Why are we doing this?

Setting the stage for this retreat

Richard D. Krugman, MD

July 24, 2012
University of Colorado School of Medicine
Trend in Sources of Revenue
1982 - 2011
No margin, no mission

• We have had double digit growth in our clinical revenue for more than a decade.
• The AEF that derives from that revenue is what has supported the early growth, and now the maintenance, of our research enterprise as well as filling in holes in our education mission which is among the least supported by the state in the nation.
School of Medicine
Academic Enrichment Funds

Total AEF Expenditures: $253,124,617

- Chair Recruitments: 45.5%
- Department Programs: 28.5%
- School-Wide Programs: 24.8%
- Renovations & Facilities: 1.3%

1 Figures for FY 2010-11 are based on expenditures through June 30, 2011.
The Core Question

• Given our current faculty, facilities, revenues and affiliations, are we organized in a way to assure that we can be as great as we want to be?

• Said another way: If we were starting over as a School of Medicine today – with 2250 faculty and $1.0 billion in revenue, how would we organize to have maximum success in each of our missions: research, clinical practice, education and community service?
The Process

• This should be a two part process:
  – “Blue sky” each mission
  – Then, identify the one-time resources necessary to get us to that future without cannibalizing anyone and without destroying what got us to where we are.

• It should also:
  – Be coordinated with the Campus master plan update
  – Be coordinated with our hospital partners and the developing health system
  – Be a magnet for philanthropy
Why ask it now?

• Many think there is no burning platform here
  – “If it ain’t broke, don’t fix it”
• There isn’t one: there are several
  – The federal budget situation makes it very likely that NIH funding will be flat for some time to come (and flat is losing).
  – There is little likelihood that there will be any significant increase in our general fund support.
  – Clinical revenue is all we have, and it is under downward pressure as well.
What this process is

• A serious attempt to engage our faculty, our program and center directors, our section and division heads, our chairs, and our dean’s office in a conversation that will shape our future.

• An attempt to see whether we can streamline the way we administer our four academic missions so that more of our resources can be used to support people and programs rather than administration.

• Choosing the 3-5 “tough” issues that need to be solved in collaboration with our University and Hospital partners so we can be the best we can be as a school.
QUESTIONS BEFORE WE BEGIN?
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Project Overview
Project Summary

- Declaration of a “blue sky” all-mission vision and strategy for the School of Medicine’s next decade
- Development of a distinguished academic strategy that enhances competitiveness of the School’s clinical partners
- Engagement of faculty and staff that respects their aspirations and builds commitment as the process unfolds
- Supporting reorganization design and adoption
- Integration with Master Campus Plan and Philanthropy

“If we were starting over as a School of Medicine today – with 2,250 faculty and $1.0 billion in revenue – how should we organize ourselves to have maximum success in each of our missions: research, clinical practice, education and community service by 2020?”

Richard D. Krugman, MD, State of the School; November 17, 2011
Navigant Team

Christine Malcolm
Managing Director
Engagement Co-Leader
Clinical Task Force

Andrew Epstein, MD
Managing Director
Engagement Co-Leader
Education Task Force

Charlie Cosovich
Director
Research Task Force
Clinical Task Force

Peggy M. Cella
Director
Community Task Force

Grendel Burrell
Associate Director
Research Task Force

John Hall
Managing Consultant
Analytics and Task Force Support

Advisory Panel of Medical Leadership

- Jointly selected by CUSOM and Navigant, including Deans, chairs, former chairs and/or other leaders
- Selected for their experience and understanding of the issues – and our joint belief that they will be helpful in raising the right issues to address
- Distinguished program builders and innovative thinkers
The planning process extends in two phases from June 2012 to March 2013

PHASE 1 – Blue Sky All Missions – Strategic Direction 2020
1. Envision the Future
2. Develop the Strategy
3. Explore the Strategy
4. Set Strategic Direction

PHASE 2 – Identify Resources Needed. Refine Strategy
5. Develop the Plan
6. Align the System

LEVEL OF ORGANIZATIONAL COMMITMENT TO THE SOLUTION
Setting Priorities: Working with Faculty to Define a Sustainable Mission-Based Future

Contribution to Margin or other Tangible Return

Sustainable advantage and distinction result from alignment across the Missions
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<th>Timing</th>
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<td>7:30 – 8:00</td>
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<td>8:00 – 8:30</td>
<td>Our Journey from the late 1990s to 2012</td>
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<td>1:15 – 3:00</td>
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<td>3:30 – 4:15</td>
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<td>4:15</td>
<td>Next Steps and Closing Dialogue</td>
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CUSOM: A Successful Journey
Mission: Providing Programs of Excellence to Colorado, the Nation, and the World

Founded: 1883
Dean: Richard Krugman, MD
Revenues: $850 million
Organizational Structure: Traditional administration and department/institute structures
Research Funding: $334 million (NIH $162M)

Number of Graduates:
- Medical Students: 156
- Residents/Fellow: 265
- PhD Scientists: 80
- Physical Therapists: 46
- Physician Assistants: 40

Faculty:
- Professor: 468 (18%)
- Associate Professor: 575 (22%)
- Assistant Professor: 730 (27%)
- (Sr.) Instructor: 864 (33%)
- Volunteer Clinical: 2,637 (100%)

Employees: 6,000

MISSION

The mission of the University of Colorado School of Medicine is to provide Colorado, the nation and the world with programs of excellence in:

Education - through the provision of educational programs to medical students, allied health students, graduate students and house staff, practicing health professionals and the public at large;

Research - through the development of new knowledge in the basic and clinical sciences, as well as in health policy and health care education;

Patient Care - through state-of-the-art clinical programs which reflect the unique educational environment of the University, as well as the needs of the patients it serves; and,

Community Service - through sharing the School’s expertise and knowledge to enhance the broader community, including our affiliated institutions, other healthcare professionals, alumni and other colleagues, and citizens of the state.

Source: CUSOM website and internal reports
Note: Mission approved by the Executive Committee and Faculty Senate in January 1993
The Last Ten Years have been Quite Remarkable

World's only completely new education, research and patient care facility and the largest academic health center between Chicago, Texas, and the West Coast.

