Matrix" Reporting Relationships
• Hire/fire authority (for that particular accountability) • Determines base compensation • Determines and articulates expectations • Completes performance evaluations • Determines pay increases and incentives • Day-to-day management and supervision of activities • Career planning and development planning	• Jointly establishes performance measures • Monitors performance measures with the expectation that they will be met or exceeded • Input to performance evaluations • Input and recommendations for pay increases • Jointly determines bonus or incentive distributions • 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

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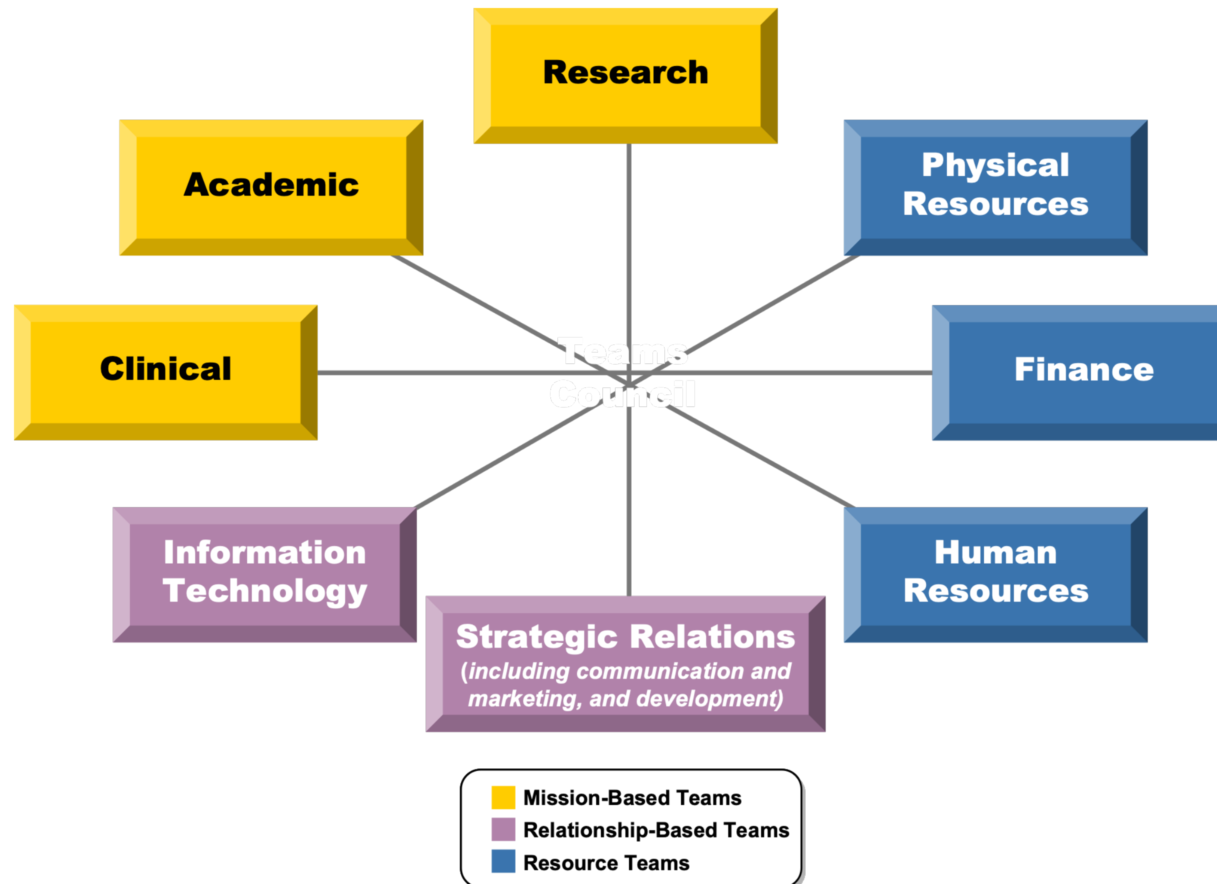
Effective Advice and Engagement of the Faculty and Leaders

Key Distinctions & Underlying Principles: Effecting powerful campus-wide realignment requires more than just one or two great leaders - - it requires mechanisms for processing and harvesting advice from the best and the brightest across all of the mission fronts. By enlisting the *engagement* of the next 100 – 200 faculty and staff leaders, better work products are produced, while simultaneously creating understanding and buy-in for the proposed solutions as well as providing the necessary training and education for the next generation of enterprise leaders.



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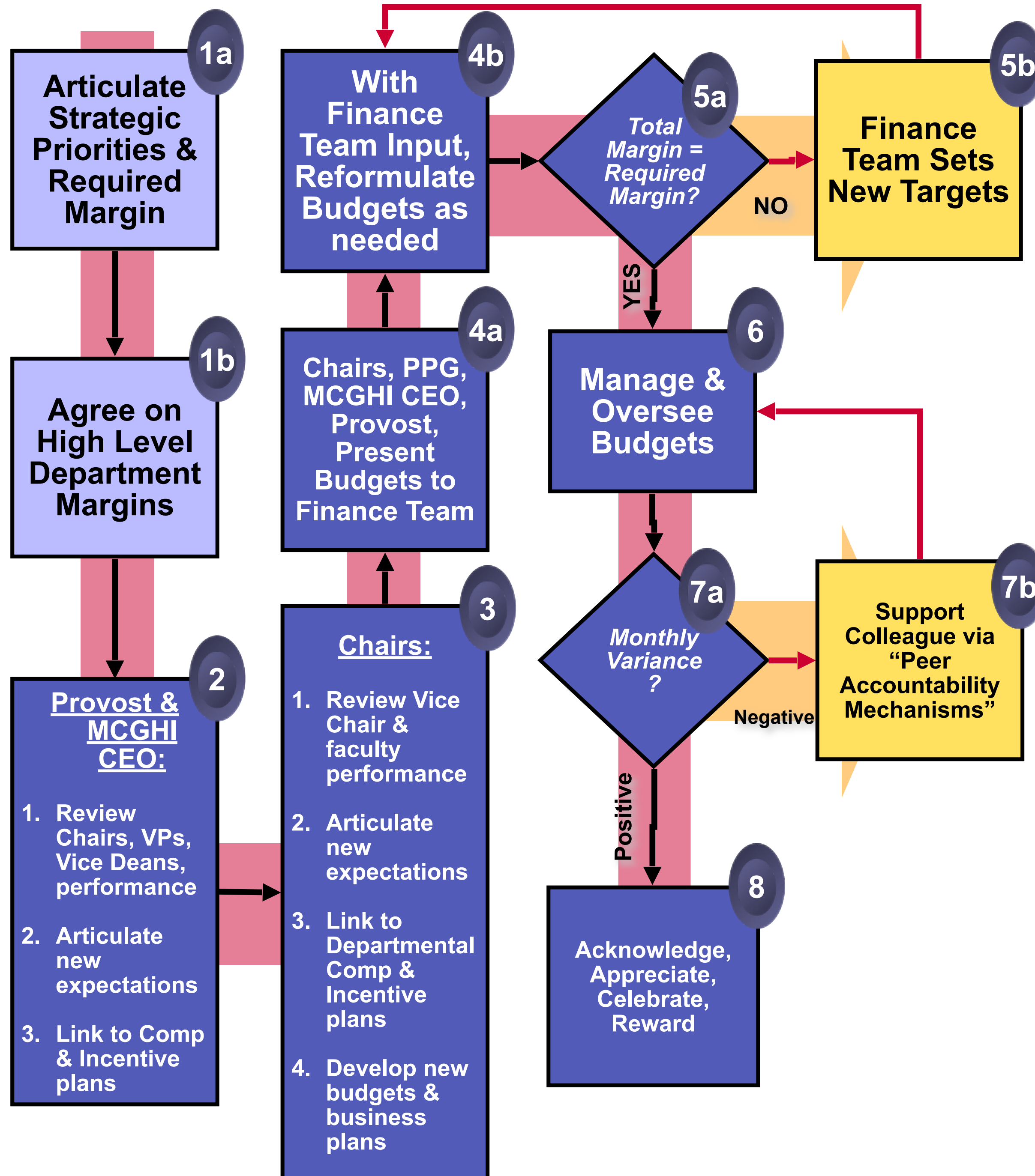
Managing from an "All Funds, All Missions" Integrated Budget Perspective



