Faculty Steering Committee MINUTES

Thursday, September 19, 2013 ● 12:00 Noon ● Daly Center, Room MS 186

Topic	*Presenter*	*Discussion*	*Action Item/Resolution*
1. Call to Order	Jodi Smith		
2. Old Business a. Approval of Minutes from August 2013	Alan Ladd	August 2013 minutes were reviewed by the committee beforehand.	Minutes were approved.
3. Dean's Business a. General Update	Jay Hess	The Dean updated the committee on his vision and plan for the School of Medicine as he begins his tenure as Dean. The Dean highly recommended the committee read the article "Transforming Academic Health Centers for an Uncertain Future" in the NEJM by Victor J Dzau, MD (see attached).	
4. Committee Report a. Faculty Development Coordinating Committee	Curtis Wright	Curtis presented the annual report for the FDCC (see attached).	
5. President's Business a. Nominations Committee	Jodi Smith	Per IUSM Faculty Constitution, the nominations committee will consist of • President-Elect – **Abigail Klemsz** (chair) • Immediate Past President – **Jerry Young** • EAD for OFAPD – **Steve Bogdewic** (Ex-officio) • "no fewer than 3 voting faculty members appointed by the President"	1. Alan Ladd, Michael McKenna, and Chandru Sundaram were selected to serve on the nominations committee. 2. Gabi Waite will talk to center directors to determine if there was any basic science faculty from a regional campus to serve.
6. New Business a. IFC Representatives	Jodi Smith	Based on the IUPUI Policy regarding the composition of the IUPUI Faculty Council (IFC), IUSM has 3 ineligible faculty members on the IFC and they need replaced. They are ineligible because they are clinical track faculty.	1. The FSC decided that Jodi will ask Karen Lee (Coordinator for Faculty and Staff Councils) for an exception to policy for this AY and allow Emily Walvoord, Abigail Klemsz and Thomas Birdas serve as part of the 13 IUSM positions. 2. It was also decided the FSC should identify a plan to initiate an amendment to the IUPUI Faculty Constitution to allow Non-tenure track faculty to serve on the IFC.
7. Questions and Adjournment	Jodi Smith		

Transforming Academic Health Centers for an Uncertain Future

Victor J. Dzau, M.D., Alex Cho, M.D., M.B.A., William ElLaissi, M.B.A., M.H.A., Ziggy Yoediono, M.D., M.B.A., Devdutta Sangvai, M.D., M.B.A., Bimal Shah, M.D., M.B.A., David Zaas, M.D., M.B.A., and Krishna Udayakumar, M.D., M.B.A.
N Engl J Med 2013; 369:991-993September 12, 2013DOI: 10.1056/NEJMp1302374

Article
References

Academic health centers (AHCs) have long led the advancement of science and medicine by pursuing missions of clinical care, research, and education. AHCs have been places where important fundamental and translational research is performed and medical innovations are created and tested. Given the dramatic changes ahead in health care and deteriorating research funding, can this record of achievement continue, or do AHCs in the United States face a growing risk of extinction?[1]

Despite their substantial societal value, these centers have an uncertain future. The health care landscape is changing rapidly owing to the Affordable Care Act, state budget deficits, and private insurers' responses to pressures to constrain cost growth. Reductions in Medicare and Medicaid reimbursement, strategies for driving health plan enrollees to lower-cost providers (e.g., having narrow networks and tiering network providers), and elimination of government funding (e.g., payments for hospitals treating a disproportionate share of low-income patients) all put pressure on AHCs.

AHCs face additional challenges specific to their research and education missions. Today, the costs of research exceed the “soft money” available to support it: for every dollar of direct federal research support, an additional 30 to 40 cents is needed from institutional resources beyond the federally negotiated indirect-overhead recovery. Total support for research will probably decline as deficit reduction becomes even more of a government priority, National Institutes of Health funding is constrained by budget cuts, industry sponsorship of research wanes, and philanthropic organizations struggle to return to pre-recession contribution levels.[2] Some portions of the research and teaching missions of AHCs are currently supported by revenues from clinical activities, but shrinking margins on clinical care revenues put this support model at risk.