And now, a partnership that builds scale and provides the foundation for future growth to address intensifying competition, market realities, and health care reform.
The CUSOM and Partners’ Footprint Encompasses a 100 Mile Radius Around the Anschutz Medical Campus

Source: Institution websites
CUSOM Differentiated in Greater Colorado Area as the Only Research Intensive Institution within 250 Miles

Zero Top 100 Medical Schools (by NIH Funding) within 250 miles of CUSOM and only four within 500 miles

Univ. of Utah
NIH Rank: #42
NIH Funding: $101M

Univ. of Nebraska
NIH Rank: #68
NIH Funding: $45M

Univ. of New Mexico
NIH Rank: #69
NIH Funding: $45M

Univ. of Oklahoma
NIH Rank: #74
NIH Funding: $38M

Source: brimr.org, nih.gov
CUSOM is a Top 30 Medical School in NIH Funding

Observations

- Top 30 Medical School in NIH Funding
- Relative ranking of NIH funding has been trending slightly downward. From #20 in 2006 to #26 in 2011, although From #28 to #26 from 2010 to 2011
- Cracking top 10 from #26 nearly 100% increase Moving from #30 to #20 (20% diff.) is much easier than moving from #20 to #10 (67% diff. in funding)
- Function of per capita productivity and size

Trended Rankings of NIH Funding to US Medical Schools

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<td>Minnesota</td>
<td>Case Western</td>
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2011 NIH Funding to Medical Schools

- $451
- $293
- $176
- $162
- $146

Source: brimr.org, nih.gov
50% of CUSOM Awards Concentrated in 10% of the Departments and Centers/Institutes

**SOM Awards by Department or Center**  
(All awards, including NIH)

- Total CUSOM annual awards exceed $330 million
- CUSOM awards declined slightly from FY10 to FY11  
  *Declined 3%; $344M in FY10 to $334M in FY11*
- Medicine, Pediatrics, and Psychiatry total over 50% of CUSOM awards
- Only two of the top ten Departments or Centers/Institutes (by total awards) grew their award total from FY10 to FY11  
  *Psychiatry grew by 10%, Pathology by 22%*
- Colorado Health Outcomes awards total grew the most out of all Departments and Centers/Institutes  
  *FY11 awards nearly 2.5 times FY10 awards*
- Of the Centers/Institutes, the Cancer Center receives the most awards at 9% of total

**Source:** CUSOM website and internal reports; *July-May Fiscal Year to Date comparison*
In 2007/2008, CU Denver Awarded a Five Year CTSA Grant to Develop and Fund the CCTSI

**Summary:** Coordinated effort of scientists, health care providers, and advocates from two research universities, six health care professional schools, five hospitals, a health care network, and more than a dozen community health programs to speed biomedical discoveries from laboratories to the lives of citizens.

**Institute's five goals:**
1. convert laboratory discoveries into clinical use;
2. bring clinical advances into communities;
3. apply new technologies to deliver personalized medicine;
4. train future researchers; and
5. advance child and maternal health

Dr. Ronald J. Sokol, Principal Investigator for the CCTSI, examines a 14-year-old who is participating in research studies that will translate discoveries into new treatments for cystic fibrosis.

Expecting to impact the health care of all of Colorado's more than 4 million residents and the 1,300 physician practices and 300 hospitals that serve them.

Source: CCTSI website
CUSOM Education and Training Programs are Top 5 in a Number of Specialties

Observations
- CUSOM is ranked a top 5 Medical School in Primary Care but ranked #36 in Research
- UW, UCSF, and UCLA are the only Western U.S. institutions ranked top 15 in Research and Primary Care
- GME (Residents and Fellows) growing at CUSOM, but growth not as robust as two other Western U.S. institutions

Residency/Fellow Matched Positions
(# in 2012 | % increase 2008-2012)

<table>
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<th>2008</th>
<th>2012 Increase</th>
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<tr>
<td>UCSF</td>
<td>417</td>
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<tr>
<td>UW</td>
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<td>Colorado</td>
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<td>UCLA</td>
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Source: National Residency Match Program; US News
Numerous Clinical Accolades for CUSOM Faculty and Partner/Affiliate Institutions - UCH

University of Colorado Hospital
Ranked #1 U.S. Academic Medical Center
Ranked #1 Hospital in Denver

2011 National Quality Leadership Award
Quality & Accountability Study

Same Four Institutions Repeated in Many of the Rankings:

Source: U.HC; U.S News
Numerous Clinical Accolades for CUSOM Faculty and Partners/Affiliates – Children’s Hospital Colorado

Children’s Hospital Colorado was recently named as one of only 12 Honor Roll Children’s Hospitals in the US, and is nationally ranked in key specialties.

### 2012 Rank

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<th>2012 Rank</th>
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<th>Cardiology &amp; Heart Surgery</th>
<th>Diabetes &amp; Endocrinology</th>
<th>Gastroenterology</th>
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Clinical Enterprise has Flourished Even Within a Fiercely Competitive Market

Greater Denver (Pop. 3.0 M) dominated by three systems: HealthOne/HCA, Exempla, and Centura

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Source: 2012 HealthLeaders Denver Market Overview
Counties Covered: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park, and Weld
Key Cities Covered: Aurora, Arvada, Boulder, Denver, Greeley, and Longmont
Note: Top Spec* refers to number of ranked specialties in US News rankings
Univ. of CO Hospital Favorable Position Among Regional Academics but Strong Local Competition from HealthOne

Comparison of Cost versus Quality from public sources indicates segmentation by system and type of facility

HealthOne/HCA facilities have the strongest position, followed by UC Hospital, Exempla, and finally Centura

Color Key
- Blue: HealthOne/HCA
- Green: Exempla
- Red: Centura
- Gray: Poudre Valley
- Lavender: Memorial
- Orange: Academic
- Tan: Independent

Source: Cost represents hospital cost per adjusted discharge (case mix adjusted [cma] and wage index adjusted [wia]); Quality based on CMS core measures; Source: INGENIX Hospital Benchmarks, www.hospitalbenchmarks.com; The Commonwealth Fund’s – Why Not the Best?
CUSOM is Beginning to Build a Strong Community Presence in the Greater Aurora Area

Community Service

- Colorado Area Health Education Centers Program works to build state-wide network capacity and strengthen academic-community linkages in four core mission areas: Health Careers and Workforce Diversity, Health Professions Student Education, Health Professions Continuing Education and Public Health and Community Education

- School of Medicine faculty and students volunteer thousands of hours to treat the underserved, underinsured and uninsured throughout the community

- School of Medicine faculty perform health consultations and screenings; others serve on boards in health-related organizations

- School of Medicine faculty teach classes throughout the community to inform the public about health education and disease prevention

Technology Transfer and Fitzsimmons

- Colorado and the Denver metro area rank fifth in the nation for commitment to technology industry growth (source: Colorado Bioscience Association)

- For every dollar the school collects from the National Institutes of Health, it returns $2.34 in business activity - the 4th highest return in the country (Families USA Global Health Initiative)

- There are more than 400 bioscience companies in the Denver metro area employing more than 16,000 professionals (Agilent, Amgen, ARCA Biopharma, Array Biopharma, Dhharmacon, Gilead Sciences, GlobeImmune, Replidyne and Roche are just a few of the successful companies that reside in Colorado)

- Sections of the Fitzsimons Life Science District remain vacant, but available space provides the opportunity for CUSOM entrepreneurs

Source: CUSOM website and internal reports
The trajectory for CUSOM over the last decade is remarkable. What is the most important thing we can do to sustain our rate of improvement and growth?

