State Universities and Private Colleges Appropriations Committee

February 11, 2010
9:00 a.m. – 12:00 p.m.
12 House Office Building

ACTION Packet

Larry Cretul
Speaker

William Proctor
Chair

COMMITTEE MEETING REPORT
State Universities & Private Colleges Appropriations Committee
2/11/2010 9:00:00AM

Location: 412 Knott Building

Attendance:

	Present	Absent	Excused
William Proctor (Chair)	X		
Ronald Brisé	X		
Rachel V. Burgin	X		
Faye Culp	X		
Chris Dorworth	X		
Brad Drake		X	
Luis Garcia	X		
Mia Jones	X		
Kurt Kelly	X		
Seth McKeel	X		
H. Marlene O'Toole	X		
Pat Patterson	X		
Betty Reed	X		
Geraldine Thompson	X		
Totals:	**13**	**1**	**0**

Location: 412 Knott Building

Other Business Appearance:

Dr. John Rock, Dean (Lobbyist) - Information Only
FIU
11200 SW 8th Street
Miami Florida 33199
Phone: 305-348-0570

Medical Education
Dr. John Pritchett (Lobbyist) - Information Only
Florida Atlantic University
777 Glades Road
Boca Raton Florida 33431
Phone: 561-297-3450

Medical Education Funding
Dr. R.E. LeMon, Associate Vice Chancellor (At Request Of Chair) - Information Only
BOG
325 West Gaines Street
Tallahassee Florida 32399
Phone: 850-245-0466

Medical Education Funding
Dr. Bernard Machen, President (At Request Of Chair) - Information Only
University of Florida
Tigert Hall
Gainesville Florida

Medical Education Funding
Dr. Judy Genshaft, President (At Request Of Chair) - Information Only
USF
4202 East Fowler Avenue, Adm 241
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Medical Education Funding
Dr. Stephen Klasko, Dean College of Medicine (At Request Of Chair) - Information Only
USF - Health
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Dr. Eric Barron, President (Lobbyist) - Information Only
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Location: 412 Knott Building

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Dr. John Fogarty, MD, Dean FSU - Information Only
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Medical Education Funding
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Medical Education Funding
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Medical School Funding
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Orlando Florida
Phone: 407-823-1823

Medical School Update
Dr. Debra German, Dean - Information Only
UCF
1000 Central Florida Blvd
Orlando Florida

COMMITTEE MEETING REPORT

State Universities & Private Colleges Appropriations Committee

2/11/2010   9:00:00AM

Location: 412 Knott Building

Summary: No Bills Considered

Brief Comparison of Florida Medical School Characteristics
1999

	Institution			
Characteristic	USF[5]	UF[5]	UM[5] (Private)	FSU[5] (Approved)
Students: Total Number[1]	386	470	588	480
Faculty				
Basic Science Faculty[1]	92	101	123	100
Clinical Faculty[1]	346	724	886	150
Total Number	438	825	1009	250
Funding				
State Appropriation	$ 38,362,419	$ 41,090,328	$ 13,645,200	$ 34,189,138
Tuition	$ 3,862,731	$ 4,691,770		$ 4,800,000
State Appropriation plus Tuition[1]	$ 42,225,150	$ 45,782,098		$ 38,989,138
Per Student Appropriation plus Tuition	$ 109,392	$ 97,409	*	$ 81,227
Approximate Total Operating Budget[2]	$ 210,000,000	$ 387,000,000	$ 500,000,000	**

Sources:

[1] Data from the Association of American Medical Colleges and Deans of Florida medical schools

[2] Approximate total operating budget reported by each institution to the Florida Board of Regents

[3] Maximum number as specified in state law

[4] 150 FTEs derived from part-time appointments with local physicians

[5] USF is the University of South Florida in Tampa; UF is the University of Florida in Gainesville;
   UM is the University of Miami in Coral Gables; FSU is The Florida State University in Tallahassee

* The University of Miami budget includes funding from the Dade Hospital Trust; full figures are not available

** A meaningful comparison can be made since the FSU proposals does not include operating a hospital
   while the budgets of the other schools include resources from sources such as: practice plans, hospital
   fees, research grants, and federal funds.