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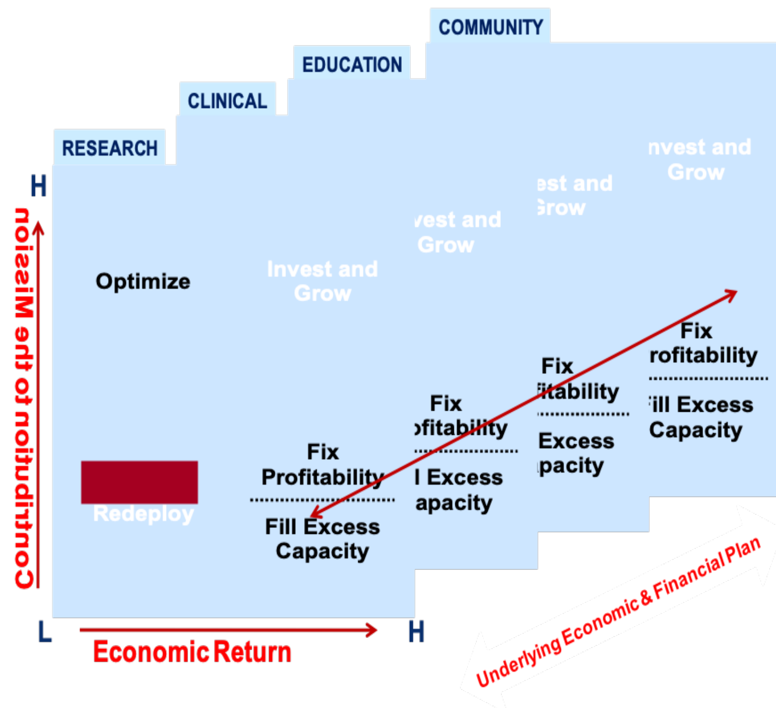
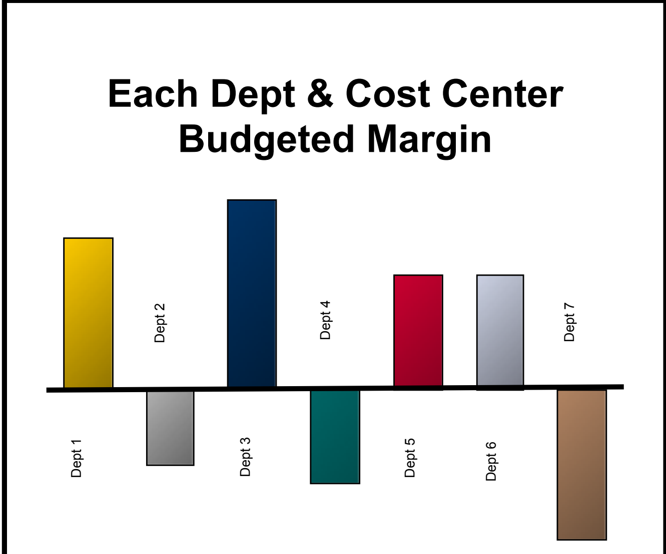
Linking the MultiYear Strategic Priorities to Budgets, Comp/Incentives, and Leadership Development



1a

Articulate Strategic Priorities & the Required Margin

(while continuously confronting that resources are scarce and difficult, explicit choices must be made)



1b

Executive Mgmt Sets High Level Margins

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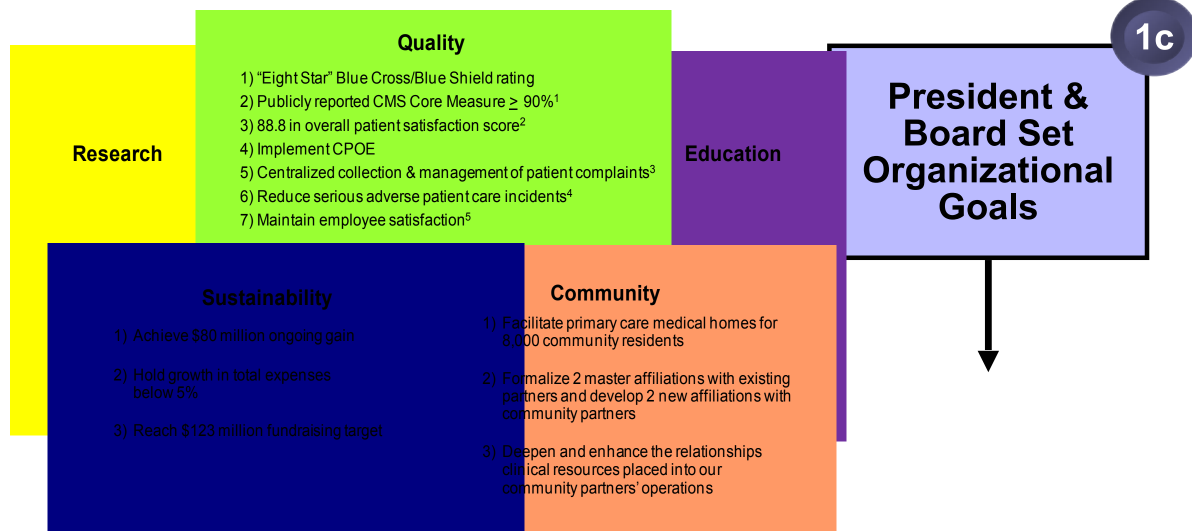