What do you see as the evolving role of the School of Medicine within the University of Colorado Health System? For each mission?

What leadership lessons have been most important to CUSOM’s success?
Case Studies: Innovation
Case Study: Duke University School of Medicine

Innovative Education Models

STRATEGIC INSIGHT

- Core basic sciences taught in first year (instead of first two years) and core clinical clerkships begin in second year (instead of last two years); in third year, 12 months devoted to scholarly investigation

- In 2009, launched a first-of-its-kind Management Leadership Pathway for Residents to groom MD/MBA or MD/MHA physician-executives

  health-system management and operations; financial management and planning; quality improvement and safety; informatics; technology transfer; global strategy and business development; research enterprise management; clinical service enterprise management; and supply chain management

APPLICABILITY TO CUSOM

- CUSOM UME office developing innovative changes to the curriculum based on three guiding principles: (1) learning communities, (2) master educators, (3) longitudinal education

- CUSOM submitted application to become coordinating center for interprofessional education and collaborative practice (CC-IPECP)

ASSOCIATED BENEFITS / CHALLENGES

- UME and GME curriculum innovations differentiate the school

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Source: Duke website
Case Study: Duke-Singapore Graduate Medical School

International Partnership with a Novel Organizational Structure

**STRATEGIC INSIGHT**

- In lieu of departmental structure, research activities organized according to a two-dimensional matrix of biological/clinical themes (signature research programs in the areas of cancer, cardiovascular disease, neurological disorders, eye disorders, and emerging infections) and research modes (discovery, translation, and clinical)
- Group leaders in these areas responsible for developing a portfolio of research activities that, to varying degrees, span the spectrum of discovery biology, translational research, and patient oriented research

**APPLICABILITY TO CUSOM**

- Duke-NUS had the advantage of building the program from scratch; in contrast, CUSOM currently has a traditional departmental structure and would require a transition

**ASSOCIATED BENEFITS / CHALLENGES**

- A new non-traditional organizational structure would require significant cultural change and could ignite unrest

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### Category | Metric
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**Location | Metro Pop.:**
- Singapore | 5.0 M

**US News Medical School:**
- (Research | Primary Care)
  - #9 | #57
  - Duke Figures

**NIH Funding:**
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  - Duke Figures

**US News Medical Center:**
- (Hospital | Children’s)
  - #9 | n/a
  - Duke Figures

Source: Duke website; *A Global Partnership in Medical Education Between Duke University and the National University of Singapore*, Academic Medicine, Vol. 83, No. 2 / February 2008
Case Study: Broad Institute

MIT and Harvard Created Separate Institute to Organize and Support Innovation

**STRATEGIC INSIGHT**

- Mission is to transform medicine by using systematic approaches in the biological sciences and bioinformatics to dramatically accelerate the understanding and treatment of disease
- To fulfill this mission, the founders realized the need for a new kind of research institution, with a collaborative spirit across disciplines and organizations, having the capacity to tackle ambitious challenges
- Organized around Core Faculty Labs, Scientific Platforms, and Scientific Programs
- Key mission is the open sharing of data produced and analytical software tools developed with the entire scientific community

**APPLICABILITY TO CUSOM**

- CUSOM currently has a traditional departmental structure with limited incentive for collaborations and would require a transition on multiple levels: culture, structure, funds flow, infrastructure

**ASSOCIATED BENEFITS / CHALLENGES**

- Systematic approach would focus CUSOM research efforts to collaboratively tackle large-scale scientific questions

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**ORGANIZED AROUND SIX AREAS OF FOCUS**

- Assemble complete picture of molecular components of life
- Define the biological circuits that underlie cellular responses
- Uncover the molecular basis of major inherited diseases
- Unearth all mutations that underlie different cancer types
- Discover molecular basis of major infectious diseases
- Transform process of therapeutic discovery & development

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Source: Broad Institute website
Case Study: Research Networking at Harvard

Chief Technology Officer and Asst. Professor, Griffin Weber MD PhD, Created Profiles

STRATEGIC INSIGHT

- Social media application, “Profiles”, performs targeted searches to find scientists based on expertise, activities, resources, institution, and geography
- Uses network analysis and visualization to reveal and recommend potential internal connections and teams and outside collaborators

APPLICABILITY TO CUSOM

- CUSOM is one of roughly 30 group members of Profiles
- **Colorado Profiles had its official, campus wide announcement this month**
- Therefore, extent of implementation and user satisfaction at CUSOM not yet determined

ASSOCIATED BENEFITS / CHALLENGES

- Collaborations may increase efficiency and productivity, and build teams or an infrastructure for larger funding streams
- Successful collaboration requires significant steps beyond the utility of the application

Case Study: KP Care Management Institute

Clinically Focused System with Expertise in Population Health and Outcomes Management Research

**STRATEGIC INSIGHT**
- Uses epidemiological research, outcomes measurement, guidelines development, and care redesign to develop and implement programs that are evidence-based and focused on meeting needs of members

**APPLICABILITY TO CUSOM**
- Do we have the systems, data, and infrastructure to answer and address the most pressing Population Health questions? If not, should we?
- KP is a fully integrated system and health plan that innately incentivizes the system to practice Population Health; whereas, CUSOM and affiliates are not fully integrated
- KP has a large member base that allows for the mind set and economies of scale to practice Population Health; whereas, CUSOM and affiliates are much smaller, but, with University of Colorado Health, the CU clinical enterprise is growing and now has the foundation to expand its member base

**ASSOCIATED BENEFITS / CHALLENGES**
- Practicing Population Health would require significant investment
- It could also make explicit the value the CUSOM brings to the state and region and close the loop from discovery to improved health

**Do We Have the Systems, Data, and Infrastructure to Answer and Address the Most Pressing Population Health Questions?**

- Are members receiving optimal medications to help prevent heart attacks and strokes?
  - Are heart attacks among members becoming more or less common over time?
- What are the most important factors in preventing hospital readmissions?
  - How many heart attacks and strokes were prevented?
  - How many members are readmitted within 30 days?
  - How many unnecessary hospitalizations and emergency room visits were avoided?