Brief Comparison of Florida Medical School Characteristics
2008

Characteristic	Institution		
	USF	UF	FSU
Students: Total Number[1]	480	509	416 / 480*
Full-Time Faculty[1]			
Total Number	666	1,287	112
Funding			
State Appropriation[1]	$ 48,724,466	$ 39,557,730	$ 34,112,166
Per Student Appropriation	$ 101,509	$ 77,727	$82,000 / $71,067*
2008 LCME Data			
10 Year Mean State Appropriation	$ 109,165	$ 106,121	N/A

* As of June 2010

Sources:
[1] Data from the Association of American Medical Colleges

Workshop on Medical Education Funding

Senate Higher Education Appropriations Committee
Evelyn J. Lynn, Chair

House State Universities & Private Colleges Appropriations Committee
William L. Proctor, Chair

February 11, 2010

Bernie Machen, DDS, MS, PhD
President, University of Florida (UF)

Michael Good, MD
Dean, UF College of Medicine (COM)

1

UF Health Science Center (HSC)

6 Colleges and Jacksonville Regional Campus
- Dentistry
- Medicine – Gainesville
- Nursing
- Pharmacy
- Public Health & Health Professions
- Veterinary Medicine
- Jacksonville Regional Campus

Major research centers and institutes
- Institute on Aging
- McKnight Brain Institute
- Cancer Center
- Clinical & Translational Science Institute
- Emerging Pathogens Institute
- Genetics Institute

2

Board of Governors Task Force Report: Medical Education Funding
December 2009

- Florida Legislature fund a base-level cost per student that excludes supplemental costs or startup costs

- UF is currently underfunded

- Based on this study:
Cost to Education Medical Student	$57,500
UF Receives Per Student	$32,105
UF Need Per Student	$25,395

3

Board of Governors Task Force Report: Medical Education Funding
December 2009

- Florida Legislature should fund a base-level cost per student that excludes supplemental costs or startup costs

- UF is currently underfunded

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1

BREAKING BARRIERS

Stephen K. Klasko, MD, MBA
Senior Vice President for USF Health
Dean, College of Medicine
University of South Florida

11 February 2010

USF
HEALTH

BREAKING BARRIERS

Things That You Think You Know About Medical Education That You May Not

- FL will soon have more state COMs than any other state except for TX
- Anticipated significant increase in cost of medical education nationally
- Complexity of the educational process
  - Active learning in small groups
  - Team training (all health professions)
- Graduate Medical Education (GME) – basically an unfunded educational mandate
- Workforce – requires an educational continuum
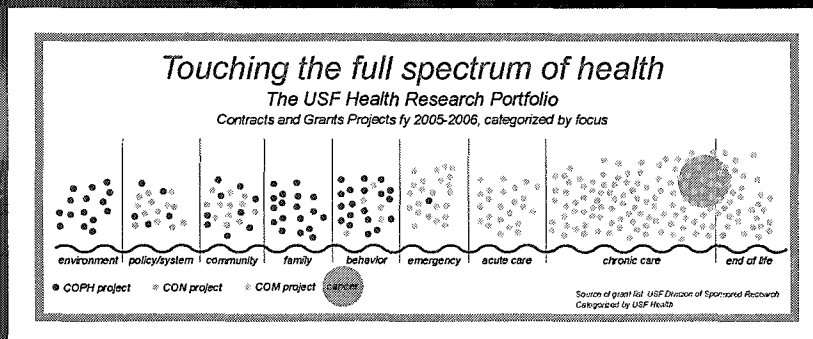
USF
HEALTH

BREAKING BARRIERS

Points of Pride

- Children's Medical Services – Tampa Bay Region – 10,000 special needs children – organize, integrate, provide majority of their care
- Areas of Scholarly Concentration & Health Leadership Track
- Bridge Clinic – student initiative providing patient care to uninsured, low-income Floridians
- Sports Medicine - $3M legislative issue; lives of K-12 student athletes saved
- PharmD – expands opportunities for health professions education and available workforce
- CAMLS – Center for Advanced Medical Learning & Simulation
- New collaborations with Moffitt

USF
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BREAKING BARRIERS

Touching the full spectrum of health
The USF Health Research Portfolio
Contracts and Grants Projects fy 2005-2006, categorized by focus

environment | policy/system | community | family | behavior | emergency | acute care | chronic care | end of life

● COPH project   ● CON project   ● COM project

Source of grant list: USF Division of Sponsored Research
Categorized by USF Health

