Vivian Lee, M.D., Ph.D., M.B.A
Senior Vice President, University of Utah Health Sciences
Dean, University of Utah School of Medicine
CEO, University of Utah Health Care

Moving Academic Medicine To Population Management

@vivianleemd
#SGIM13
- $2.3 Billion Budget
- $230.5 Million in research grants
- Over 19,000 employees
- Over 1 Million patient visits
- Only academic medical center in the state serving the LARGEST GEOGRAPHICAL AREA of any medical center in the US
- Top 10 in QUALITY 3 years running in the nation
- Patient satisfaction among the highest in the US (90th% system-wide)
THE PRESENT REALITY

The landscape for health care is changing rapidly, we, and everyone else in the country, are operating under greater financial constraints than ever in all three of our core missions—clinical care, research and education.
Limited and Shrinking Resources

The Fiscal Cliff, if left standing, will affect Medicare, the physicians and hospitals that treat Medicare patients, medical research, medical training and both military and veteran benefits, among others.
The National Institutes of Health is losing $1.55 billion of its $31 billion annual budget, a 5% slice to medical research.

@vivianleemd
#SGIM13
Limited and Shrinking Resources

The cost of health care in the past 50 years has risen more than 800%. That’s almost 5-times the rise in GDP and more than 50-times the rise in the average American wage. This is an unsustainable model that will bankrupt our families, our companies and eventually our country.

@vivianleemd
#SGIM13
what the DEAN sees

health care CRISIS

@vivianleemd
#SGIM13
Five percent of our population is responsible for 50% of health care costs. The inverse is also, unfortunately, true.
Academic medical centers are mostly tertiary and quaternary care. The University of Utah is about 5% primary care, and the current health care system drives patients to higher levels of care.
Health Care Pyramid

The future is going to be driven by population management and primary care, because it has to be.
changing ENVIRONMENT payment reform

• Fee for service
• The more you do, the more money you make
• Specialists dominate
• Insurers control cost

• Constrained payment
• The more you do, the less money you make
• Primary care dominates
• Employers control costs (with patient co-pays)

BETTER LIKE THIS? OR LIKE THIS?

@vivianleemd
#SGIM13
How do we shift the Endeavor that is Academic Health Care?
In the next 20 years, the US will grow by 150M. Health care will be driven by population management and primary care. This means: Information powered clinical decision making, primary care-led clinical workforce, patient engagement and community integration.
Lessons Learned
Ensure that primary care has a voice

- Ensure that primary care has a voice at the table, serves as a resources and partner in change.
help your **DEAN**
lead change

- Change the focus
- Sensitize to environmental cues
- Create **urgency**
- Use data to motivate change

- Ensure alignment
- Educate, communicate, repeat, reinforce
- Work as a team

@vivianleemdx
#SGIM13
Change the focus

Change the culture
Lessons Learned

Sensitize to environmental cues

- If there is a major shift
  - e.g. in Utah it’s the change in Medicaid payment starting Jan 1, 2012 to a constrained payment PMPM model.
  - Employers reaching out for solutions to employee health

- Bring in external validation

- Keep focus

@vivianleemd
#SGIM13
Lessons Learned

Create Urgency

- Sound the alarms
- It’s time for change and if we do it well, we’ll be fine
- But, we have to change

Reminder: Have a Sense of urgency!
Lessons Learned

Use the data to motivate change

Just over 3/4s of acute-care patients require relatively straightforward “community appropriate” (acute care).

<table>
<thead>
<tr>
<th>Severity of Illness</th>
<th>“Community Appropriate” 75.7%</th>
<th>Tertiary 24.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Risk of Mortality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>Minor</td>
</tr>
<tr>
<td>Minor</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Moderate</td>
<td>37.5%</td>
<td>28.4%</td>
</tr>
<tr>
<td>Major</td>
<td>1.2%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Extreme</td>
<td>0.1%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Note: Excludes newborns and hospital types that are not direct competitors
Source: Utah Hospital Discharge Database, 2008-2011
Lessons Learned

Use the data to motivate change

Academic medical centers may focus on tertiary/quarternary, but the majority of the patients receive “commodity” care

Note: Excludes hospital types that are not direct competitors
Source: Utah Hospital Discharge Database, 2008-2011
Lessons Learned

Reduce variability, Know your costs

- Make sure that there is a clear understanding of the value of primary care—both in terms of population management as well as directly counting the downstream revenue.

@vivianleemd
#SGIM13
Lessons Learned
Educate, Communicate

www.algorithmsforinnovation.org
Lessons Learned

Alignment

- Emphasize the importance of alignment across the entities
  - Hospitals
  - Clinics
  - Faculty practice leadership
  - Dean/Chairs

@vivianleemd
#SGIM13
Lessons Learned

Work Together

@vivianleemdm
#SGIM13
Vivian Lee, M.D., Ph.D., M.B.A
Senior Vice President, University of Utah Health Sciences
Dean, University of Utah School of Medicine
CEO, University of Utah Health Care

THANK YOU!

@vivianleemd
#SGIM13
1) Health care crisis slides (we can use AAMC)
2) Academic medical centers are like the inverse pyramid—we are all tertiary and quaternary care. UU is about 5% primary care, for example
3) Yet the future is really going to be driven by population management and primary care—some statistics or quotes would be helpful here.
4) How do we shift the Titanic (or Endeavour) that is academic health?
5) A slide that allows me to share with the audience my perspectives as Dean/CEO on changing the focus and culture in our system
6) A few observations and lessons learned:
   Educate, communicate: highlight townhalls, blogs, brainsharks, etc
   Create an urgency/sound the alarms—it's time for change, and if we do it well, we'll be fine, but we have to change
   If there is a major shift (eg in Utah it's the change in Medicaid payment starting Jan 1 2012 to a constrained payment PMPM model), take advantage of it to draw attention to shifting financial models
   Emphasize the importance of alignment across the entities—Hospitals, Clinics, Faculty practice leadership, Dean/Chairs
   Use the data to motivate change: eg Grant's data that over 60% of our services are really "commodity"--ie anyone in community can do it
   Ensure that primary care has a voice at the table and can continue to reinforce themes
   The $'s—make sure that there is a clear understanding of the value of primary care—both in terms of population management as well as directly counting the downstream revenue