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Source: KP website
For Innovation, Mayo Created a Separate Structure and Business Model in a Protected Environment

**STRATEGIC INSIGHT**
- Goals: (a) understand patient needs, (b) innovate care delivery, (c) foster open collaboration, and (d) generate economic impact
- Focuses on three platforms:
  1. practice redesign: reduce costs by 30% and improve outcomes,
  2. community health transformation, and
  3. care at a distance: extending specialty care beyond traditional hospital/clinic setting

**APPLICABILITY TO CUSOM**
- With similar access to a range of care disciplines and settings, CUSOM has the ability to develop a center for innovation

**ASSOCIATED BENEFITS / CHALLENGES**
- Become a national research leader in care delivery innovation
- Develop platform to foster internal and external collaborations
- Opportunity to leverage experiences and additional scale of newly formed University of Colorado Health and other partners/affiliates

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Source: [www.mayo.edu/center-for-innovation](http://www.mayo.edu/center-for-innovation)
Case Study: Cleveland Clinic Wellness Institute

High Acuity/Complexity Institution Developing a Leadership Position in Wellness

STRATEGIC INSIGHT

- Institute predicated on belief that soaring health care costs can be reined by encouraging, supporting, and incentivizing healthier living
- One of many programs, LifeStyle 180 is a lifestyle modification program that incorporates yoga, cooking, and instruction in stress management for patients with chronic diseases
- Strong support from senior leadership and even designated a Chief Wellness Officer position (Dr. Michael Roizen)

APPLICABILITY TO CUSOM

- As a recent addition to the campus, the Anschutz Health and Wellness Center opened in April 2012

ASSOCIATED BENEFITS / CHALLENGES

- Medical community not paid for health and wellness nor does the NIH allocate significant funds to health and wellness; therefore, there is a need to attract philanthropy and explore partnerships and collaborations: Need to become a nationally renowned center
- Need to ingrain health and wellness into all four missions throughout the Anschutz Medical Campus and among CUSOM’s affiliates

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Source: Cleveland Clinic website
Case Study: Dartmouth-Hitchcock ACO

Selected to Participate in Pioneer ACO Model Sponsored by CMS Innovation Center

STRATEGIC INSIGHT

- Created in mid-2009, Dartmouth-Hitchcock Health allows health service providers in the region to strategically partner with one another in order to improve population health.
- Created core competencies in population health and patient management: created of Chronic Disease Super Registry, developed targeted clinical pathways care process interventions.
- Seven year ACO journey includes multiple CMS pilot programs: achieved savings in all five years, but received bonus payment in only three out of five years, totaling $11 million in performance payouts.

APPLICABILITY TO CUSOM

- CUSOM and University of Colorado Health have the infrastructure and geographic reach to create a State-Wide ACO in CO.

ASSOCIATED BENEFITS / CHALLENGES

- Opportunity to create a sustainable health system and garner additional revenue.
- Requires core competencies in sophisticated data procurement and analytics, care management, and population health.

<table>
<thead>
<tr>
<th>Category</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Metro Pop.:</td>
</tr>
<tr>
<td>US News Medical School: (Research</td>
<td>Primary Care)</td>
</tr>
<tr>
<td>NIH Funding: (2011 Dollars</td>
<td>Ranking)</td>
</tr>
<tr>
<td>US News Medical Center: (Hospital</td>
<td>Children’s)</td>
</tr>
</tbody>
</table>

Source: Dartmouth-Hitchcock website, ACO Interim Report
Case Study: HBS Business Plan Competition

Business Plan Competitions Convene Investors and Entrepreneurs

STRATEGIC INSIGHT

- Contest open to all Harvard MBA candidates as well as eligible graduate students from around Harvard University
- In 2012, eighty teams judged by experts from fields such as venture capital, angel investing, consulting, law, accounting, life sciences, philanthropy, social entrepreneurship, and academia

APPLICABILITY TO CUSOM

- Infrastructure and experience for CUSOM and Leeds School of Business to collaborate and develop a Life Sciences Business Plan Competition hosted at the Anschutz Medical Campus
- CU Boulder (Leeds School of Business) MBA program is nationally ranked and will be hosting the CU Cleantech New Venture Challenge

ASSOCIATED BENEFITS / CHALLENGES

- Builds an entrepreneurial culture among faculty and students
- Convenes faculty and students (and their work and intellectual property) with venture capitalists, angel investors, and entrepreneurs

2012 Business Plan Winner:
Vaxess Technologies
$25,000 First Place Award

The big idea: This venture is working to commercialize a Tufts University technology that stabilizes vaccines into a thin film strip which can be shipped and stored without refrigeration, eliminating the need for a cold chain. Vaxess aims to not only lower the cost of distribution, but also to increase access to life-saving products for people around the world.

As Profiled in Inc. Magazine

Source: Harvard School of Business website
Case Study: UCSF

Chancellor Proposing New Structure for School, Loosening Ties with University

STRATEGIC INSIGHT

- Chancellor Susan Desmond-Hellmann is asking what is the right governance and the right financial relationship between UCSF and the UC system.
- “Looking for two attributes — that it be fair and transparent — so if I’m asking UCSF faculty, staff and students how can we better spend money, I need to be able to tell them this is how that money comes back from the system and this is what it’s being spent on”
- “When we look at our 10-year financial plan, there are a couple of major things to think about: NIH funding, state funding, health care reform even philanthropy for UCSF are under pressure”

APPLICABILITY TO CUSOM

- While UCSF’s approach addresses its particular organizational design and relationships, it presents an innovative structural option for issues that are relevant at CUSOM

ASSOCIATED BENEFITS / CHALLENGES

- May allow CUSOM to get innovations to the public easier and faster

Source: UCSF website; [www.bizjournals.com/sanfrancisco/blog/2012/01/susan-desmond-hellmann-ucsf-uc.html?page=all](http://www.bizjournals.com/sanfrancisco/blog/2012/01/susan-desmond-hellmann-ucsf-uc.html?page=all)
Nationally Ranked Medical Center with a Commitment to Permanent Improvement

STRATEGIC INSIGHT
- UCLA Medical Center led a multi-year strategic transformation of hospital experience – focusing on quality, reliability, service and a patient centered environment. These improvements have been not only sustained, but continue to be improved upon. They have led to national recognition, growth, and financial success.

APPLICABILITY TO CUSOM
- Each of CUSOMs hospital partners are committed to breakthrough quality and seek true partnership with the faculty in so doing. UCLA demonstrates the benefit of this partnership.
- Close collaboration with the University Hospital and Colorado Children’s Hospital will create improved safety, reliability, and quality – and an even more compelling patient experience.

ASSOCIATED BENEFITS / CHALLENGES
“The last decade has been marked with remarkable success, accomplishment and growth. We have participated in the transformation of the Medical Center, and its success – we know that we can accomplish anything we set our minds to, with the right leadership and culture.”