COM Research Funding $111.7 M → $212.2M (90% increase over 5 years)

USF
HEALTH

BREAKING BARRIERS

USF Health Facts 2009 -2010

Student Enrollment

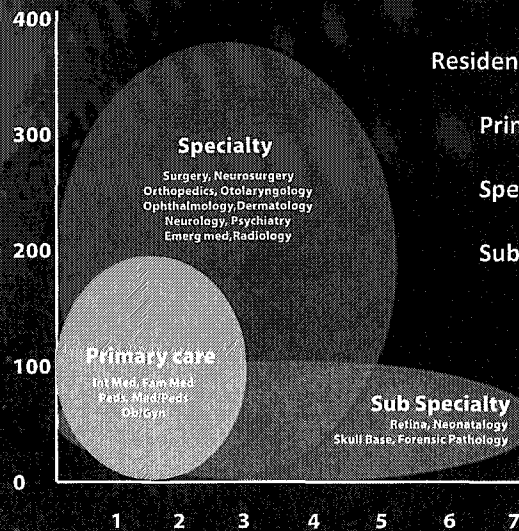| Medicine	Nursing	Public Health
482 MD	666 BS	651 Masters
83 Doctoral	636 MS	123 Doctoral
195 MS	79 Doctoral	
87 Graduate Certificates		
106 DPT		

Total USF Health Faculty: 665

USF Health has awarded 13,000+ degrees since 1974

GME - 674 residents (PGY 1 to PGY 7); 87 programs

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BREAKING BARRIERS

Providing the Full Spectrum of GME

Specialty

Surgery, Neurosurgery
Orthopedics, Otolaryngology
Ophthalmology,Dermatology
Neurology, Psychiatry
Emerg med,Radiology

Primary care

Int Med, Fam Med
Peds, Med/Peds
Ob/Gyn

Sub Specialty

Retina, Neonatalogy
Skull Base, Forensic Pathology

Resident numbers by specialty:

Primary Care: 199

Specialty: 390

Sub-specialty: 85

USF
HEALTH

BREAKING BARRIERS
Issues Particular to USF

- USF Health Practice Group – Financial challenges
  - Bottom line loss last FY in spite of increased productivity
  - Break-even prior to that
  - This FY loss through Oct 31 is $1.7M; plan to break-even
- No Hospital at (or owned by) USF
  - Surgery, but no anesthesia, pathology, radiology or facility fee
- GME – Academic faculty – do their own cases and teach the residents (and medical students)
  - Federal GME funding (Medicare & Medicaid) → hospital
    - Pays direct medical expenses – i.e. Salary & Benefits of residents
    - Does NOT pay faculty
  - There is no fund source for instruction of residents
- Combination of above factors = Unsustainable Model without parity funding from the state of Florida

USF
HEALTH

BREAKING BARRIERS
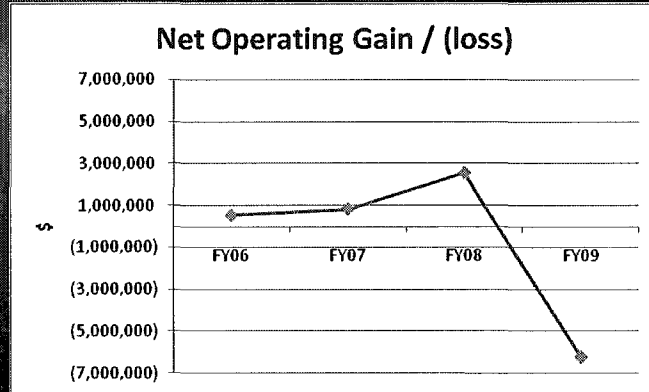## USF Health Practice Group Faculty Productivity

Work Relative Value Units (RVUs)
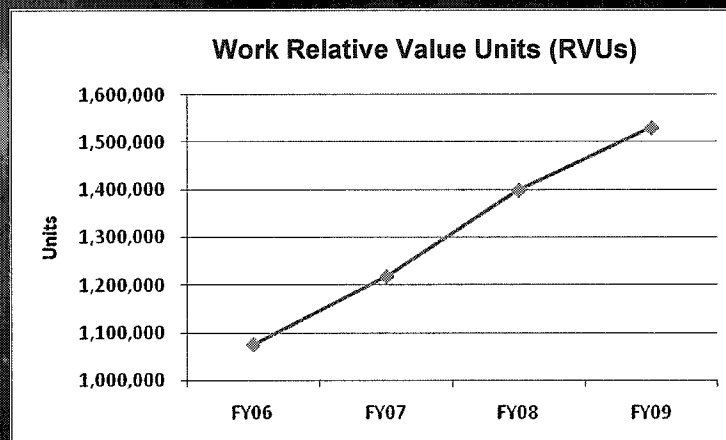
Data based on USF Faculty Productivity, excluding the DIO

