External Review of the University of Minnesota Academic Health Center:
Final Report

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Background/Charge

The University's Academic Health Center (AHC) is one of the most comprehensive in the nation. It is the primary provider of healthcare workers in Minnesota, home to significant research breakthroughs, and a provider of quality clinical care in a wide range of disciplines and specialties.

Over the past 15 years the University of Minnesota (U of M) AHC has undergone several external and internal reviews, including a self-study in 2011. The last review, while valuable, answered mainly questions surrounding the structure of the AHC and was not intended to answer broader questions involving the future of the University's health sciences. Moreover, because of its internal construction, the 2011 self-study was received with skepticism by many within the University and the schools that comprise the AHC.

While many of the University’s health science schools are highly ranked, the Medical School's reputation and rankings, which have gradually declined, are of great concern throughout all the schools of the U of M AHC. Also of concern is considerable uncertainty surrounding the rapidly changing healthcare environment and how best to position the U of M AHC to prepare for the changes afoot.

President Kaler has set improving the reputation of the Medical School and the entirety of the health sciences programs as a strategic goal for the University. To help create a path forward, the president decided to commission an external review of the AHC.

The president asked Dr. Ken Kaushansky to serve as the chair of the External Review Committee and recruited Dr. Lee Goldman and Dr. Carol Aschenbrener to join him. Our biographies are attached.

In May of 2012 President Kaler charged this external committee with a forward-looking review including the following questions:

• How does the U of M AHC compare with its peers nationally?
• What changes and investments are necessary to meet our goal of providing top-rated health science education, research, and clinical care?
• How do the AHC and schools with in it maximize the partnership with the University of Minnesota Physicians (UMP) and Fairview Health System?
• Is the AHC structured to respond to the changing healthcare environment?

Process

In preparation for the review, we were provided summaries of past reviews of the AHC, budget and accreditation documents, information regarding the healthcare landscape in Minnesota, survey results from faculty and staff of the AHC, and summary documents about the major components of the AHC. From August 1–3, 2011, we conducted on-campus interviews with AHC faculty, staff, and administration, as well as senior leadership from the University. That information, combined with our assessments, resulted in our findings.

Survey results

Prior to the on-campus portion of the review, a survey was sent to all AHC faculty and staff, a population totaling 9,289. The survey was included as part of the review process to gather a broader level of input than was possible through in-person interviews and to give the whole AHC community the opportunity to make their voices heard. The survey was qualitative and included all open-ended questions. The results are therefore difficult to quantify, but they do provide information about the concerns of faculty and staff.

The survey asked questions similar to those posed by President Kaler in his charge to the review team, as well as specific questions about challenges facing colleges and centers, and asked respondents what they felt was most important for the reviewers to focus on.

Responses were received from every college in the AHC, with 48 percent of responses coming from the Medical School. Responses reflected the wide range of views held across the AHC about the current status and the strengths, opportunities, and barriers going forward.

The following issues were mentioned many times by survey respondents as important considerations for the reviewers:

• The leadership structure of the AHC
• The value of the current AHC structure
• The relationship with Fairview Health Services
• The University’s relationship with the broader healthcare community
• The strength of the Medical School
• Funding for the health sciences
• A lack of vision for the AHC and/or Medical School
• Interdisciplinary education—both as a strength and an area needing additional focus
• The need to connect research with teaching and with clinical care

Strengths identified by respondents included a number of different specialties and departments as well as interdisciplinary education and research. Opportunities in education and research included improvements in technology, facilities, funding, and faculty
recruitment and support. Respondents identified primary care as an area for improvement, as well as improving relationships between UMP and Fairview Health Services, better facilities, and more focus on patients.

**On-campus interviews**
The committee was on campus in early August for two and a half days. Beginning with a meeting with President Kaler to discuss the charge, we had the opportunity to meet with more than 50 faculty, staff, and administrators in groups small enough to allow for dialogue. Participants represented a wide range of disciplines and roles within the AHC and the University.

Each interview began with a short explanation of the process and asked participants to talk about what they saw as the opportunities and challenges facing the AHC and the health science schools. Participants seemed pleased to be included in the process, and the conversations were productive and candid.

**Findings**

Our overall impression was that the University of Minnesota’s health sciences are strong, but are at risk from several external and internal forces.

The AHC has many assets, including the breadth of work and the strength of world-class faculty and programs, high-quality students, and an impressive research portfolio. There was a great deal of internal pride and external admiration (on the part of the review committee) for the state of interdisciplinary education and collaborative research. Because of the comprehensive nature of the health science enterprise at the University of Minnesota, there is a tremendous opportunity to lead nationally in these areas. And with this foundation there exists the potential to move up to the next tier of national rankings.