Source: UCLA website; Prescription for Excellence: the UCLA Experience, and NY Times
Case Study: Mayo Clinic Faculty Multispecialty Practice

Pioneered the Integrated Group Practice Over 100 Years Ago

STRATEGIC INSIGHT

- Mayo Clinic’s successes are deliberate
  1) Salary-based compensation fosters team-oriented patient care and peer accountability
  2) Supportive infrastructure allows physicians and other caregivers to excel at clinical work
  3) Physician-led governance structure promotes a patient-centered culture
  4) Full integration of the hospital and clinic and the use of a shared electronic medical record across inpatient and outpatient settings critical to realize efficiencies and promote clinical excellence

APPLICABILITY TO CUSOM

- UPI currently an MSO with the opportunity to become an integrated multispecialty group practice

ASSOCIATED BENEFITS / CHALLENGES

- Developing a distinct culture, infrastructure, and strategy may allow UPI to improve clinical outcomes, patient experience, and patient value


## Category | Metric
--- | ---
Location | Rochester, MN | 0.2 M
Metro Pop.: MSA: Rochester, MN | | | 0.2 M
US News Medical School: Research | #27 | #31
Primary Care | | |
NIH Funding: 2011 Dollars | $194 M | #18
Ranking | | |
US News Medical Center: Hospital Children’s | #3 | n/a
Imagine a Case Study of CUSOM in 2020.

What would you like it to say?
Emerging Context for Medical Schools and Academic Clinical Enterprises
Setting the Stage: *High Cost, Not High Value*

**Health Care Expenditures by Country**

2008 *per capita Healthcare Expenditures and as a % of GDP*

Among these developed nations, the U.S. is the highest cost (on both a per capita and a % of GDP basis), yet has the lowest life expectancy at birth.
# The World is Changing Rapidly for Health Systems and Academic Health Enterprises

Increasing Volatility and Complexity…Across All Missions

<table>
<thead>
<tr>
<th>Macro Economic Factors</th>
<th>1. Impact of demographic and disease burden trends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Increasing health care as percent of GDP, and highest cost globally</td>
</tr>
<tr>
<td></td>
<td>4. Health care reform and changing payment models, flat NIH funding, scrutiny on costs and impact of research</td>
</tr>
<tr>
<td></td>
<td>5. Growing regulatory burden and increased transparency</td>
</tr>
<tr>
<td></td>
<td>6. Natural disasters</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Science and Technology Trends</th>
<th>7. Growth in interdisciplinary and team science</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8. Growth of comparative effectiveness research and implementation science</td>
</tr>
<tr>
<td></td>
<td>9. HIT adoption/proliferation, evolving into database/statistical science, digital revolution</td>
</tr>
<tr>
<td></td>
<td>10. Blurring boundaries among academia, industry, government, and funders</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Workforce and Education Trends</th>
<th>11. Generational shifts in leadership, faculty, staff, residents, and students</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12. Physician/nurse shortages and resident work hours</td>
</tr>
<tr>
<td></td>
<td>13. Team-based care and education/training</td>
</tr>
<tr>
<td></td>
<td>14. Diversity shifts in patients, trainees, and faculty/staff</td>
</tr>
<tr>
<td></td>
<td>15. Evolution of maintenance of licensure and certification</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Trends</th>
<th>16. Growing payer concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17. Increased focus on outcomes, reliability, safety, cost and the patient experience</td>
</tr>
<tr>
<td></td>
<td>18. Increasing emphasis on prevention and population health</td>
</tr>
<tr>
<td></td>
<td>19. Health system consolidation and physician acquisition</td>
</tr>
<tr>
<td></td>
<td>20. Emergence of accountable care organizations to improve quality and reduce waste</td>
</tr>
<tr>
<td></td>
<td>21. Migration to lower acuity/cost settings</td>
</tr>
</tbody>
</table>

### Academic Medicine Also Impeded By Structure and Culture

- Hierarchical structures lacking flexibility
- Intricate organizational culture and decision-making
- Slow to adapt
- Less efficient than competing provider institutions
Patient Protection and Affordable Care Act (PPACA) Changed the Conversation

“What got you here, won’t get you there!”

2009

March 2010: U.S. Congress Passes Historic Affordable Care Act

Productivity / reimbursement compression

2010

Medicare productivity adjustments commence

2011

Medicare Reimbursement cuts

2012

2013

2014

2015 +

March 2010: U.S. Congress Passes Historic Affordable Care Act

Medicare Reimbursement cuts

Value Based Payments

Alternative Quality Contracts Example of “Competition Preempting Reform”

Medicaid withholds

ACO & Medicare Shared Savings

Medicare Value-Based Purchasing

Bundled payments

Wellness rewards

HAC penalties

Meaningful Use incentives

Insurance

National High Risk Pool Interim Reform (lifetime limits, annual limits, rescission restrictions, etc)

Insurance Reforms
- Guaranteed Issue Mandates
- Exchanges
- Subsidies, Tax credits
- Insurer Tax

Cadillac Tax
The AAMC National Readiness for Reform Assessment Revealed a Lack of Readiness Across All Missions

AAMC Assessed Nine Categories Across Missions

- Obviously, some institutions are more prepared than others in selected categories, but National results indicate the AAMC members are not ready for reform in many of the categories assessed.
- Readiness for reform in the Education mission is further along than the Research mission, followed by the Clinical mission.

Source: AAMC Readiness For Reform Assessment Results, Conroy, Enders; January 2011
Increased Integration of the Research Mission with the Care Delivery System

- (We are creating) an Informatics Division in an academic department and the recruitment of faculty informaticians to conduct research utilizing our system's electronic health information.
- Reform needs to focus on high cost, unfunded or underfunded health delivery systems (trauma, burn, adult critical care) with safety net programs.
- (We) expect increased focus on translational health services research and comparative effectiveness studies of treatment alternatives, especially surgical vs. non-surgical approaches.
- We have incorporated CER into our annual operating plan. We are part of a multi-institutional CTSA affiliation.
- We are currently implementing an EHR and anticipate and are working through issues related to integrating research findings into practice guidelines and improvements.
- We are in the process of forming an institute for Public Health & Health Services Research. This institute will formally link our research mission in health services with our care delivery systems.