USF
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BREAKING BARRIERS

USF Health Practice Group
Financial Trends

Net Operating Gain / (loss)

Data based on audited financial statements

USF
HEALTH

BREAKING BARRIERS

USF Health Practice Group
Productivity and Financial Trends

	Charges	Collections	Work RVU	Net Operating Gain / (loss)
FY09	279,297,886	100,171,562	1,530,349	(6,198,037)
FY08	239,271,260	86,001,923	1,398,979	2,550,706
FY07	213,942,850	77,348,028	1,218,183	827,137
FY06	185,958,390	70,162,432	1,075,864	529,683

- Data based on audited financial statements and faculty productivity (excluding the DIO)
- Current loss from operations through October 31. 2009 is ($1.7M)

USF
HEALTH

What We Forgot To Teach in Medical School....and Why It Matters

The Unintended Consequences of the Health Care Reform Revolution

Stephen K. Klasko, MD, MBA
CEO, USF Health
Dean, College of Medicine
University of South Florida

Much energy has been expended on the exact mechanism by which health care will be reformed and whether or not it will be beneficial and, more importantly (at least to some in the debate), who we can blame if it fails. But we have missed an essential fact. The world of academic medicine and the fragile relationship between hospital-university-practice group and even patients and students have already changed dramatically. Even in the pre-reform era, in September 2009, the economy, unemployment and threat of major change have conspired to materially impact growth rates in most of our markets:

> 61% of hospital facilities reported lower patient volumes, with 11% reporting more than a 20% decline

> 57% of academic medical centers reported a decrease in elective procedures

> For the first time in over 25 years, surgical procedures in the US declined by 6%

> *(Opinion Research Corporation Survey: Trends Impacting Healthcare Channels and the Medical Device Industry, September 2009)*

Add this to the nearly historic decrease in state funding or replacement of recurrent funding with time limited "stimulus funding" and it would seem like a good time for academic medical centers to rethink some of the "sacred cows" that have haunted us in the past and make them into hamburgers. While many of us have chosen to "wait for the whitewater of change to subside" the chances are that if you care enough to be sitting at the annual meeting of the AAHC, you are already one of the few that is "more optimistic about the future than the past."

While we have all said it in different ways, the challenge is probably best outlined by the Institute of Medicine's Committee on Quality of Healthcare in America when they stated, "the American healthcare delivery system is in need of fundamental change." The current care systems cannot do the job. Trying harder will not work. Changing systems of care will. In other words, doing the same thing that didn't work the first time and expecting different results is not a successful business strategy. Changing the DNA of healthcare will require a very different approach and one in which both our faculty and students may need different skill sets to be prepared for.

As a medical school dean and CEO of a health system which is in the midst of a transformation, I have searched for the answers of some key questions that have allowed me to be optimistic that academic medicine can thrive in Tampa and that the future is indeed brighter than the past. In order to come to that conclusion, I needed to answer three questions:

> Do we need to change the way we select and educate physicians?

> What are the major transformations that will need to occur to avoid repeating past mistakes?

> What lessons will we wish we had learned in 2009 if we were to look back from the future?

The answers to these questions led me to five conclusions that have transformed our blueprint for strategic action at USF.

Conclusion #1: Doctors are not like other people.