Our interviews covered a wide range of topics but several specific themes emerged. These centered primarily on the structure of the AHC, the status of the Medical School, and the clinical relationships among the school, clinical practices, and the hospital and clinics. There is a range of opinion about all of these issues.

**Culture**

Before discussing future strategy and tactics, we would like to comment on the culture we observed during our time on campus.

To move the AHC forward, there are evident cultural challenges to overcome. First and foremost, an imbalanced amount of energy is being spent on organizational issues (e.g. who should lead the AHC, what should the mission of the AHC be, and what is the value added of the AHC) that appear to be affecting the quality of the work and environment in the AHC. Addressing these issues and refocusing on the future and the University’s opportunities to advance will be an important first step in moving the health sciences from good to great. The agents of change are the faculty members. Like in all academic medical centers, faculty drives the core mission of the health sciences: teaching, research, and clinical work. It will be important to ensure that faculty voices are heard throughout this process and that the
University and the AHC continue to strive to provide the support necessary for great teaching, research, and clinical practice.

**Structure and leadership**

It was clear from the differing opinions heard by the committee that there is no consensus about the “right” structure or leadership model. The two major points of discussion were 1) the value added of having an administrative structure that oversees the functioning of the healthcare mission of the University of Minnesota (the AHC), and 2) whether the dean of the Medical School (or any health science school’s dean) should also hold the role of head of the AHC. It was also clear that these discussions have been a primary focus for far too long and that there is a desire to have these functional questions answered and to move on.

The committee heard from many that the AHC administrative structure is not well understood and there is concern that the individual schools do not receive enough value from it. On the other hand, we heard several examples of good service and value from the various components of the administrative structure. There was agreement that greater transparency about the cost and function of the AHC structure would be welcomed.

There is also a variety of opinion about the leadership structure. Many believe that the dual role of vice president for health sciences and dean of the Medical School can be a conflict of interest and/or that the job is too big for one person. From the majority of Medical School faculty members with whom we spoke, somewhat surprisingly, the committee heard that the school would prefer a dean focused on only the Medical School, without serving as head of the AHC. But in the true spirit of having one’s cake and eating it too, most in the Medical School also wanted the dean to be granted a direct reporting line to the president, despite acknowledging that no other dean in the University holds that distinction.

**Medical School**

There was agreement in essentially every corner of the University that the Medical School needs to become more highly regarded, based on enhanced research, educational innovation, and clinical impact, both locally and nationally. Because the Medical School, as in any mature academic health center, is the largest school, it is to the benefit of all when the school is thriving. Each of the health science schools acknowledged there is benefit to them, their rankings, or their research and training opportunities, to be connected to a strong Medical School. It was also made clear that the improvement should not be made at the expense of other schools.

However, there is no clear vision of how to accomplish the goal of strengthening the Medical School. People seem to feel they are in neutral, which is creating a malaise. One faculty member said there is no “north star” guiding the work. We asked, many times, “Who do you want to be?” The responses made it evident that there is no consensus regarding the goals or aspirations of the Medical School.

**Clinical relationships**

A great deal of concern was expressed about the relationship with Fairview Health Services. Interviewees mentioned a discordance in fundamental values and missions, challenges with clinical training sites, and barriers to interprofessional education, as well as problems with funding for the Medical School.
This relationship, its origins, and its future are consuming the discussions of clinical care at the University to the exclusion of preparation for changes in care resulting from healthcare reform and development of new clinical partnerships.

**Recommendations**

1. **Update the administrative structure of the AHC for 2012 and beyond**

The committee heard a number of concerns about the size or purpose of the administrative structure that supports the Academic Health Center.

While the origins of the shared services model make sense, to move forward, the priority must be to determine the right-size structure for 2012 and for 10 to 15 years from now. The services should be sufficient to provide quality support to the health sciences schools and colleges, as well as the research enterprise, interprofessional education, and the centers, without adding unnecessary staff and burden to the operation. And this must be done in a transparent and highly visible fashion, to attain the requisite buy-in from rank-and-file faculty members.

The committee believes that there is an opportunity to make changes to update the role of the AHC administration, and to centralize or localize functions where appropriate. Specifically, the committee heard that there is support for a more central connection for AHC Information Technology Services and Human Resources. Interviewees identified that this type of connection worked well for the legal and financial services offered by the AHC. Whether changes are necessary or all of the services stay in place, an important step is clearly communicating the role, purpose, and value of the AHC administration going forward.

We understand that many aspects of this work have been reviewed and analyzed several times over the past 10 to 15 years. It is likely that decisions can be made with a thorough review of that work. The president may also consider an external audit of these functions, but whatever route is chosen, faculty representation is critical, and the visibility and transparency of the process and conclusions even more so.

2. **Determine the leadership structure of the health sciences**

As noted, there was a great deal of discussion about the dual role of vice president for health sciences and dean of the Medical School. Each different leadership model—whether this is one position or two—has pros and cons.