Medical Education

- The Hospital & University have begun a Patient Safety Education Committee that meets monthly and has the following goals:
  1. Provide innovative institutional oversight for Patient Safety & Quality to Residents
  2. Recommend to GMEC, QI methods which align with (the hospital and university) quality and patient safety efforts
  3. Support QI methods that integrate patient safety and scholarship
  4. Develop a standard toolkit for resources which promote resident scholarship of patient safety
  5. Encourage faculty development around patient safety
  6. Achieve a national presence for the University in the education of quality and safety
  7. Develop a resident council subcommittee on patient safety
  8. Report on measures/efforts through GMEC.
Care Delivery Innovations

- We created transition managers to coordinate discharges and facilitate transfers to the next level of care.
- Several clinical pathways, spanning the care continuum are at various levels of development (i.e. Patient Centered Care model, structured interdisciplinary rounding, breast cancer care coordination; chest pain care coordination; ED handoff process to/from providers; and short-stay, observation, and care initiation units).
- Our organization recently entered into a collaborative partnership with the local FQHC; this partnership will be key to resident education in primary care as well as access to primary care from the emergency department.
- We participate in the CMS Physician Group. Practice demonstration and we have "ACO" pilots with two private insurers.

Quality Reporting

- Implementing full inpatient modules at present time; ambulatory EMR in place for multi-specialty medical group and faculty clinics; beginning roll out of EMR to affiliated private physicians....
- We currently capture all of the quality data from an EHR; however, we do not REPORT all of our quality data from the EHR - some of the data is abstracted/reported manually; this is a big distinction and believe most facilities are experiencing similar issues.
- We have a data repository for data mining and have begun physician specific pay for performance (and reporting).

Payment Reform

- The CMO has managed over 150,000 lives (more than $750 Million premium revenue) for the past 15 years. CMO has core competencies in Care Coordination, Chronic Disease Management, and Tele-monitoring for this population. Its interventions have demonstrated its ability to reduce medical expense. In addition CMO works with the community on population health initiatives.
- We are working with the (State) Insurance Department on planning efforts to create a State Health Insurance Exchange, and other State agencies to improve patient access.

Source: AAMC Readiness For Reform Assessment Results, Conroy, Enders; January 2011
AAMC Members Comment About Progress/Issues
Readiness for Reform Assessment

Patient Access
- We have 500 PCPs in our 5 hospital network. We have three FQHP that are staffed by our faculty.
- It is our goal to ultimately move toward use of telemedicine and increase opportunity for e-consults once satisfied with security of such communication(s).
- Epic is being implemented, which will allow patients with electronic access to health information. In addition, an ambulatory strategy including ED expansion and satellites will provide greater access for patients.

Community & Patient Engagement
- (We have) started working with nurse navigators and patient navigators in some of our community sites and practice offices. We also have health coaches in a Health Center and Patient Ambassadors in some programs...
- Patient and Family Centered Care is an attribute of our care transformation model. It includes patient and family advisors in committees across the organization.
- Patient participation in our Passport to Wellness pilot program has proven successful and indicated patients can be much more involved in their chronic disease management when given the appropriate guidance and encouragement/partnerships.
- Advancing the health of the community is part of our organizational mission. We have an established Office of Community Health lead by the Chairman of Family and Social Medicine.
- We have a well established department of community health improvement as a component of our Quality Institute. This department serves as a nexus between the delivery system and community based programs. The department compiles an annual community benefits plan that is approved by the Board of Trustees.
- We recognize the need for developing competencies in the area of population management. Our goal is to first develop this capability using our employee base though our health plan.

Source: AAMC Readiness For Reform Assessment Results, Conroy, Enders; January 2011
Preserving both Mission and Margin Poses a Disproportionate Challenge in the Reform Era

Education, Research, and Patient Care

AMCs have fundamentally different cost structures than other types of hospitals due to the added complexities of high acuity services and mission related costs.

<table>
<thead>
<tr>
<th>Estimated Cost Per Case</th>
<th>Academic Medical Center</th>
<th>Other Teaching Hospitals</th>
<th>Urban Community Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base costs</td>
<td>$3,974</td>
<td>$3,984</td>
<td>$3,993</td>
</tr>
<tr>
<td>Wages and case-mix costs</td>
<td>$2,214</td>
<td>$1,389</td>
<td>$985</td>
</tr>
<tr>
<td>IME and other mission related costs</td>
<td>$2,360</td>
<td>$674</td>
<td>$260</td>
</tr>
<tr>
<td>Total</td>
<td>$8,548</td>
<td>$6,047</td>
<td>$5,238</td>
</tr>
</tbody>
</table>

Negative margins in research and education missions are subsidized by positive margins in clinical services.

Financial cuts to clinical mission will put added pressure on financial support for education and research missions.

Why focus on the clinical mission? Although the education and research missions are what differentiate and define academic medicine, the clinical mission drives the margin, and therefore, when discussing financial viability and strategic planning, the clinical mission is at the forefront of the conversation, especially during a time of acute fiscal pressures.

CUSOM Revenues Driven by Clinical Mission

- Similar to other AAMC institutions, CUSOM revenues driven by clinical sources (50%) followed by research support (30%)
- In the past, revenues doubled every ten years; nevertheless, just in the past several years, growth has weakened, especially in the Practice Plan (blue) and Grants & Contracts (green)

AAMC National Data Revenue Sources

CUSOM Trend in Revenue Sources (1982 – 2011)

Drastic Payment Reductions to AMCs Threaten Support for the Academic Mission

Most of Our AMC Clients Forecast a Medicare “Cliff”

Some have assumed $15 - 25M of new costs because of new resident work rules, not accounted for in this model.

What is the business plan for academic medicine in this environment?

Source: Navigant Client Data
Historically, CUSOM Margin has been Slightly Below Break Even

- Historically, CUSOM margin slightly below break-even
- Over the past five years, both revenues and expenses growing at same rate (roughly 7%)
- Future pressures on clinical revenue and research support could decrease margin substantially, unless diminished growth/decline in revenues are tracked by a similar movement in expenses

What if annual growth in revenue dropped to 4% and growth in expenses were maintained at 7%?

$100 M loss by 2015

CUSOM Trended Net Income [Margin]

Source: CUSOM website; LCME Part I-A Annual Financial Questionnaire on Medical School Financing – Revenue and Expenditure History Five Year Trend
Note: FY2009 bump due to Tobacco settlement funds and Stabilization funds, as well as improvements in productivity and contract rates for practice plan
Insurance Reform Likely to Exacerbate Physician Shortages in Colorado

Increasing demand for care will require new approaches to educating health professionals; research supported transformative care, an aligned and integrated clinical delivery system, serving the increased health needs of the community.

As the state’s only medical school, CUSOM will face significant pressure to respond to provider shortages for the people of Colorado

What is the likelihood (and risk) of a new medical school in Denver?

Recent experience: Massachusetts has an oversupply of physicians, yet now that health reform is implemented, over half of all primary care practices are closed to new patients – especially new Medicare and public payer patients.

CUSOM is a Regional Resource: Retention of Residents in the Region is Key

- **Low per capita physician supplies** in surrounding states.
- **Below-median primary care residents** in Colorado and surrounding regions.
- **Retention of residents** is above the median in Colorado and better than in the surrounding states.