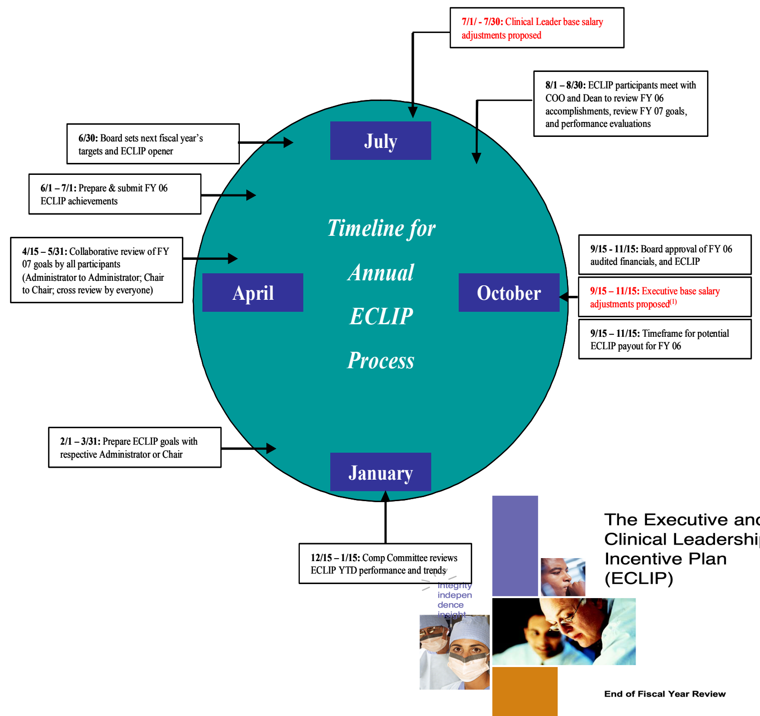

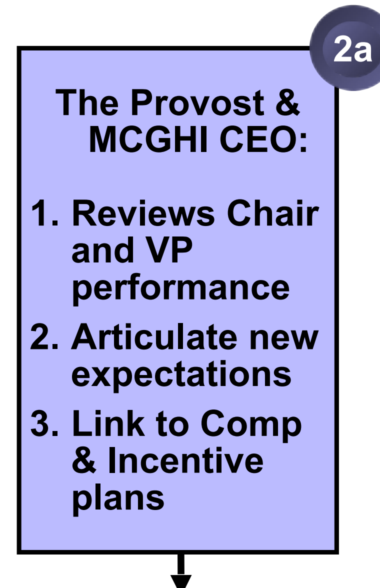

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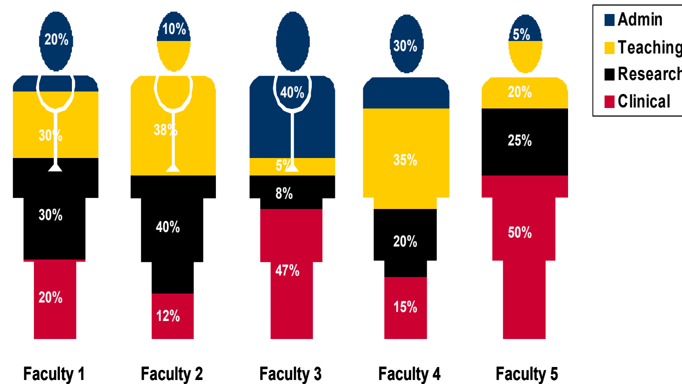
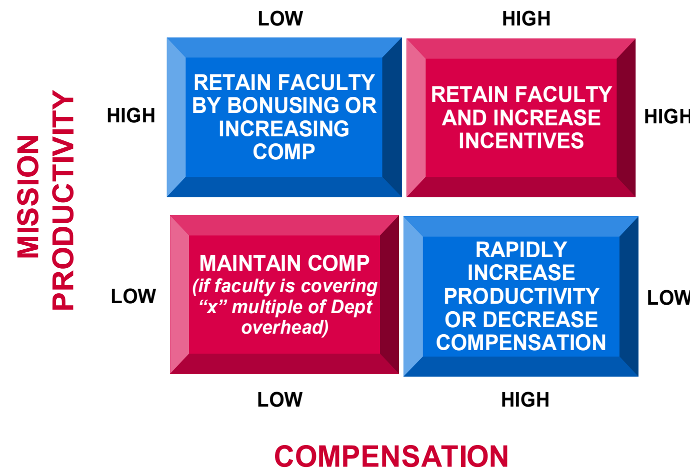
Linking the MultiYear Strategic Priorities to Budgets, Comp/Incentives, and Leadership Development



Balancing Compensation, Productivity, Retention & Career Goals



2b

THE CHAIRS:

1. Review faculty performance
2. Articulate new expectations
3. Link to Dept Comp & Incentive plans
4. Develop new "business plans"
5. Link to new FY Budget

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Effectively Managing the Transition Process

• **FORMULATION**	**100 in :**	**1 out**
• **CONCENTRATION**	**10 in :**	**1 out**
• **MOMENTUM**	**1 in :**	**1 out**
• **BREAKTHROUGH**	**1 in :**	**20 out**
• **MASTERY**	**1 in :**	**100 out**

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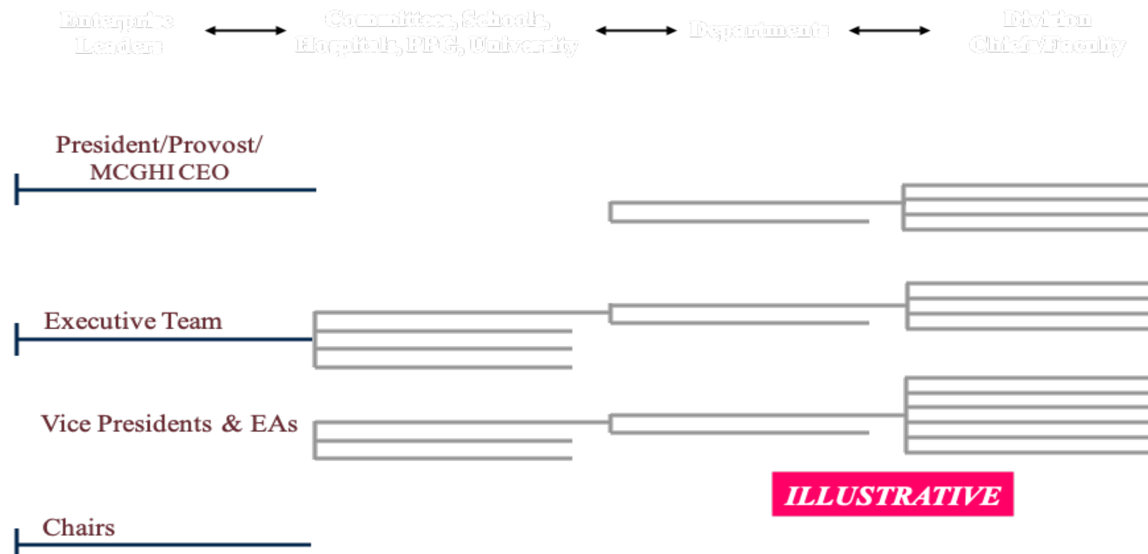

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Effectively Managing the Transition Process

The Future-Oriented Department Chair

R. Kevin Grigsby, DSW, David S. Hefner, MPA, Wiley W. Souba, MD, ScD, MBA, and Darrell G. Kirch, MD

ABSTRACT

The authors describe the current dilemma facing academic health centers (AHCs) as they recruit department chairs. In the past, leaders at AHCs predominantly were concerned with fulfilling the esteemed tripartite missions of patient care, research, and education. Today, their time and energy are occupied by a different set of tasks that have a distinct business orientation, including winning contracts, enhancing revenue, reducing costs, recruiting and managing a diverse workforce, and dealing with consumer satisfaction and marketing. New visions and strategies must be developed—requiring different dimensions of leadership.