The committee believes that there is a great deal of work that needs to be done: The Medical School needs to improve and the University needs a clinical delivery strategy that is far less “dependent on the kindness of strangers.” In order to focus on that work, the leadership model that is best for the University of Minnesota needs to be decided.
There is no right answer. We will offer an analysis of the options available. However, we also believe that regardless of the model chosen, the definition of vision and clear strategic priorities is imperative and should be articulated and strongly endorsed by the president as soon as the structure and leadership are determined; in our opinion no one else can substitute.

**Model 1: Continue a dual leadership role, possibly augmented by an adviser for health systems strategic decisions**

The committee discussed during several interviews the differences between a dean who is purely academic, and a dean who is both academic and executive (in the vernacular referred to as “weak dean” and “strong dean” models, respectively). With the broad agreement that the Medical School needs to be stronger, it follows that the school will require strong leadership. Executive/academic dean positions generally have at least two of the following three responsibilities: oversight of a practice plan, leadership of a hospital, and/or responsibility for other health sciences schools.

At the University of Minnesota, the hospital is owned by Fairview Health Services, the dean has some responsibility for the practice plan, and the other health science schools report largely to the provost and only to the vice president for health sciences for interprofessional education and clinical work. In addition, the larger centers (including the Clinical and Translational Sciences Institute and the Masonic Cancer Center) are a part of the AHC, not the Medical School. Separating the dean and vice president for health sciences positions therefore leaves the dean’s job relatively weak, which could adversely affect the ability to strengthen the Medical School.

Under this model, because improving the Medical School is a priority for the University and because the University is involved in a complicated clinical relationship, it may make sense for the leader to hire a senior adviser to develop a health systems strategy in order to effectively allow for both jobs to be done by one person.

**Model 2: Separate roles, each with clear responsibilities**

In this scenario, it is critically important to ensure the Medical School dean’s and the vice president for health sciences’ positions are of sufficient magnitude to attract outstanding leaders.

To strengthen the dean’s role, consider giving the dean of the Medical School more responsibility for the practice plan. This may be accomplished by having the dean also chair the Board of University of Minnesota Physicians. Also consider moving the large centers of research currently administered in the AHC to the Medical School.

The vice president’s role, in addition to health system strategy work and an emphasis on external relationships, could have more oversight of the health sciences schools, either with or without responsibility for promotion and tenure.

For this scenario to work, it will be essential to find two leaders who can work effectively together.
**Model 3: Medical School dean with a vice president of clinical services title, and a rotating convener of the health sciences schools**

In this model, the dean of the Medical School assumes the clinical and research responsibilities currently held by the vice president for health sciences. The Deans’ Council would continue to meet, convened by a rotating chair, for work on mutual priorities and interdisciplinary education and research.

This model creates an executive/academic Medical School dean position and relieves the conflict of interest concerns expressed by deans of the other health science schools. It, however, loosens the association between the health science schools, which may affect the collaborative work currently being done. It would be difficult to have substantial administrative responsibilities under the authority of a rotating leadership.

**3. Implement strategic planning for the Medical School**

We heard from many interviewees that the Medical School needs a vision of where it is going and how it will get there. The faculty needs inspiration—a “north star”—perhaps in no area more mission critical than research (see point 4, below).

To begin to refocus the Medical School on the future (rather than the problems of the past) the review committee recommends that President Kaler charge the dean of the Medical School to carry out a strategic planning process. This process should broadly involve faculty and staff, as well as the research and healthcare communities. At the end of the process, it is critical that the plan is endorsed and embraced by internal and external stakeholders.

A new, inspirational vision will be important both for driving excellence internally and for building support in the community. Advocates and philanthropists in Minnesota will be an important part of ensuring continuing prominence of the University and the health sciences.

**4. Strengthen the focus on the Biomedical Discovery District**

The Biomedical Discovery District (BDD)—with the focus on collaborative research, the new flexible space, and the targeted areas of excellence—is a golden opportunity to improve research funding and rankings. The committee was struck by how infrequently the interviewees even mentioned the potential for excellence the BDD can engender, but we believe strongly that this is an exciting opportunity for the University and must be an area of planning and focus.

The committee recommends the University determine the scientific priorities with an emphasis on what will be the strength of the University’s health sciences. One possibility is convening a space planning committee and building around the best faculty/researchers in the new space, while ensuring representation from a broad range of disciplines. Obviously, the Medical School strategic plan should dovetail with the emphasis planned for the BDD.
Ultimately, investment in targeted faculty recruitment in determined areas of excellence will drive increased National Institutes of Health and industry funding, economic impact, and school rankings.

5. Develop a strategy for healthcare reform

Analyzing the full scope of the legal relationship between the University and Fairview Health Services was outside the work of this committee. However, we understand that in addition to financial challenges, there are longstanding agreements between the two organizations that would make dissolving this relationship extremely challenging.