Looking ahead, there is a risk of what a PricewaterhouseCoopers report termed a “margin meltdown.”[3] A growing gap between the excess costs of fulfilling AHCs' academic missions and the available funding will jeopardize the integrity of those missions. In short, profound changes are needed in AHCs' organization and operations.[4]

The transformation will require both rethinking and staying true to AHCs' core missions. Must AHCs be more selective about areas in which they aim to excel? Are they structured appropriately and optimally sized? Are their current measurements of success appropriate? Are planning and decision making for their academic and clinical missions appropriately aligned?

One key consideration will be balancing specialized clinical excellence and population health. Excellence in tertiary and quaternary care has been critical to AHCs' success. However, as large national employers and insurers seek best-in-class care, partly through “centers of excellence” designations, and as even subspecialty health care becomes commoditized, we believe that AHCs must build up highly differentiated programs of distinction — world-class, cutting-edge, highly specialized clinical programs that are leveraged and integrated with translational research and advanced training. Such programs should be capable of producing game-changing advances and delivering superlative care. Of course, achieving this goal will not be easy. To increase the chances of success, AHCs must play to their strengths and adopt clear strategies, prioritization, and implementation.

Simultaneously, AHCs will have to become higher-performing regional health systems, spanning the spectrum from community-based and primary care to highly specialized hospital and post-acute care, all linked by effective information systems. Greater clinical integration is needed among hospitals, faculty, and employed and unemployed community-based partners; such integration may be achieved through formal arrangements conducive to improving the consistency, efficiency, and quality of care for individual patients, as well as health outcomes for populations. To improve performance, we believe that AHCs should refocus their efforts on their tripartite mission, and we suggest four approaches to doing so. First, AHCs should leverage their university affiliations and redesign care delivery, drawing on insights from health and behavioral economics, psychology, sociology, policy and management, industrial engineering, and computer science.

Second, we believe that AHCs will need to increase the yields of research, accelerating the translation of results into practice and boosting their impact on medicine and health. Doing so will require establishing an effective “discovery-to-care continuum”[4] to facilitate more seamless translation, by creating structures integrating centers of clinical and translational research with offices of program management, regulatory affairs, education and training, biostatistics and biomedical informatics, and central biobanking, among others. Such structures can catalyze interdisciplinary collaborations and assemble resources into shared core services and facilities that offer natural economies of scale. More should also be done to foster a strong culture of innovation and reward entrepreneurship.

AHCs should also seek to optimize the size of their research enterprise. Specific areas of research excellence could be emphasized, and support for unfunded research rationalized. AHCs should develop meaningful measures of research success that are related to scientific and societal impact rather than to funding obtained or articles published. Dedicated grant-application resources could also be created, and more structured mentoring provided.

Intrinsic assets of AHCs, such as access to biologic samples and clinical data, should be better leveraged. In the Big Data era, AHCs should strive to become “learning health systems” by making clinical data “research grade” and lowering the costs of data acquisition and knowledge generation. Our institution, like many others, has migrated to a single comprehensive electronic health record platform, which allows us to convert health data from a byproduct of care delivery into a central asset for

improving research and translation.[5] The data-and-technology revolution also offers new ways to engage patients, through e-health, mobile devices, and increased personalization driven by advanced analytics.

It's likely, however, that AHCs cannot make this transition to true learning health care alone. We therefore recommend that AHCs seek new research and other collaborations with diverse partners — including nonmedical university disciplines, industry, and businesses — and engage in public–private partnerships and multisite collaboratives.