The authors offer concrete recommendations for recruiting, retaining, and sustaining department chairs, and argue that a deliberative, thoughtful process of engaging chair candidates should begin by focusing on the candidates' values as a first priority. Candidates who most clearly share organizational values should then be engaged in an iterative process of developing a shared vision, resulting in a letter of agreement that explicitly states the mutual expectations and commitments of both the organization and the candidate. Once department chairs are in place, ongoing development through leadership training, mentoring, and other investments help to retain and sustain them.

Acad Med. 2004;79:571–577.

Recruiting department chairs at academic health centers (AHCs) has become an even more challenging endeavor in recent years. Long gone is the perception held by some faculty members that the position of department chair is honorific and reserved for the person who has demonstrated personal excellence across all three missions of patient care, research, and education (the so-called triple threat). Being a department chair now requires greater preparation and broader expertise than ever before. Drawing on our own experiences as leaders and managers in AHCs, in this article we describe the current dilemma facing AHCs as they recruit department chairs. We outline the desirable characteristics of department chairs in the current environment, and offer concrete recommendations for recruiting, retaining, and sustaining department chairs. In sharing our experiences we wish to encourage readers to adopt these or similar approaches at their own institutions.

Dr. Grigsby is vice dean for faculty and administrative affairs, Dr. Souba is John A. and Marian T. Waldhausen professor and chair of the department of surgery and director of the Penn State Hershey Center for Leadership Development, and Dr. Kirch is university senior vice president for health affairs, dean of the college of medicine, and chief executive officer of the medical center; all are from the Pennsylvania State University College of Medicine and Milton S. Hershey Medical Center, Hershey, Pennsylvania. Mr. Hefner serves as executive director and chief operating officer of the Penn State Milton S. Hershey Medical Center and is a senior partner with CSC Global Healthcare Solutions, Houston, Texas. *Portions of this article were presented at the Association of American Medical Colleges' Faculty Affairs Professional Development Conference, Park City, Utah, August 3–6, 2002.*

Correspondence and requests for reprints should be addressed to Dr. Grigsby, Vice Dean for Faculty and Administrative Affairs, Penn State University College of Medicine, 500 University Drive, H184, Hershey, PA 17033; e-mail: (kgrigsby@psu.edu).

THE CURRENT DILEMMA FACING ACADEMIC HEALTH CENTERS

Over the past decade, the turmoil ensuing from the transformation of the health care industry has been impressive. Stemming largely from a major revision of the industry's payment structure, AHCs have experienced the interplay of powerful market forces and a shift in the power base away from providers and toward payers (employers and insurers) and the pharmaceutical industry. Physicians have less clout in the marketplace and less autonomy in practice. In the past, faculty leaders at AHCs were concerned predominantly with fulfilling the missions of patient care, research, and education. Today, their time and energy are occupied by a

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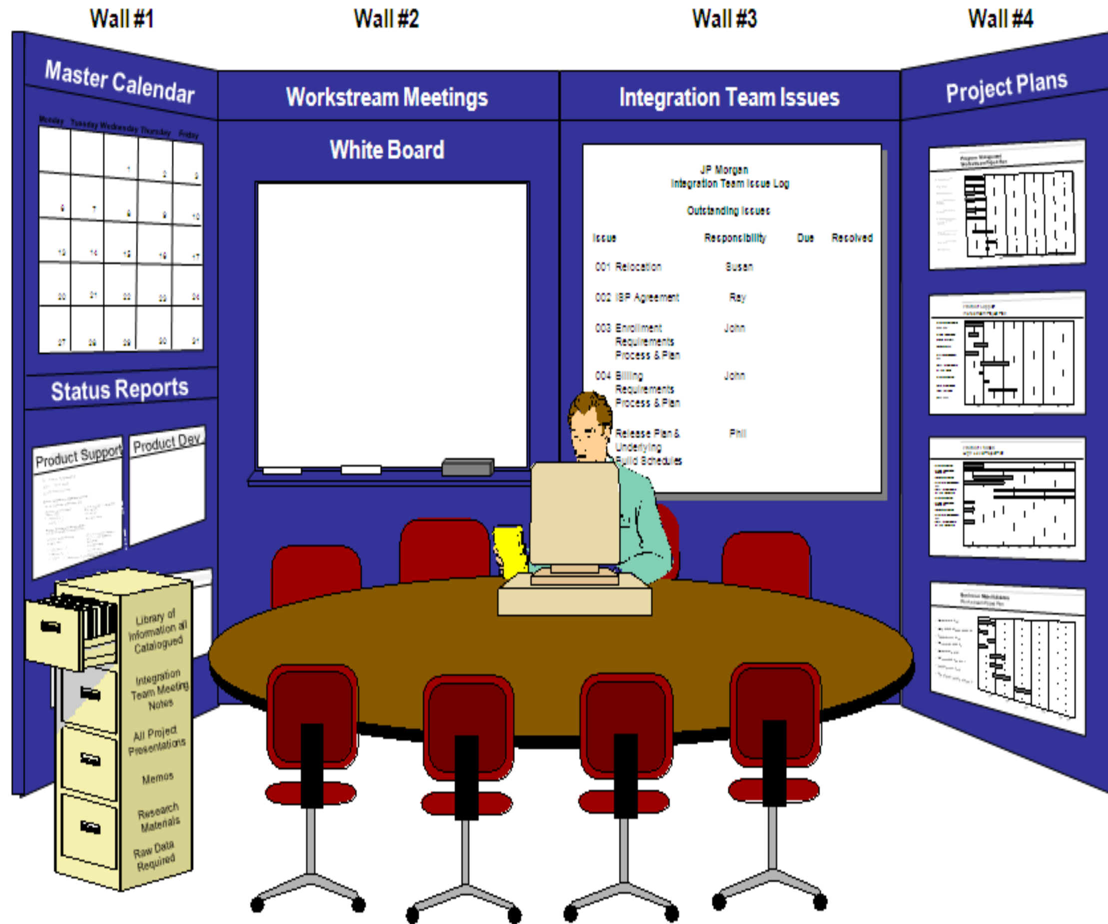
Executing and Leading Multiple, Complex, Simultaneous Initiatives

ILLUSTRATIVE



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MASTER UCMC Strategy Goals Scorecard 011808.xls [Compatibility Mode] - Microsoft Excel