Source: United Health Foundation. America’s Health Rankings, 2011
Growing Pressures and Competition May Define the Research Enterprise in the Foreseeable Future

Research Operations Include Internal and External Pressures and Competition

- Securing grants and funding from government and industry
- Managing the Institutional Research Board (both efficiency and cost structure)
- Publishing articles (increasing quantity and improving quality by publishing in the most “prestigious journals”)
- Competing for institutional capital expenditures to expand and improve facilities and technology
- Increased burden of administrative duties over scientific work
- Growing need for expertise in new fields, such as informatics

An increasing percentage of total research funding may come from private funding from industry

Adjusted for inflation, NIH funding decreasing

If sequestration is triggered in January 2013, NIH funding will be cut by 9.1% (or $2.8 billion)

PhRMA Member Health R&D Funding Outpacing NIH Funding

Research Context Shifting: Implications for Science, Community, and Clinical Partners

While there is strategic advantage in a broad spectrum of scientific and scholarly inquiry, financial pressures and slow growth in NIH funds coupled with financial incentives from alternative sources provide incentives for implementation science.

What is the research spectrum for CUSOM in 2020?

Traditional individual investigator basic science research

Clinical quality, community health improvement and health outcomes research
Each day, there are 7,000 new Medicare beneficiaries

- Chronic conditions account for a majority of Medicare spending growth
- The aging US population will continue to drive up the rate of chronic conditions, requiring a more robust continuum of care
- Five chronic diseases—heart disease, cancers, stroke, COPD and diabetes—account for two-thirds of all deaths in the United States and chronic diseases account for 75 percent of national total health care costs
- A third of total US health care spending is due to expenses in the last year of life
- Current health care infrastructure, which is designed to treat acute illness, is not effective at treating chronic illness and addressing personal behaviors associated with poor health

Source: US Census Bureau; AHA Cost of Caring Report, AMA Health Care Trends
“Triple Aim” Philosophy Provides a New Paradigm

“The Best Care, for the Whole Population, at the Lowest Cost”

**Metrics:**
- QUEST outcomes
- Select HEDIS metrics
- Health status
- Mortality rates

**Population Health**

**Metrics:**
- Patient satisfaction
- Patient Activation Measure scores

**Experience of Care**

**Metrics:**
- Total medical PMPM
- Total Medical Trend
- Total Rx PMPM
- Admissions/1000
- Readmission rate

**Per Capita Costs**

Source: The term “Triple Aim” is a trademark of the Institute for Healthcare Improvement
A Barrier to “Triple Aim” - Health Care is Fragmented and Navigation is Difficult

Historical Model
- Patients and their families must coordinate services and navigate between programs and sites of care on their own.

Future Model
- Care organized around the patient and coordinated across the continuum.
- Navigation between services and sites of care is proactively facilitated and managed by providers for the patients and their families.
“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

A 2003 Study found that adults in the US received 54.9% of recommended care:
- Acute care – 53.5%
- Chronic conditions – 56.1%
- Preventive care – 54.9%

AHRQ has been tracking progress on improvement, finding that practice is slow and uneven – major deficits remain.

“for individuals and populations ...”

Results of a Reanalysis of the Monthly Prevalence of Illness in the Community and the Roles of Various Sources of Health Care

ProvenCare™

Bundled flat rate pricing for CABGs “Surgery with a warranty”

Results in the first year of implementation

- 86% to 100% compliance w/standards
- 80% reduction in InHospital mortality
- 13% overall complications reduction
- 40% reduction in neurologic complications
- 61% reduction in reintubation
- 19% reduction in 30 day readmission rate (6.9 to 5.6%)
- 16% ALOS decline (6.3 to 5.3 days)
- 5% reduction in hospital charges

Other modules in development: cataract surgery, PTCA, knee replacement, low back pain, prenatal care and bariatric surgery

Source: Geisinger Health System
UHC Has Shown That The Populations Required to Support Subspecialty Tertiary/Quaternary Care are Vast

<table>
<thead>
<tr>
<th>Financial Core Business</th>
<th>Median AMC Program Volume</th>
<th>Incidence Per 1,000 Population</th>
<th>“Covered Lives” Required</th>
<th>Ambulatory Encounters to Manage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craniotomy (bleeds/implants)</td>
<td>80</td>
<td>0.08</td>
<td>1,038,961</td>
<td>4,155,844</td>
</tr>
<tr>
<td>Heart Transplants</td>
<td>30</td>
<td>0.01</td>
<td>4,285,714</td>
<td>17,142,857</td>
</tr>
<tr>
<td>Cardiac Valves</td>
<td>165</td>
<td>0.31</td>
<td>532,864</td>
<td>2,131,455</td>
</tr>
<tr>
<td>Brain Cancer</td>
<td>75</td>
<td>0.06</td>
<td>1,171,875</td>
<td>4,687,500</td>
</tr>
<tr>
<td>Leukemia</td>
<td>85</td>
<td>0.12</td>
<td>696,721</td>
<td>2,786,885</td>
</tr>
</tbody>
</table>

Population management is blunt instrument to protect complex core – high risk / low reward unless systemic overhaul of delivery system occurs

Source: UHC
Ambulatory Quality Categories in a Leading AMC Group

- Clinical
  - Adult (Diabetes, Hypertension, CAD, Depression, Cancer Screening)
  - Pediatrics (Well baby visits, Adolescent wellness, Asthma)
  - Population Health (Obesity, Smoking)
  - Others (Anticoagulation, Intravascular Devices, Anticonvulsants)
- Patient Experience
  - Others (Anticoagulation, Intravascular Devices, Anticonvulsants)
- Patient Safety
  - Medication Reconciliation, Post Hospital follow up, Post ED follow up, test notification, referral communication
- Operations Quality
  - Access, pre-visit testing, after visit summary (including time to completion and availability)
- Learning and Teaching Environment
  - Academic detailing, CME, GME