In an article that I co-wrote for the *Physician Executive* with Richard Shel, chair of negotiations at Wharton, entitled, "Biases Physicians Bring to the Table" we posited that by the way physicians have been selected and educated, we have joined a cult. That cult is based on four biases—an autonomy, competitive hierarchal and non-creativity bias---and that in order to "change the DNA" of our faculty, we will have to deprogram those biases before we can "reprogram" a different more future- oriented faculty. That set of biases hinders us in collaborative negotiating, helps explain the lack of trust that often exists in a medical staff, and accounts for some of our risk aversion and unwillingness to think differently. In one part of the study, we found that 78% of MBAs viewed creativity as part of their success, 53% had a significant creative outlet such as painting or cooking, 93% were able to elicit examples where creativity had helped solve a major pro at work within the last year and 85% routinely read books outside their field. Among physicians, only 12% viewed creativity as one of the major determinants of success. We had significantly fewer hobbies outside of medicine, and when we did, they often honed the same precision skills that we need in our medical career such as flying or sailing. In essence, the number one differentiator of creativity is that MBAs believed they were creative, which allowed them to feel comfortable about an uncertain future and positively affected their willingness to take risk. Physicians, by and large, believed they were not. Because of that, they felt their life was affected by external factors. Among academic physicians, a major source of pessimism was that we had become autonomous creatures losing control.

In fact, one need go no further than a comment made by a business colleague who said, "Let me get this straight. You still accept students into medical school based on science GPA, MCATs and organic chemistry grades, yet you're amazed that doctors are not more empathetic communicative and creative." In fact, in a recent survey we asked graduating residents after a year in practice or on faculty what they "wished they had learned." As it turned out, it was not more microbiology, biochemistry or gynecology. Instead, their shortcomings included being an individual in an organization, marketing their practice, making patients happy, collaborative negotiations, and managing up. So, if there was ever a time to rethink the educational mission, that time is now. At USF we have responded in three ways:

1) The Healthcare Leadership Track at USF Health

   The Macy Report commissioned by the AAMC in 2008 was unanimous in the view that "medical educators should seize the current call for expanded enrollment as an opportunity to make additional improvements." This report stated what we already know, namely that we need to bring medical education into better alignment with societal needs and goals. In essence, we are still teaching physicians what they needed to know in the past, instead of preparing them for the future.

   Our goal was to take a cohort of students, select them based on leadership potential, create a four-year curriculum around the skill sets needed in the future, and then tailor their clinical clerkships and externships in such a way that the above biases will be deprogrammed from the start. During the formation of this track, it became clear to us that in 2009, in order for this to be successful, we would need a hospital partner that was philosophically close to us in relationto leadership training, inter-professional education and commitment to the

education and practice of quality and safety. This medical school track will begin admitting students next year—students who are selected based not only on scientific parameters, but valid emotional intelligence and leadership potential parameters. with a curriculum that will be both inter-professional and co-designed from colleagues in leadership executive education, as well as correcting the deficiencies cited above.

2) Areas of Scholarly Concentration for Medical Students

At USF, we began a program whereby every medical student must take a forty credit hour "minor" that will expand their horizon and foster their creativity. That minor can be in business, public health, law, education, health disparities or research.. This program not only adds another area of expertise for each medical student graduating from USF, but also allows for a smoother route to dual degrees including MD-MBA, MD-JD, MD-MPH or MD-PhD.

3) Inter-professional Education

The inability to create high-powered teams among healthcare professionals is one of the obstacles to future success in an environment where that teamwork will be a necessary component of a quality accountable system. Over the past three years, we have made a solid commitment to training doctors, nurses, public health professionals and pharmacists together. We want them to recognize how to combat the obstacles to team success, such as poor communication, lack of trust and personality issues. Beginning in 2010, every medical student will be required to take one course in public health, pharmacy and nursing around quality, safety and epidemiology.

Conclusion #2: We need to move from SOFTIs to CRISPs.

Improving the value equation in healthcare will require a different mindset as it relates to departments and service lines. Unfortunately, the dialogue has been confused, as definitions of service lines have often been mediated by hospital marketing executives and the decisions surrounding their formation are often done without significant faculty involvement. As a health science center which does not own or control its own hospital, we had an opportunity to create an endowed ambulatory center of the future. We were challenged by a donor to overcome the service obstacles that are often associated with academic ambulatory care.

Planning for this center included patient, nursing, public health and pharmacy input into the "ideal patient experience." It was designed to guarantee more efficient communication. The implementation of the USF Morsani Center for Advanced Healthcare allowed us to create a multidisciplinary program designed to enhance access, create more efficient care and improve outcomes. The organizational implications of these goals required us to transform our faculty from "SOFTIs" - silos of full time individuals - to "CRISPs" - clinical and research integrated strategic programs.