	B	C	J	K	L	M	U	W	X
15		AMBULATORY *Executive Sponsors - Carolyn Wilson ; Harvey Golomb, MD , Jeff Finesilver; PMO - Sunitha Sastry, Jason Whorley*	S	O	N	D	YTD	Variance	
16	A1	Improve normative patient mix	47.2%	48.6%	50.2%	50.5%	48.4%	1%	A1
17	A2	Maintain ambulatory patient satisfaction for "overall satisfaction"	90.0	89.0	88.4		88.4	30%	A2
18	A3	Increase ratio of new patients to returning patients in priority programs	19.7%	21.2%	20.7%	19.7%	20.5%	-2.0%	A3
19	A4	Reallocation of space in a more efficient and effective manner							A4
20	A5	New structure defined/implemented with efficiencies	$98.27	$80.81	$89.64	$99.98	$90.01	$9.42	A5
21		HR REDESIGN *Executive Sponsor - Maya Bordeaux; PMO - Melissa Bacon, Juan Guillen*	S	O	N	D	YTD	Variance	
22	HR1	Prioritize policies between UC and UCMC that can be integrated for consistency and administrative ease							HR1
23	HR2	A robust learning and development program for targeted UCMC workforce constituencies							HR2
24	HR3	Standardized, integrated, UCMC HR data/reports to support management and leadership decisionmaking							HR3
25	HR4	Develop a performance management, professional development and goal setting model for targeted clinical enterprise leadership roles							HR4
26	HR5	Consistent with the UCMC strategic plan, develop a workforce gap analysis for the clinical enterprise							HR5
27		PERIOP *Executive Sponsors - Jeff Apfelbaum, MD; Tom Cutter, MD; Allan Gray; Jeff Matthews, MD; Arthur Haney, MD; PMO - Margaret Tobin*	S	O	N	D	YTD	Variance	
28	P1	Increase block capacity to grow high priority programs	4.0	4.0	4.0	4.0	4		P1
29	P2	Achieve flex (volume/mix-adjusted) cost reductions	($561,000)	($373,000)	(480,000) est.		(480,000) est.		P2
30	P3	Grow surgical volume for high priority programs in all locations procedures are performed	1,415	1,642	1,543	1,394	9,256		P3
31	P4	Improve OR profitability/OR hour	$2,401	$2,382	$2,476		$2,385		P4
32	P5	Improve compliance with CMS antibiotic stipulations as well as avoid incidents of laterality confusion or instrument retention	>90%	>90%	>90%		>90%		P5
33	P6	Achieve High Score for GOR Patient rating of OR/RR Staff	88.8	90.1	91.4		90.5		P6
34		PHOENIX, CIS/INFORMATICS *Executive Sponsors - Eric Yablonka, Sandy Senti, and Conrad Gilliam; PMO - Ruby Blasak-Rodriguez, Wendy Yee, Juan Guillen*	S	O	N	D	YTD	Variance	
35	IS1	"Phoenix: Complete development of 200 order sets by end of FY08							IS1
36	IS2	Update Phoenix Plan, Timeline, and Budget with approval from management and the board							IS2
37	IS3	Consolidate BSD and Medical Center IS Help Desks by the end of FY08							IS3
38	IS4	Improve Help Desk first call resolution by 10%							IS4
39	IS5	Support development of the Research Informatics plan including budget and program roadmap							IS5

P1

FY08-FY10 Organization Goals | FY08 Organization Goals | FY08 Org Goals Scorecard | FY08 Redesign Scorecard | FY08 Red

MASTER UCMC Strategy Goals Scorecard 011808.xls [Compatibility Mode] - Microsoft Excel

Row	B	C	J	K	L	M	U
34		**CIS/INFORMATICS** *Executive Sponsors - Eric Yablonka, Sandy Senti, and Conrad Gilliam; PMO - Ruby Blasak-Rodriguez, Wendy Yee, Juan Guillen*	S	O	N	D	YTD
35	IS1	**Phoenix: Complete development of 200 order sets by end of FY08					
36	IS2	Update Phoenix Plan, Timeline, and Budget with approval from management and the board					
37	IS3	Consolidate BSD and Medical Center IS Help Desks by the end of FY08					
38	IS4	Improve Help Desk first call resolution by 10%					
39	IS5	Support development of the Research Informatics plan including budget and program roadmap					
40		**QUALITY** *Executive Sponsor : Bruce Minsky, MD; PMO - Carianne Johnson*	S	O	N	D	YTD
41	Q1	** Establish Quality Program and 3-year priorities					
42	Q2	Achieve full accreditation and maintain status with accrediting agencies		>90%	>90%	>90%	
43	Q3	Improve performance on HQA hospital quality measures					
44	Q4	**Improve performance on BC/BS Hospital Profile to qualify for BC/BS quality bonus	6 stars				
45	Q5	Lower SSI (Surgical site infection) rates for SCIP-related procedures	3 of 8	3 of 8			
46		**SUPPLY CHAIN** *Executive Sponsor - Victoria Humphrey; PMO - Donna Leonard, Juan Guillen*	S	O	N	D	YTD
47	SC1	Secure an at-risk 3 year, $30M savings consulting partnership for Supply Chain Redesign					
48	SC2	Reduce "supply expense per CMI-adjusted discharge" by year end	$ 1,975	$ 1,820	$ 1,852		
49	SC3	Reduce "inpatient drug expense per RX intensity weighted discharge" by year end	148	175	222		
50	SC4	Implement $13M in supply chain cost reductions	$5.869M	$7.690M	$9.010M	$10.289	
51		**THROUGHPUT AND FILL** *Executive Sponsors - Carolyn Wilson & Harvey Golomb, MD; PMO - Carianne Johnson, Rupa Sampath*	S	O	N	D	YTD
52	TF1	Reduce average length of stay (ALOS)	5.94	5.69	5.37	5.69	5.65
53	TF2	Stable readmission rate***	5.6%				5.6%
54	TF3	Increase case mix index (CMI)	1.63		1.67		1.65
55	TF4	Increase in % target program outside transfers placed	81%	76%	78%	79%	80%
56	TF5	Increase % placement of priority program outside transfers placed within 24 hours	69%	68%	74%	73%	72%
57	TF6	Increase in number of transfers from Mitchell ER to other hospitals	83	85	76	79	436
	TF7	**Increase in private payer mix (gross charges)	36.5%	39.7%	39.5%		37.5%

FY08-FY10 Organization Goals | FY08 Organization Goals | FY08 Org Goals Scorecard | FY08 Redesign Scorecard | FY08 Red

Executing and Leading Multiple, Complex, Simultaneous Initiatives ala' John Kotter

EIGHT STEPS TO TRANSFORMING YOUR ORGANIZATION

1 Establishing a Sense of Urgency
- Examining market and competitive realities
- Identifying and discussing crises, potential crises, or major opportunities

2 Forming a Powerful Guiding Coalition
- Assembling a group with enough power to lead the change effort
- Encouraging the group to work together as a team

3 Creating a Vision
- Creating a vision to help direct the change effort
- Developing strategies for achieving that vision

4 Communicating the Vision
- Using every vehicle possible to communicate the new vision and strategies
- Teaching new behaviors by the example of the guiding coalition

5 Empowering Others to Act on the Vision
- Getting rid of obstacles to change
- Changing systems or structures that seriously undermine the vision
- Encouraging risk taking and nontraditional ideas, activities, and actions

6 Planning for and Creating Short-Term Wins
- Planning for visible performance improvements
- Creating those improvements
- Recognizing and rewarding employees involved in the improvements

7 Consolidating Improvements and Producing Still More Change
- Using increased credibility to change systems, structures, and policies that don't fit the vision
- Hiring, promoting, and developing employees who can implement the vision
- Reinvigorating the process with new projects, themes, and change agents

8 Institutionalizing New Approaches
- Articulating the connections between the new behaviors and corporate success
- Developing the means to ensure leadership development and succession

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1. **Context Setting**
2. **Funds Flow Redesign**
3. **Redesigning Processes**
4. **Aligning Management, Advice, and Engagement**
5. **"All Funds, All Missions" Integrated Budgeting & Accountability Mechanisms**
6. **Effectively Managing the Transition Process**
7. **Embedding Talent Management**
8. **Breakthrough Sustainable Results**
9. **(Re) Positioning for Health Reform**