Third, we're convinced that medical education and training must be reinvented to adapt to the changing health care paradigm. We think that AHCs should reexamine traditional beliefs and approaches to medical education, questioning its cost and duration. Should education shift toward using dedicated instructors, increased online instruction, simulation, even gaming? Can AHCs shorten training time by streamlining the educational continuum — for example, providing a focused 3-year medical school curriculum in primary care, plus a 2-to-3-year residency?

AHCs would also be well advised to expand beyond their focus on physician education and think more expansively about programs for other health professionals and about emerging areas such as population health management, clinical informatics, and leadership and management. Robust interprofessional education will be important, since health system performance will increasingly depend on high-functioning, team-based approaches to care. Health care reform's success will depend on modernization of health education so that students and trainees learn transparency and accountability while developing competencies in social determinants of health, health economics, and informatics.

Fourth, we believe that AHCs require enterprise-wide planning and management to prepare for their uncertain future. The PricewaterhouseCoopers report highlights AHCs' decentralized structures as a barrier to their ability to respond to these challenges.[3] AHCs are complex organizations — amalgamations of health care units with traditional departments, disciplines, and thematically organized research institutes. Such decentralization has permitted innovation, but a culture of faculty individuality and autonomy can conflict with the imperatives of team-based care and regulatory compliance. In true enterprise-wide planning and management, leaders, faculty, and administrators from throughout the enterprise would engage in coordinated planning to affirm, align, and prioritize specific aspects of their institution's missions; develop clarity about decision rights and accountability; and agree on and implement changes that enable long-term sustainability and success. They must ensure that critical decisions and tradeoffs — such as priority setting regarding faculty hires or allocation of clinical and research support in a resource-constrained setting — are made collaboratively and serve the entire institution's long-term interests.

AHCs urgently need to reexamine their approaches, challenge sacred cows, and prepare for transformation. Above all, as they pursue these new directions, AHCs must remain accountable to society both locally and globally.

Balancing AMCs' Missions and Health Care Costs — Mission Impossible?

Elizabeth G. Nabel, M.D., Timothy G. Ferris, M.D., M.P.H., and Peter L. Slavin, M.D.
N Engl J Med 2013; 369:994-996September 12, 2013DOI: 10.1056/NEJMp1309179

Article
References

When major provisions of the Affordable Care Act (ACA) are implemented next January, few institutions will feel the pressure to control costs more acutely than academic medical centers (AMCs), which must balance the imperatives of clinical care with cost-intensive missions in research, teaching, and community health. Massachusetts AMCs don't have to guess at the law's likely impact: in 2006, our state launched its own health care reform involving principles and policy solutions similar to the ACA's. Massachusetts therefore provides a laboratory for gauging the effects of such reforms.

Having largely solved the insurance problem, Massachusetts passed sweeping cost-control legislation in 2012, including setting a target ceiling on growth of total medical expenses. Although Massachusetts' health care costs are among the highest in the country in absolute terms, they're among the lowest when adjusted for cost of living (see maps

Average Premiums for Employer-Based Insurance Plans for Population Younger than 65, as Percentage of Median Household Income, 2003 and 2011.

).[1] Nonetheless, AMCs' share of hospital admissions is higher in Massachusetts than in any other state, and AMCs' costs are typically higher than those of non-AMC providers.[2] As a national hub for medical research and education, Massachusetts must carefully limit the growth of health care costs without undermining the future of this important resource.

At the state's two largest AMCs, we've addressed this challenge in part by using known methods for improving access, continuity, and care coordination, relying heavily on data and measurement.[3] We call this approach population health management, and implementing it poses different risks and challenges for AMCs than for others. Balancing efforts to contain costs against investment in our missions involves trade-offs among important goals. We view meeting this challenge as a key contribution we can make to health care's future.