Preventive Care Measures for 200,000 Patients

<table>
<thead>
<tr>
<th>Preventive Care Measures for 200,000 Patients</th>
<th>11/07</th>
<th>7/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Preventive Bundle</td>
<td>9.2%</td>
<td>28%</td>
</tr>
<tr>
<td>Breast Cancer Screening (q 2 40-49, q 1 50-74)</td>
<td>46%</td>
<td>61%</td>
</tr>
<tr>
<td>Cervical Cancer Screening (q 3 yr Age 21-64)</td>
<td>64%</td>
<td>74%</td>
</tr>
<tr>
<td>Colon Cancer Screening (Age 50-84)</td>
<td>44%</td>
<td>63%</td>
</tr>
<tr>
<td>Prostate Cancer Discussion (Age 50-74)</td>
<td>72%</td>
<td>75%</td>
</tr>
<tr>
<td>Lipid Screening (Every 5 yr M &gt; 35, F &gt; 45)</td>
<td>75%</td>
<td>85%</td>
</tr>
<tr>
<td>Diabetes Screening (Every 3 yr &gt; 45)</td>
<td>85%</td>
<td>88%</td>
</tr>
<tr>
<td>Obesity Screening (BMI in Epic)</td>
<td>77%</td>
<td>96%</td>
</tr>
<tr>
<td>Documented Non-Smokers</td>
<td>75%</td>
<td>78%</td>
</tr>
<tr>
<td>Tetanus Diphtheria Immun. (every 10 yr)</td>
<td>35%</td>
<td>68%</td>
</tr>
<tr>
<td>Pneumococcal Immunization (Once Age &gt;65)</td>
<td>84%</td>
<td>86%</td>
</tr>
<tr>
<td>Influenza Immunization (Yearly Age &gt;50)</td>
<td>47%</td>
<td>57%</td>
</tr>
<tr>
<td>Chlamydia Screening (Yearly Age 18-25)</td>
<td>22%</td>
<td>35%</td>
</tr>
<tr>
<td>Osteoporosis Screening (every 3 yr Age &gt; 65)</td>
<td>52%</td>
<td>73%</td>
</tr>
<tr>
<td>Alcohol Intake Assessment</td>
<td>84%</td>
<td>89%</td>
</tr>
</tbody>
</table>

Source: 1. Atrius, 2. Geisinger
Institutions must address how to optimize performance in the current environment while also preparing to “jump” from Curve #1 to Curve #2.

**Curve #1: FEE-FOR-SERVICE**
- All about volume
- Reinforces work in silos
- Little incentive for “real” integration

**Curve #2: VALUE-BASED PAYMENT**
- Achieving “Triple Aim”, as per IHI:
  - Better Care Experience for Individual
  - Better Health for Populations
  - Lower Per Capita Costs

Clinical example depicted here, but the Two Curve Challenge relates to the Research and Education missions as well.

Source: Futurist Ian Morrison; Institute for Health Improvement
These Major Trends, Combined with the Poor Economic Conditions, Mean that Academic Medicine will Face a Period of High Volatility and Complexity
The financial driver for medical schools and teaching hospitals has been well-reimbursed subspecialty medical care. This business model has changed.

- Fiscal pressures (Federal and State Budget Crisis, Reform Milestones, Unsustainable Rise in Costs) expected to strain revenues and financial support across missions, necessitating medical schools and academic clinical enterprises to rethink their financial model and competitive position.

- In order to successfully implement the Triple Aim, institutions will need to undertake an arduous and dramatic transition to a Curve 2 business model (value-based payment versus fee-for-service), that requires true clinical integration and incentive structure alignment, culture change, and a new, aligned infrastructure to manage population health.

- Research expanding scope of work: informatics, population health, health services research, translational, comparative effectiveness research, etc.

- Physician shortages (especially primary care) expected to continue as reform milestones extend insurance coverage
What will be the impact of these forces on CUSOM?

Do you think your work will be affected more or less than the work of your colleagues?

What changes are you making or will you need to make to address these major environmental shifts?
An Ambitious, Achievable, and Transformational Future:

“Stand and Deliver” Table Reports

1. Aspirational Vision
2. Innovation Focus
3. Overcoming Economic Barriers
Opportunity to Continue Paving the Path to a Bold Future

History
Last ten years have been remarkable

Other Top Tier Medical Schools
Are also attempting to chart a bold future

The Emerging Context for Medical Schools
Fiscal pressures are straining the missions that may require schools to rethink their business models and/or engage in cost reductions

The CUSOM Future
Bold directions required to maintain CUSOM’s ambitious and transformational trajectory

10 Years From Now
Will we take a path as bold as during our previous 10 years?
## Retreat Schedule

### July 24, 2012

<table>
<thead>
<tr>
<th>Timing</th>
<th>Topic</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 – 8:00</td>
<td>Breakfast</td>
<td></td>
</tr>
<tr>
<td>8:00 – 8:30</td>
<td>Our Journey from the late 1990s to 2012</td>
<td>Dean</td>
</tr>
<tr>
<td>8:30 – 10:30</td>
<td>The Case For Change</td>
<td>Navigant</td>
</tr>
<tr>
<td><strong>10:30 – 11:00</strong></td>
<td><strong>Break</strong></td>
<td>**</td>
</tr>
<tr>
<td>11:00 – 12:30</td>
<td>Workshop Session with Mission Groups</td>
<td>Navigant</td>
</tr>
<tr>
<td><strong>12:30 – 1:15</strong></td>
<td><strong>Lunch</strong></td>
<td>**</td>
</tr>
<tr>
<td>1:15 – 3:00</td>
<td>Workshop Session with Mixed Mission Groups</td>
<td>Navigant</td>
</tr>
<tr>
<td>3:00 – 3:30</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>3:30 – 4:15</td>
<td>Task Force Chair Panel Debriefing</td>
<td>Navigant</td>
</tr>
<tr>
<td>4:15</td>
<td>Next Steps and Closing Dialogue</td>
<td>Dean</td>
</tr>
</tbody>
</table>
Vision 2020

Our Picture of the Future
Sustainable advantage and distinction result from alignment across the Missions.

Optimize
Invest to Grow
Redeploy
Fix Profitability / Fill Excess Capacity
Workshop Session One: In Mission Groups

• Consider:
  – What is the big picture in your Mission?
  – Where is your field going?
  – What innovations exist on campus? Externally?

• Given that:
  – What are you most passionate about?
  – At what can you be (or remain) the best?
  – What will fuel your economic engine?
Given your knowledge of developments in your Mission, take a few minutes to answer these questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are you deeply passionate about?</td>
<td></td>
</tr>
<tr>
<td>At what can you be (or remain) the best?</td>
<td></td>
</tr>
<tr>
<td>What will fuel your economic or resource engine?</td>
<td></td>
</tr>
</tbody>
</table>
Workshop Session Two: Across the Missions

- What do you have to offer the other Missions?
- What do you need/want from the other Missions?
- At what can you be uniquely the best if organized strategically?
- What will fuel your economic engine?
Take a few minutes to answer these questions, then discuss at your table

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you have to offer the other Missions (be specific)?</td>
<td></td>
</tr>
<tr>
<td>What do you need/want from the other Missions (be specific)?</td>
<td></td>
</tr>
<tr>
<td>At what can you be uniquely the best if strategically organized?</td>
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<tr>
<td>What will fuel your economic or resource engine?</td>
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</table>