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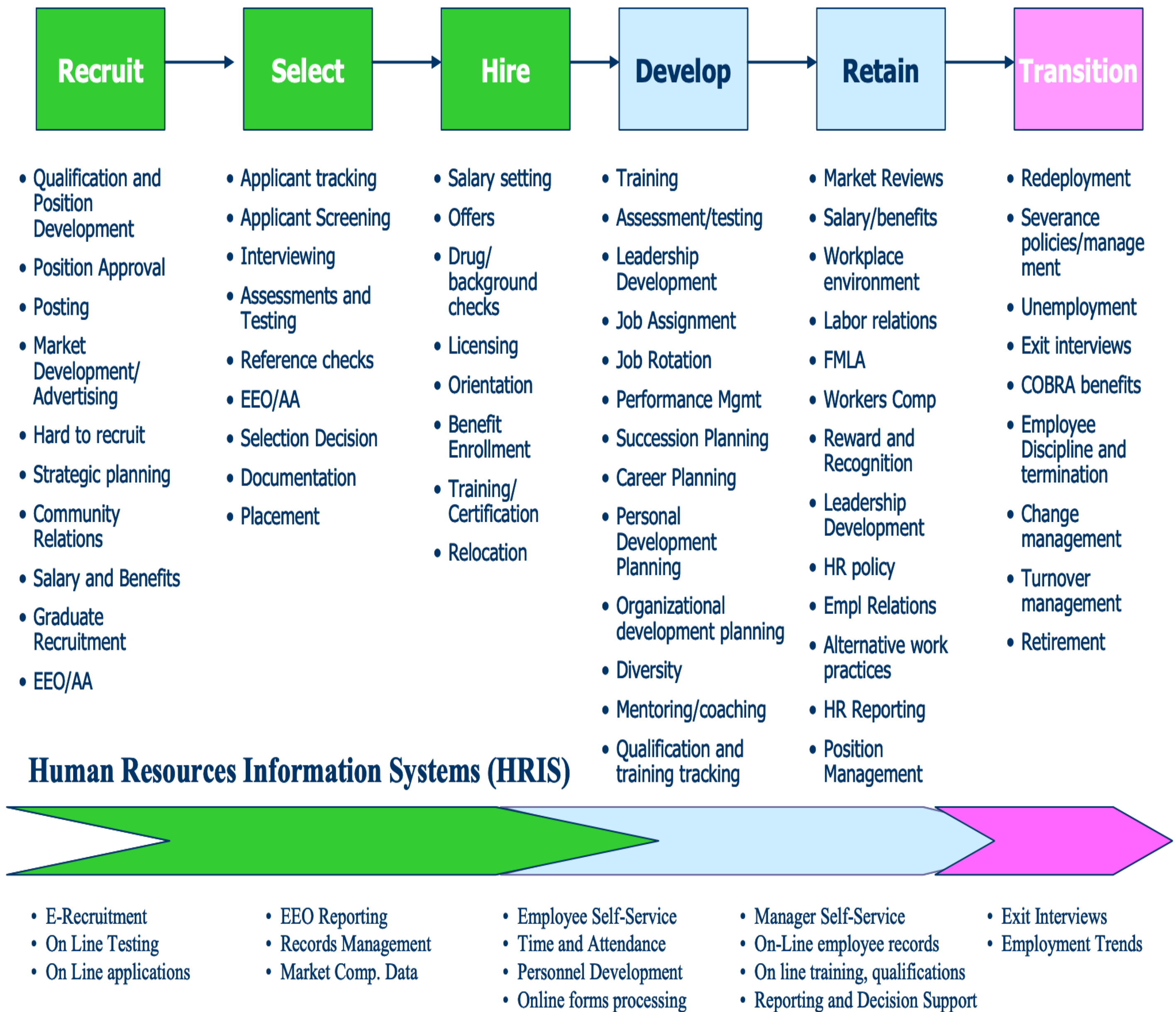
A Process View of Talent Management & Leadership Development



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Investing in Your Future Leaders

Key Distinctions & Underlying Principles: Formalized internal leadership training programs are a critical success factor for sustaining enterprise alignment.

Mission-Based Management: Leveraging Your Leaders

Penn State Hershey
Center for Leadership Development

About Us
Meet the Team
Our Services
Heart of Leadership
Resources
News & Events
Links
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Center for Leadership Development Home
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THE CENTER FOR LEADERSHIP DEVELOPMENT
AWARE • ADAPTIVE • CARING

We seek to develop all students, residents, faculty, and staff to become leaders and to lead effectively within their jobs and roles. The leaders who will distinguish themselves at Hershey Medical Center and the College of Medicine and who will play a significant role in making us the top Academic Medical Center will be those individuals who demonstrate that they are **AWARE, ADAPTIVE and CARING.**

Back

Leadership Message

Register for Classes

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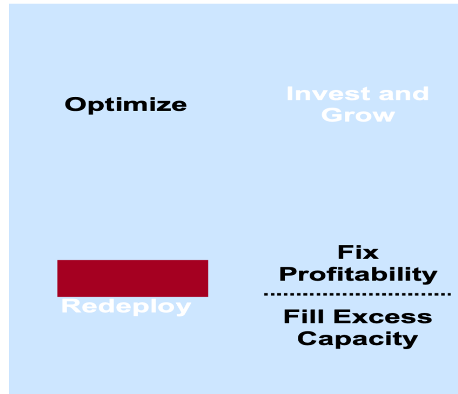
Breakthrough Sustainable Results (illustrative)

Implementing a Series of Difficult Choices

- PeriOp Flow
- Bed Capacity & Control
- Ambulatory Care
- Entire Labor Pool

- Inpatient Psychiatry
- General Ophthalmology
- Low Risk Obstetrics
- General Medicine
- General Pediatrics
- etc
- etc
- etc

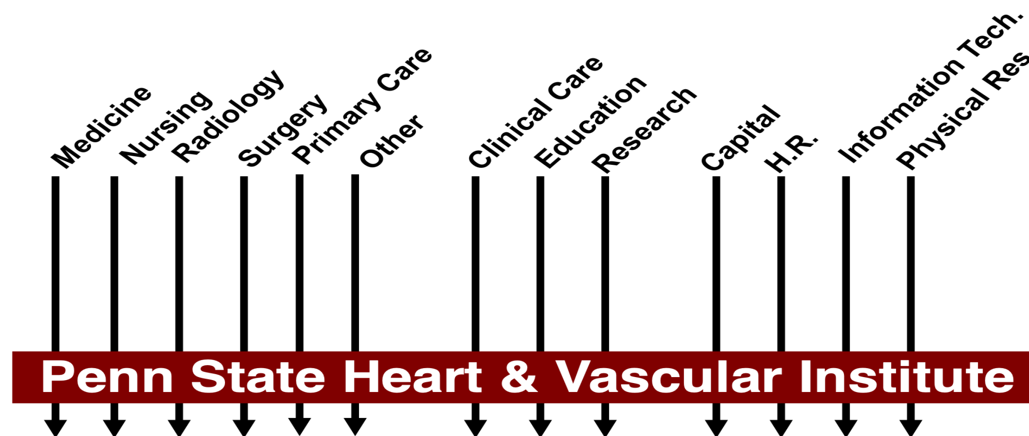


- Cancer
- GI
- Advanced Surgery
- Neurosciences
- High Tech Imaging
- Highly Distinctive Programs