So, each one of our providers in that building began a process of understanding what will increasingly be a truism of an entrepreneurial academic model, namely that there are two parents—the academic entity as well as the entrepreneurial multi-disciplinary CRISP. In this two-paycheck model, an orthopedic surgeon will receive his/her academic payment from the orthopedic department, but his/her clinical incentives will be based on the success of the entire sports medicine team, consisting of orthopedic surgeons, family physicians, physical therapists and other sports-related providers.

This approach has had mixed success. On the one hand, this entrepreneurial approach created an unprecedented interest among the academic faculty in business development, service and market share that resulted in patients' service guarantees, a coordinated electronic pharmacy program, "mystery shoppers" to determine service lapses and a unique cross-provider retail partnership with a regional supermarket. On the other hand, the CRISPs have been limited by inconsistency in support among clinical chairs, as well as decreased state funding which has limited our ability to support the appropriate behavior. The next step will be to clearly demarcate the responsibility and accountability of the academic department leaders, as opposed to the CRISP CEOs.

Conclusion #3: It is difficult to get someone to understand something when their salary depends upon them not understanding it. —*Upton Sinclair*

In academic medicine, on both the hospital and university side of the equation, we have been guilty of sending mixed messages as it relates to incentivizing behavior consistent with the organization's goals. Based on publicly available data, we reviewed a variety of CEO and hospital senior management incentives that were often inconsistent with the stated goals and vision of the health center. For example, in many cases the board's stated goals were quality, service, national prominence and community well-being. Often the CEO and his/her immediate senior managers were paid based on hospital census, net-net financials and bond rating. It is fair to say that business principles would predict that if you want to see what the hospital will look like ten years from now, one can look at the CEO's incentive package today. Conversely, there are a growing number of very innovative incentive packages that nonprofit board members are encouraging for their hospital senior executives. In these models, the medical staff/faculty is involved in senior management incentive discussions and those incentives are largely based on objective parameters of patient satisfaction, national prominence balanced dashboards of objective quality data and physician/faculty satisfaction.

At USF, we decided to embark on a bold initiative of tying faculty incentives to the organization's strategic goals. This initiative, called AIMS (Asset Investment Management System), involved over one hundred faculty members. It was created over three years by a council tri-chaired by an academic basic science chair, academic clinical science chair and an administrative chair. It has now evolved to include RVUs, research productivity and EVUs in what has become a faculty-directed and modified incentive system for our future. At the same time, we initiated a web-based system and approved the purchase of a health data repository, entitled HART (health analytical reporting and tracking), which extracts and stores performance data from the many data sources within the academic medical center and University. This real-time, all-source mechanism allows a faculty member to understand exactly what his/her goals are, separate those goals into their academic and entrepreneurial components, and be able to real-time assess their potential for incentive payment or salary adjustment. This flexibility, real-time reporting and continuous communication with the faculty has been a major driver in promoting the culture change necessary to maintain the entrepreneurial academic model.

Academic medicine is an extraordinarily complex environment and incentive systems have often had unintended, sometimes mission-counter consequences. The most recent addition to AIMS will be a comprehensive, data-driven and mission-based educational value unit (EVU) model that will ensure faculty are given appropriate credit for their instructional effort in Undergraduate Medical Education, Graduate Medical Education and Graduate Education (Masters and PhD). Faculty who are assigned to major teaching/ leadership roles, and/or essential educational administration activities that exceed our 5% minimum standards, will be provided with EVU credit that supports salary and release time to enable them to fulfill their assigned duties. Data will also be collected on faculty achievement of excellence in performance benchmarks related to these assigned roles. Faculty members' achievement

of benchmarks will guide discretionary bonuses and support tenure and promotions decisions.

Conclusion #4—Process drives culture and building a performance culture requires leadership development, mentoring and succession planning.

There has been increasing interest in leadership training for faculty senior managers as well as academic leaders, but are we even targeting the people who will lead the cultural transformation? Through my work at the Governance Institute, surveying over fifty CMOs and VPMAs, there is an almost uncannily consistent distribution of faculty/medical staff and their attitude toward the organization's leadership. In round terms, there was a mean of twenty percent of the medical staff who consistently and vocally supported the leadership, fifteen percent who represent a vocal minority of naysayers and a relatively silent majority among the rest of the faculty. In these organizations, we found that the CMO/dean spent much of their time on the "converted," way too much time frustrating themselves trying to "heal" the disenfranchised and the least amount of time on the segment that can make the largest impact on cultural transformation, the nearly silent majority.