In 2011, Brigham and Women's Hospital (BWH) and Massachusetts General Hospital (MGH), through Partners HealthCare, chose to participate in risk-based contracts with commercial payers and the Centers for Medicare and Medicaid Services as a Pioneer

Accountable Care Organization. Under these contracts, we share financial risk for the increase in total medical expenses for patients who see primary care physicians (PCPs) in our network. If our cost growth exceeds that of a comparison group, we pay penalties; if it's lower than that group's, we share in the savings. These contracts cover more than 400,000 patients — more than one third of the patients who receive care in our hospitals annually. In addition to the financial incentive, these contracts help us restrain cost growth by providing a measuring stick to assess our progress in developing and deploying innovative care-delivery processes that are more efficient and more satisfying to patients and that result in higher-quality care.

We've focused first on primary care as the hub for managing populations' care through preventive services, care for chronic illnesses, and care coordination for high-risk patients. We're expanding our cadre of employed PCPs and advanced practice nurses and are committed to ensuring that all our primary care practices become certified by the National Committee for Quality Assurance (NCQA) as Patient-Centered Medical Homes. So far, about 350 providers are engaged in practice redesign, and six lead practices have achieved NCQA recognition.

The most expensive component of this expanded investment is 71 “high-risk care managers” who work closely with PCPs, each coordinating the care of approximately 200 high-risk patients. This program arose from a successful Medicare demonstration project started at MGH in 2006 and expanded to BWH in 2009. Independent evaluations have found cost reductions of 2.5% to 19% for the care of multiple successive cohorts of enrollees — for total taxpayer savings of more than $50 million. The nearly three-to-one return on investment has made this program the centerpiece of our efforts and given us greater confidence to take on further cost-containment challenges.

Unlike the failed managed-care efforts of the 1990s, our initiatives involve our specialists as well. Specialists' decisions drive a large fraction of costs, especially for commercially insured populations. Having assessed our primary care population's unmet needs, we're adding clinical staff in such areas as mental health, general cardiology, dermatology, and physical therapy. We are changing the way we provide care, using innovative approaches such as referral management, virtual visits, one-time home nursing visits, team-based care, and home telemonitoring. We have a process for actively reviewing and redesigning the way we deliver care, condition by condition, that emphasizes optimizing the patient's care experience (continuity of information, management plan, and relationships) and the efficient delivery of services throughout an episode of care. For example, we've reduced admissions for transient ischemic attacks by making the required testing immediately available for outpatients; we've improved diabetes care by automating referrals to diabetes counselors; and we've begun reviewing specialist referrals to identify opportunities for providing consultations without requiring face-to-face visits. Changing these processes presents unique challenges to AMC physicians, partly because care delivery is only one of their responsibilities, in addition to research and teaching.

These changes in clinical process require additional investment in information systems and analytic resources. To ensure consistent clinical communication and assess our progress in population health management, we're consolidating our clinical

and administrative systems onto a single electronic platform. This new infrastructure requires investment, which is not provided by the risk-based contracts, and success in these contracts means lower clinical revenues. Moreover, government payer rates have not kept pace with inflation for more than a decade. Therefore, funding for these new AMC costs must come from growth in regional, national, and international referrals and reductions in our cost structure — a difficult and perennial problem that we are addressing.

A second difference from 1990s managed care is our development of a coordinated process for sharing risk across our AMCs and physician groups. Our performance framework encourages shared practices for managing care for populations rather than holding each physician accountable for individual patient costs. Accordingly, the financial risk shared with payers is held at the level of the integrated delivery system. In turn, we've created an internal incentive system designed to accelerate and reinforce the adoption of primary and specialty care programs and encourage local innovation and strong performance on quality and safety metrics. Each AMC has invested in the infrastructure required for its physicians to meet the internal incentive goals.

Although we have only 18 months of experience with risk-based contracts, our approach is showing promise. Our cost trends have been lower than local and national comparison benchmarks,[4] suggesting that even at the current historically low rates of cost escalation, our efforts are paying off. Nonetheless, challenges and tensions remain — among them, balancing the imperative of cost-efficient, high-quality clinical care with our research, education, and community health missions, especially as federal budget cuts and payment rule changes impose substantial pressure. We do not yet have solutions to these difficult challenges, but we're committed to innovative approaches to solving them.