- Supply Chain
- Revenue Cycle

11

Academic Departments ***Missions*** ***Support of Missions***



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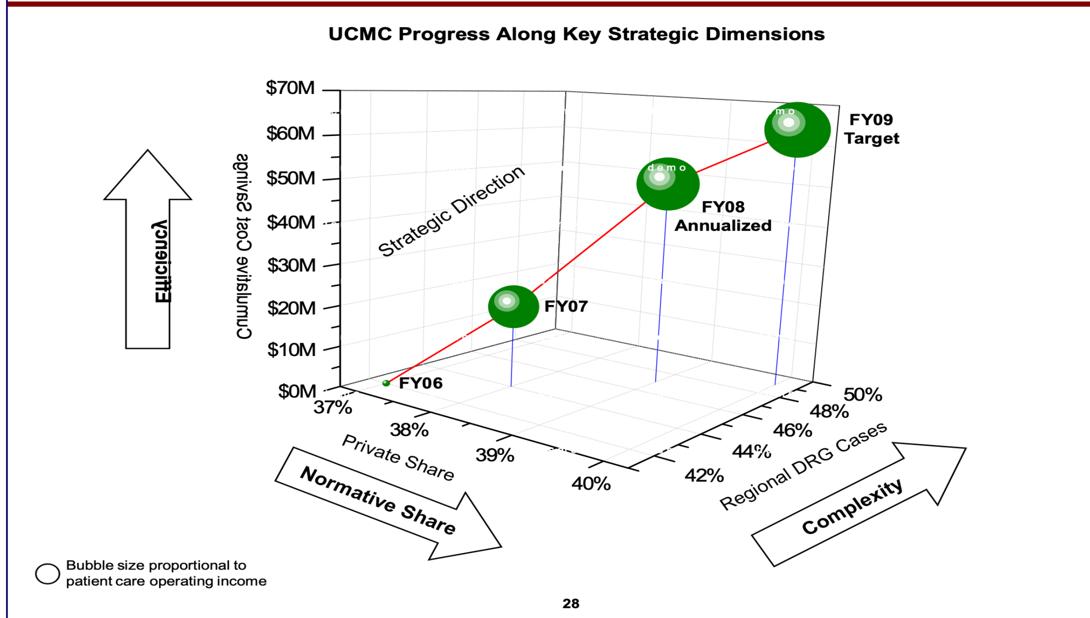
Breakthrough Sustainable Results (illustrative)



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Breakthrough Sustainable Results (illustrative)

Systems-Based Practice at Penn State: Putting Theory into Practice

Richard Simons, MD, Beth Garrison, MPA, David Hefner, MPA, Donna Reck, MSN, Michael Weitekamp, MD, MHA

When the ACGME general competencies were introduced several years ago, many program directors were particularly puzzled about two competencies: systems- based practice (SBP) and practice-based learning and improvement. Fortunately, most program directors consulted the ACGME tool box; sought counsel from their specialty program directors' organizations; or borrowed ideas from other residency directors at their own or neighboring institutions to begin the process of incorporating SBP into their programs.

ACGME mandates that the sponsoring institution, through its Graduate Medical Education Committee (GMEC), ensure that each residency program is providing the appropriate educational venues and evaluation systems to address the competencies. But, other than monitoring each program for compliance, what should the role of the institution be in this new era of training? In this article, we describe our institutional approach for systems-based practice.

We believe the current organization and governance of the Penn State College of Medicine and the Medical Center is one of the key factors in our progress with the ACGME Outcome Project. The governance model also exemplifies Penn State College of Medicine/Hershey Medical Center's own "systems" thinking. Governance of the institutions is unified by the fact that the Medical Center's Chief Executive Officer (CEO) of the Hershey Medical Center is also the Senior Vice President for Health Affairs of the Penn State University and Dean of the College of Medicine. The Executive Director (hospital director), the Chief Medical Officer, the Chief Nursing Officer and the Vice Dean for Educational Affairs (who also serves as Chair of the GMEC) report directly to the CEO of the medical center. This organizational structure is important, by linking the interdependent missions of the academic health center. Under the vision and leadership of Darrell Kirch, MD, who serves as the CEO and Dean, a "unified campus team" structure has been put into place to improve input to the institution's decision-making process. In this model, there are three mission teams (academic, clinical and research) and five supporting teams (finance, human resource, information technology, physical space and strategic relations). Each team is composed of 12 to 16 members who meet weekly for two hours to perform the "work" of the team.

The teams tend to deal with more strategic rather than operational issues and work together to set the direction for the institution. Each team has a leader (frequently a department Chair) who is represented on the Teams Council where recommendations from each team are considered and decisions made. In addition to the Team Leaders, the Teams Council also includes the Executive Director, the Chief Medical Officer, the Chief Nursing Officer, the Chief Financial Officer, the Vice Dean for Faculty and Administrative Affairs, the Vice Dean for Educational Affairs, the Vice Dean for Research Affairs. Accordingly, a true team-style for decision-making exists with input from the individuals who comprise the membership. The team structure helps to insure that all missions of the academic medical center are coordinated to achieve success. This "system" of shared decision-making has proven to be effective in creating the appropriate environment to nurture each of the three core missions of our academic medical center.

"The team structure helps to insure that all missions of the academic medical center are coordinated to achieve success. This "system" of shared decision-making has proven to be effective in creating the appropriate environment to nurture each of the three core missions of our academic medical center."

The Vice Dean for Educational Affairs is responsible for providing a "Medical Education Accreditation Update" to the Teams Council on a quarterly basis. This has been a useful forum to share information about the relevance and importance of the ACGME core competencies in residency education with the leadership of the medical center. From the inception of the core competencies, there has been support and alignment for the competencies from the Dean, Executive Director and departmental chairs.

In the early stage of the ACGME Outcome Project, the Graduate Medical Education Office sponsored a series of workshops on the competencies for program directors and key faculty. This was an important first step in educating the faculty about these issues, especially systems-based practice and practice based learning and improvement. To assist program directors with their task of teaching "systems" issues, the Office initiated a monthly "Core Competency Lecture Series" that has been well-received by residents and program directors alike, with average attendance of approximately 350. Topics have been selected with the input from program directors, and have included health insurance, malpractice, medication errors and computerized physician order entry, patient safety, health care economics, health care disparities, regulation of health care in the United States, principles of continuous quality improvement and professionalism. We have found that community experts in various health care-related industries (e.g., health insurance executives, corporate CEO's,

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Breakthrough Sustainable Results (illustrative)

Table 1

Performance Measure Comparisons, The Pennsylvania State University (Penn State) College of Medicine and Milton S. Hershey Medical Center, Hershey, Pennsylvania, Fiscal Year (FY) 2000 and FY 2004