We believe that the transformation of the organization starts with changing the leadership culture -- one leader and potential leader at a time. In essence, we needed to change the DNA of our medical school. So, in 2005, USF created a Center for Transformation and Innovation (CTI). Its charge was to accelerate the vision of USF Health by transforming the leadership DNA at all levels within the organization. The goal was to develop leaders through a systematic succession planning and talent management process, providing the necessary skills through leadership development, removing disincentives, and shifting beliefs. This Center created a path to physician leadership development through a model program, The Leadership Institute at USF Health, designed to promote a culture of leadership excellence and success.

The Leadership Institute at USF Health guides participants through cultural and leadership challenges in a way that builds our organization's core vision – transforming how healthcare is delivered and how health is understood in a continuum, from the environment, to the community, to the individual. To achieve this transformation, we enhanced the tools of leadership — Leading with Strategy, Leading People, and Leading for Results -- with the four-year goal of converting over one hundred medical staff/faculty members to leadership and strategically aligned roles in the organization. This center created a path to physician leadership which included creating the right environment, developing leaders in a way that met our goals..

The Succession Planning program at USF Health is a deliberate and systematic effort to ensure leadership continuity in key positions and to encourage individual advancement. The Leadership Institute at USF Health focuses on those professionals who demonstrate high leadership potential within USF Health and are already making a positive difference within the organization. The foundation premise of top-level leadership development is that leaders are not simply born, but are created through life experiences, reflection, and learning.

The healthcare industry may be unique in the enormity of the talent challenges that confront it. If there were ever a "perfect storm" related to succession development and talent management, it is most acute in healthcare, according to Allan Schweyer, Human Capital Institute. *(The State of Talent Management in the Healthcare Industry, Allan Schweyer, Human Capital Institute in partnership with Lawson Software, May 2009)* He goes on to say that while it is true that the aging population restricts talent for all industries, it is only in healthcare and life sciences that it so profoundly impacts demand at the same time. To prepare, he suggests that healthcare organizations:

1. Build and maintain a strong employer brand and cooperate to build a strong brand for the industry;
2. Develop strategic and ongoing succession planning and development processes;
3. Create strategic recruitment plans and develop a variety of creative tools to attract top talent;
4. Build effective on-boarding and mentoring programs and processes;
5. Create great places to work so that the top talent will remain with healthcare organizations;
6. Identify and develop leaders at all levels and dedicate the resources necessary to accomplish and sustain leadership development throughout the organization and over time;
7. Communicate and manage your plan effectively; and
8. Reward talent with strategic employee recognition.

Our Center for Transformation and Innovation has allowed us to merge the appropriate bold corporate best practices into our academic environment to confront these talent challenges that have been and will continue to be a major drive of culture change in our organization.

Conclusion #5: We tend to overestimate technology in the short term and underestimate it in the long term. ---*Roy Amara*

At USF, as at many other academic medical centers, we have patted ourselves on the back for converting to electronic medical records and utilizing today's technology effectively. But in many cases, we have not understood the extent of the long-term changes that will occur with the combustion of a new wave of consumer technologies, as well as the gap between the electronic and technologic footprint of the senior managers as compared to the generation represented by our students and younger patients.

The pace is revealing. The number of health-related web sites in the past two years has increased by one hundredfold. The number of people under age 40 that said they get a "significant amount "of health information online has increased by tenfold. Google, Microsoft and Yahoo have stated that they view healthcare as their number-one revenue opportunity, and one of the fastest growing segments of healthcare, medical tourism, is marketed almost exclusively online.

In a recent survey that I conducted, it became increasingly evident that patients and students under age 35 expect healthcare to act as a "consumer sport" in the near future:

71% expect that their doctor's visits would have online scheduling with comparative rates by 2011.

83% expect that they will be able to access their health records with the same ease in which they view their online accounts within two years.

85% expect that there will be social networking opportunities to discuss health related topics and compare providers and

92% expect to have two-way electronic communication with their providers.