The work currently under way to redefine the relationship through the integrated structure, to partner more effectively, and to drive resources to the Medical School is important to the long-term success of the health sciences.

At the same time, it is not enough to wait for this relationship to improve. In the Twin Cities market, 60 percent of physicians are employed. As that number increases, it will have significant implications for the University’s specialists.

The committee recommends that University of Minnesota Physicians and the AHC work to strengthen and develop new clinical partnerships in the community and regionally to improve access to clinical training sites and to improve market share. It is also worth exploring expanding the University’s role in primary care and in health outcomes research. The committee feels that this aspect of clinical development cannot be overemphasized. The University must take an aggressive posture in becoming self-sufficient in the healthcare marketplace; otherwise, the clinical research, training, and revenue possibilities that come from a robust healthcare endeavor will be even more endangered.

The rapid pace of healthcare reform requires the University to participate and to lead. The UMP is highly respected within the region, but its success in making an important clinical impact is being held back by the priorities of its hospital partner. Success in today’s marketplace requires that energy be redirected from a focus on past decisions to how the University’s clinical practice can succeed in the future.

Conclusion

The University of Minnesota’s Academic Health Center is strong. It plays a major role in the development of healthcare professionals for Minnesota and the nation, provides quality clinical care, and has a long history of important research breakthroughs.

The College of Pharmacy, School of Dentistry, and College of Veterinary Medicine are well ranked and play critical roles as the only schools for their professions in the state or region. The School of Public Health is a top-ten school, and the School of Nursing is playing a pivotal role in training nurses at the top end of their professions and with its growing research portfolio.
The Medical School has faced a number of challenges over the last two decades but is the main provider of physicians in Minnesota, offers the metro area's largest specialty practice plan, and has strong faculty performing groundbreaking research. The critical components exist to reverse the negative reputational trajectory and feelings of malaise that exist.

With the changing healthcare environment and the rapid pace of the biomedical sciences, the breadth of the expertise at the University of Minnesota—within and outside the Academic Health Center—offers great opportunity for excellence.

With new vision, important structural and leadership decisions made, and a focus on the future, the committee believes the goals expressed by President Kaler and those within the health sciences will be realized.

We thank all of you who participated for your time and candor.
External Review Committee

Dr. Kenneth Kaushansky

Dr. Kaushansky is the senior vice president for health sciences and dean, School of Medicine, at Stony Brook University. He previously served as professor and chair of the Department of Medicine at UC San Diego and as faculty at the University of Washington and Hematology section chief at the University of Washington Medical Center. Dr. Kaushansky earned his B.A. and M.D. degrees from the University of California, Los Angeles, and completed his residency and fellowship at the University of Washington.

Dr. Kaushansky has earned many awards and honors, including the Outstanding Investigator Award from the American Society for Medical Research and the Dameshek Award from the American Society of Hematology. Dr. Kaushansky is a member of the Institute of Medicine, the American Society for Clinical Investigation, and the Association of American Physicians.

Dr. Lee Goldman

Dr. Goldman is the executive vice president for health and biomedical sciences and dean of the Faculties of Health Sciences and Medicine at Columbia University. Previously he served as professor and chair of the Department of Medicine and associate dean for clinical affairs of the School of Medicine at the University of California, San Francisco, and professor of medicine at Harvard Medical School and professor of epidemiology at Harvard School of Public Health. He received is undergraduate degree, master’s degree in public health, and medical degree from Yale University. He did his clinical training in medicine at UCSF and Massachusetts General Hospital, and in cardiology at Yale New Haven Hospital.

Dr. Goldman as published more than 450 scholarly research articles and is the lead editor of the recently renamed Goldman’s Cecil Medicine. Dr. Goldman is a member of the American Society for Clinical Investigation and the Institute of Medicine. He has served in leadership positions in a number of organizations and has received the highest awards from the Society of General Internal Medicine, the American College of Physicians, and the Association of Professors of Medicine, as well as the Outstanding Achievement Award from the American Heart Association.

Dr. Carol Aschenbrener

Dr. Aschenbrener is the chief medical education officer at the Association of American Medical Colleges (AAMC). Before joining the AAMC she spent seven years as a consultant to academic health centers, focused on strategic planning. Previously she served as the chancellor of the University of Nebraska Medical Center and held various positions in the Dean’s office at the University of Iowa College of Medicine. Dr. Aschenbrener received her B.A. from Clarke College, her M.S. from the University of Iowa, and her M.D. from the University of North Carolina. She did her residency training at the University of Iowa Hospitals and Clinics.

Dr. Aschenbrener has served on the LCME, the ACGME, the Iowa Medical Society Board, and the AMA Council on Medical Education.