Measure	FY 2000	FY 2004
No. (%) Penn State medical students who passed the United States Medical Licensing Examination (USMLE) at first attempt		
USMLE Step 1	95/108 (88.0)	122/124 (98.4)
USMLE Step 2	98/98 (100)	110/119 (92.4)
% Graduating students who overall were satisfied with the quality of their medical education	82.0	86.7
Total annual sponsored research funding (US$ in millions)	$54.7	$98.5
No. of annual clinical encounters		
Admission	20,622	23,700
Clinic visit	524,411	697,235
Emergency room visit	33,705	45,044
Surgery	15,897	18,254
Annual revenues (US$ in millions)		
College of medicine	$176.5	$191.2
Medical center	$438.0	$602.4
Total campus	$614.5	$793.6
Percentage of medical center revenue transferred to the college of medicine (US$ in millions)	6.3 ($27.7)	3.9 ($23.5)
Medical center margin after funds transfer (US$ in millions)	–$21.8 (deficit)	$16.4
Annual fund-raising (US$ in millions)	$12.8	$27.2

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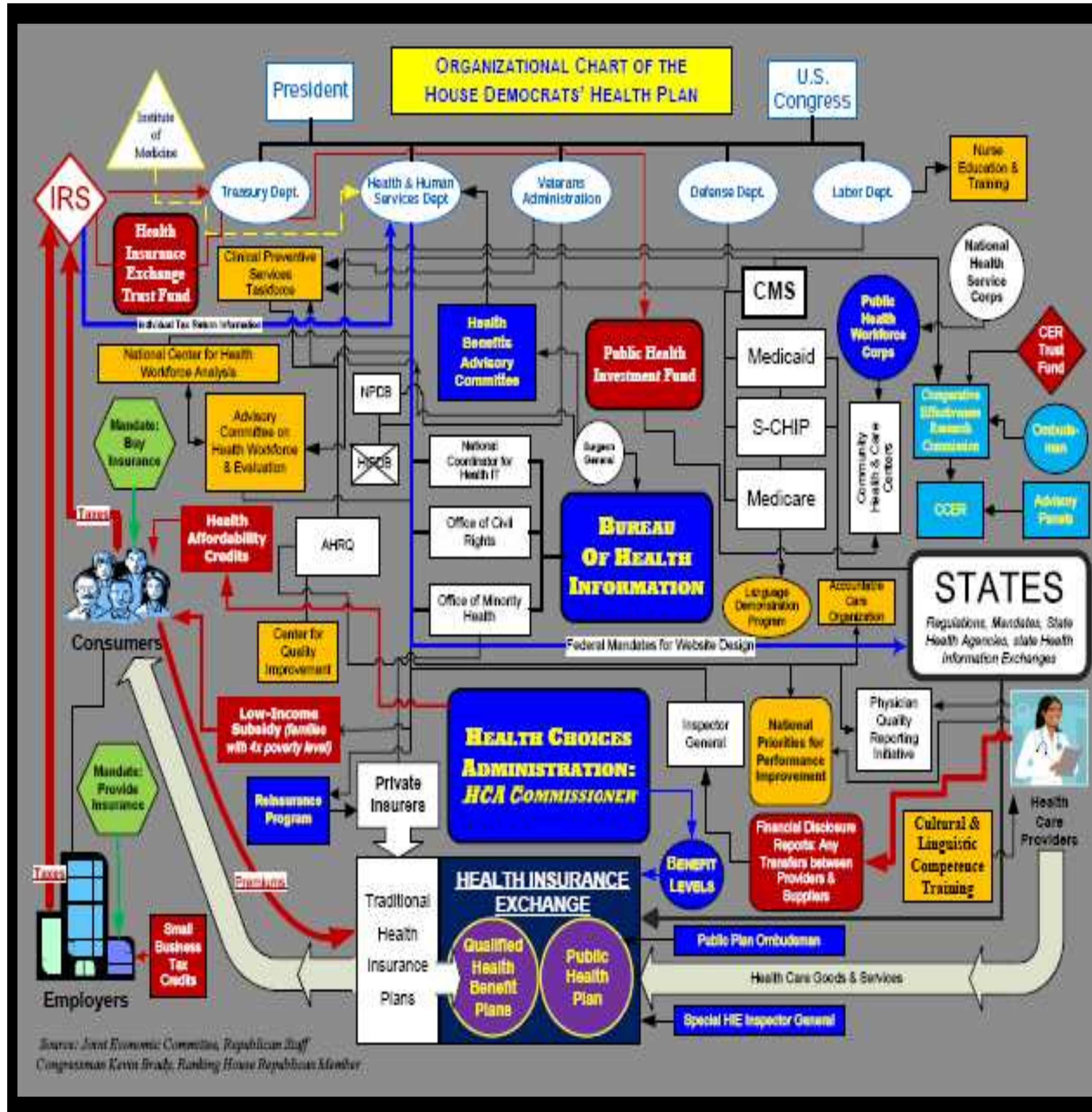
(Re)Positioning for Health Reform

Key Distinctions & Underlying Principles: XXXXXXX



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10. Board Leadership

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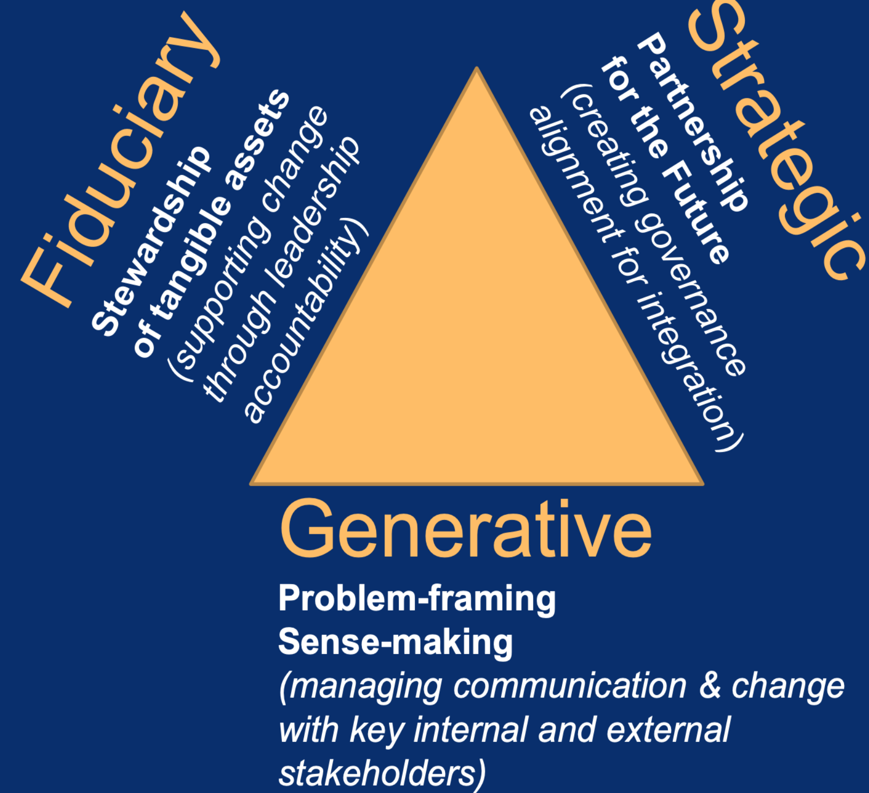
The Board's Work in Leading Transitions



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