At USF Health, we are embarking on an extreme technologic makeover that includes the following:

a) PaperFree Tampa Bay—A federally funded program in which we partner with the colleges of education, engineering and communication to recruit and train "electronic healthcare ambassadors," a group of vendor-agnostic missionaries whose goal is to transform an entire ten-county region to an electronic health record environment. The federal funding is being used to create a curriculum, hire and train health care ambassadors, create consumer awareness, and accomplish the goals of 100% of physicians using e-prescribing as well as providing them decision support for electronic health records. The University of South Florida will produce a national demonstration that will build a clear and measurable IT infrastructure for a community-based electronic prescribing system within health practitioner's offices throughout this ten-county area.

b) Assessment of technical competence through a Center for Advanced Medical Learning and Simulation--- The Center will be a world-class, state-of-the-art medical conference facility that will house ~56,000square feet and provide a real-life working and teaching environment. It will be located in a controlled access secure area equipped with advanced technology to facilitate the transfer of knowledge and skills to the learner. In addition to being a sophisticated training center, it will also include two research and development components. One is the concept laboratory for prototype development and testing of new techniques and technologies in robotic, computer-assisted and image-guided surgery. Another is the educational research component, which will house researchers and staff who will examine and test educational practices to assist faculty, staff and students apply knowledge and technology to produce valid and innovative education for healthcare professionals. We will be partnering with leaders in flight simulation, as well as industry leaders, to create valid means and standard deviations of technical competence on the road to valid simulation-based credentialing and quality training.

c) Partnership with Apple Inc. through a leadership symposium in digital healthcare-- A steering committee was created with thought leaders in the use of digital media in healthcare and healthcare education, including health science representatives from USF, MD Anderson Cancer Center, Duke University, Medical College of Georgia, and the University of Michigan. This created a national conversation on how to leverage technology and mobile devices to increase access to healthcare curricula. These discussions of e-learning environments, learning knowledge centers and effective use of digital media education have created a unique opportunity to have a public-private dialogue of changes in technology as well as teaching strategies and skill sets that will be necessary for a very different future.

d) Emerging technologies such as Human RFID, Second Life and closed loop EMR malpractice mitigation modules.

In 2006, a member of the president's cabinet said this about our military future: "There are known knowns. These are things we know that we know. There are known unknowns. That is to say, these are things we know we don't know. But there are also unknown unknowns. These are things we don't know we don't know." Whether or not that was accurate from a military point of view, it could be a signpost for the future of university-hospital relationships in the current uncertain healthcare future.

We <u>know</u> that the economic and political pressures currently driving the healthcare reform debate will stress the already fragile economic and strategic partnerships in academic medicine between hospitals, universities and physician faculty. We <u>know</u> that we <u>don't know</u> how the cost, access and quality changes and mandates will affect our traditional clinical, research, educational and academic missions. So, will that create a den of piranhas -- a new era of animosity and distributive negotiating between the traditional components of academic medical centers? Or will it create a tropical aquarium, whereby these extreme pressures force an era of collaboration and overcome the competitive, hierarchal, autonomous and non-creative biases that we have traditionally fallen victim to? At USF Health, we <u>don't know</u> the answer to that, but we <u>do know</u> that:

> *the training of new healthcare leaders,*

> *the movement toward integrated strategic partnerships between faculty of different departments and colleges,*

> *incentive programs that are faculty driven and reflect the new definitions of academic excellence and collaboration,*

> *changing the DNA of academic healthcare through fostering creativity in an entrepreneurial-academic model, leadership training and succession planning,*

> *and the development and employment of new technologies to better serve our students and patients*

will help us create an environment whereby each component of our academic medical center is bringing us closer to an optimistic future.

As an organization, the AAHC is taking a leadership role in moving academic health centers in advance of and beyond what any legislation can provide. At USF Health, we believe that focusing on our greatest asset, our people, will be the differentiating factor in making that change. We found that creating the incentives and exciting the people in the organization who "get it" were the motivating factors to change.

While Congress is discussing the concept of the creation of "health innovation zones," our nation's academic health centers have the opportunity to lead that charge. Our ability to boldly lead in an entrepreneurial, academic and interdisciplinary manner will require a change in our traditional academic medical culture. Culture change is often a long and painful process. At USF Health, we have shortened that process by creating a sense of urgency, pulling together the guiding team, developing the culture change vision and strategy, communicating for understanding and buy-in, empowering others to act, producing short-term wins, and not letting up.