Fortunately, our teaching mission is wholly compatible with our care-delivery changes: we are educating providers and physicians-in-training about the future of clinical care. New payment systems encourage a convergence of AMCs' clinical and community health missions: investments in community health have historically been charitable but now promise to reduce medical expenses for affected populations. The impact on basic, clinical, and population-based research is less clear. Innovation distinguishes AMCs, and ensuring that basic biomedical discovery flourishes as we invest in care delivery will require vigilance.

AMCs' complex organizational structures and historical focus on tertiary inpatient care may appear incongruent with success in contracts requiring commitment to change and reduced use of hospital services. Charting our course under the current economic pressures won't be easy. But our AMCs have built their reputations by addressing society's most pressing health care challenges, and today's central challenge is the rising cost of health care. Fortunately, AMCs specialize in innovation. We must now apply that capability not just to scientific aspects of medical care but also to the systems delivering it.

Indiana University School of Medicine
Committee Report Template

Please submit this report to Melody Darnall at mldarnal@iupui.edu.

Committee Name: Faculty Development Coordinating Committee

Committee Chair Name: Emily Walvoord and Jeffrey Rothenberg

Committee Chair Email: ewalvoor@iu.edu and jeffroth@iu.edu

Meeting Frequency: monthly plus intermittent meetings for those involved in Sloan grant

---

What is the mission of your committee?

- To inform the strategic plan for faculty development by actively engaging with OFAPD. This will include evaluation of policies, assistance in reaching a broader group of faculty and the development of novel programs and/or policies crucial for the maintenance of high levels of faculty vitality at the IUSM.

What has your committee accomplished this year?

- High level of participation. Attendance at our 1st 2 meetings this year has been 16/27 and 22/27 members with 17 departments represented. The members are charged with keeping their colleagues informed of FD offerings, bringing faculty concerns to the committee, and assisting with the development of new programs and policies.
- "Tips and Tricks for new Research faculty" was developed and is now posted on both the OFAPD and Research affairs websites: https://faculty.medicine.iu.edu/tipsTricks/index.html
- Feedback was provided to OFAPD in the refinement of a set of faculty competencies to be used for recruitment of new faculty.
- Assistance and support was provided to 2 members of the FSC in the development of an upcoming OFAPD session: Strategic Service: The Benefits and Opportunities of Committee Service.
- Multiple committee members have been actively involved in the IUSM ACE/Sloan Award to Accelerate Faculty Career Flexibility. Members are serving on the Faculty Appointments and Promotion Criteria Committee (which has split into a committee addressing how team science is valued and another to clarify clinical, affiliate, volunteer, and part-time faculty expectations and promotion criteria) or the Dependent Caregiving Committee
- A collaborative project with IU Communications is underway to inform the development of a robust school-wide scientific events calendar.

What goals does your committee have for the next academic year? How can the Faculty Steering Committee help you to accomplish those goals?

- In addition to continue to work on many of the projects listed above, our major goal, along with the Women's Advisory Council, is to assist OFAPD in the development of a school-wide Career Development Consultation (CDC) program. The goal of CDCs are to empower and assist faculty with: defining their career path, setting goals, developing timelines, planning for promotion/tenure and increasing their social network to facilitate collaborations and/or potential mentoring experiences. Faculty participants will receive brief, directed, career development advice during a 1 hour meeting. A senior leader will be selected from outside of the faculty member's home department and the discussion will be based on the participant's individual career development plan that is reviewed by the consultant prior to the session. For the past 3 years, junior faculty participants in LAMP have been using this system. The feedback has been highly positive from both participants and consultants. We would like to expand the CDC program to be able to offer it to all interested faculty at IUSM. The committee is currently refining the training, recruitment (for consultants and participants), procedures, and outcomes assessments for the program.
- The FSC can assist by providing feedback on the CDC development plan and encouraging the use of the program once developed.