Association of Administrators in Academic Pediatrics
Winter Regional Conference – St. Petersburg, Florida
January 12, 2017 – January 14, 2017

*Theme: Here We Grow Again!*

Thursday, January 12th

| | |
|---|---|
| 4:00 PM | The Vinoy's Standard Check In Time |
| 5:00 PM – 8:00 PM | Registration Opens – The Vinoy Mezzanine Terrace Lobby |
| 6:00 PM – 9:30 PM | Networking Reception – The Vinoy Mezzanine Terrace |
| 9:30 PM – 11:00 PM | Hospitality Suite Open – Suite 253 |

Friday, January 13th

| | |
|---|---|
| 7:30 AM – 8:30 AM | Breakfast and Registration<br>The Vinoy Palms Court Center – Royal 1A |
| 8:30 AM – 8:45 AM | Welcome<br>The Vinoy Palms Court Center – Royal 1B<br>Beeper Rauckman Bennett, MHA, BSN, RN<br>Senior Director of Administration, Department of Surgery<br>Johns Hopkins All Children's Hospital |
| 8:45 AM – 9:30 AM | A Journey Toward Academic Transformation<br>Sylvia Powell, MBA<br>Assistant Vice Dean of Administration<br>Office of the Vice Dean of Education<br>Johns Hopkins All Children's Hospital |
| 9:30 AM – 9:45 AM | Sponsor Presentation: MillicanSolutions<br>Wesley Millican, President |
| 9:45 AM – 10:30 AM | Strategies in Affiliations and Collaborations<br>Jackie Crain, JD, MBA<br>Vice President and Chief Strategy Officer, Senior Counsel<br>Johns Hopkins All Children's Hospital |
| 10:30 AM – 11:00 AM | Break<br>The Vinoy Palms Court Center – Royal 1A |

| | |
|---|---|
| 11:00 AM – 11:45 PM | Co-Management Agreements: Physician-Hospital Alignment and Integration "When the Dust Settles"<br>Anthony Napolitano, MD<br>Chairman, Department of Medicine<br>Johns Hopkins All Children's Hospital<br>Associate Professor<br>Johns Hopkins University School of Medicine |
| 11:45 PM – 1:00 PM | Lunch Break<br>The Vinoy Palms Court Center – Royal 1A |
| 1:00 PM – 1:45 PM | Power Session<br>Mike Corbo and Nina Pickett |
| 1:45 PM – 2:30 PM | Marketing and Branding for Affiliations and Collaborations<br>Sylvia Ameen, CFRE<br>Vice President, Marketing & Communications<br>Johns Hopkins All Children's Hospital |
| 2:30 PM – 3:00 PM | Power Session<br>Mike Corbo and Nina Pickett |
| 3:00 PM – 6:00 PM | Afternoon Free |
| 6:00 PM – 9:00 PM | Evening Event<br>The Parkshore Grill Wine Cellar<br>300 Beach Drive NE |
| 9:30 PM – 11:00 PM | Hospitality Suite Open<br>The Vinoy – Suite 253 |

Saturday, January 14th

| | |
|---|---|
| 8:00 AM – 9:00 AM | Breakfast<br>The Vinoy Palms Court Center – Royal 1A |
| 9:00 AM – 9:45 AM | Creating Partnerships to Optimize Physician Engagement<br>Gregory A Hale, M.D.<br>Division of Hematology and Oncology<br>Johns Hopkins All Children's Hospital |
| 9:45 AM – 10:15 AM | Academic Transformation – Managing Change<br>Paul Colombani, M.D., FACS, FAAP<br>Chairman, Department of Surgery<br>President, All Children's Specialty Physicians<br>Robert Garrett Professor Emeritus of Pediatric Surgery<br>Professor of Surgery, Pediatrics and Oncology<br>Johns Hopkins University School of Medicine |
| 10:15 AM - 11:15 AM | Break and Power Session<br>Mike Corbo and Nina Pickett |
| 11:15 AM – 12:00 PM | Development & Integration of a Pediatric Sports Medicine Program<br>P. Patrick Mularoni, MD, FAAP, FACEP, SAQSM<br>Medical Director, Sports Medicine<br>Johns Hopkins All Children's Hospital<br>Associate Professor, Pediatrics<br>Johns Hopkins School of Medicine |
| 12:00 PM – 12:15 PM | Sponsor Presentation: [for]MD Physician Collaboration Network<br>Greg Chang, Cofounder<br>Dan Schweber, Manager, Community Development |
| 12:15 PM – 12:30 PM | Sponsor Presentation: Culbert Health Solutions<br>Michael Cleary |
| 12:30 – 12:45 | Closing Remarks |

# JHACH: A Journey towards Academic Transformation

Sylvia R. Powell, Associate Dean, Johns Hopkins All Children's Hospital

AAAP Winter Regional Conference, St. Petersburg, FL.
January 13, 2017

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
ALL CHILDREN'S HOSPITAL

# Our History & Culture

1926 – American Legion Hospital for Crippled Children

1967 - All Children's Hospital

2010 - All Children's Hospital New Facility

2011 – All Children's Hospital Johns Hopkins Medicine


2016 – Johns Hopkins All Children's Hospital

## Vision

Creating healthy tomorrows…for one child, for All Children

## Mission

Provide leadership in child health through treatment, education, advocacy and research

*Treatment*
Deliver quality services with compassion and commitment to family centered care

*Education*
Provide educational programs for our patients, families, employees and healthcare professionals

*Advocacy*
Provide leadership in promoting the wellbeing of children

*Research*
Develop, support, and participate in clinical, basic and translational research

## Values

- Honesty and Integrity
- Inspiration and Hope
- Collaboration and Team Work
- Inquiry and Innovation
- Compassion and Respect
- Responsibility and Safety

## Value Statement

"There is only one child in all the world and that child's name is All Children"
- Carl Sandburg

## Our Culture

We trust each other to do the right thing for patients, families and each other. We inquire and inspire, we embrace change, we create knowledge and train future pediatric leaders. We strive to be the best.

# The Story - Beginnings

- Community Hospital, private practice model.
- Excellent regional reputation – 17 counties market
- Robust Balance Sheet
- New state of the art facility
- Expert Clinicians – broad representation of pediatric specialists and subspecialists
- Medical Staff > 250; ~130 employed; others private or USF faculty
- Board's vision of an academic hospital

# Outreach Centers & Hospital Affiliates/ Collaborations

**Primary Service Area:** West Central Florida
- Total Population: **5.5 Million**
- Total Population Age 0-17: **1.2 Million**

## Outpatient Care Centers

Brandon

East Lake

Ft. Myers

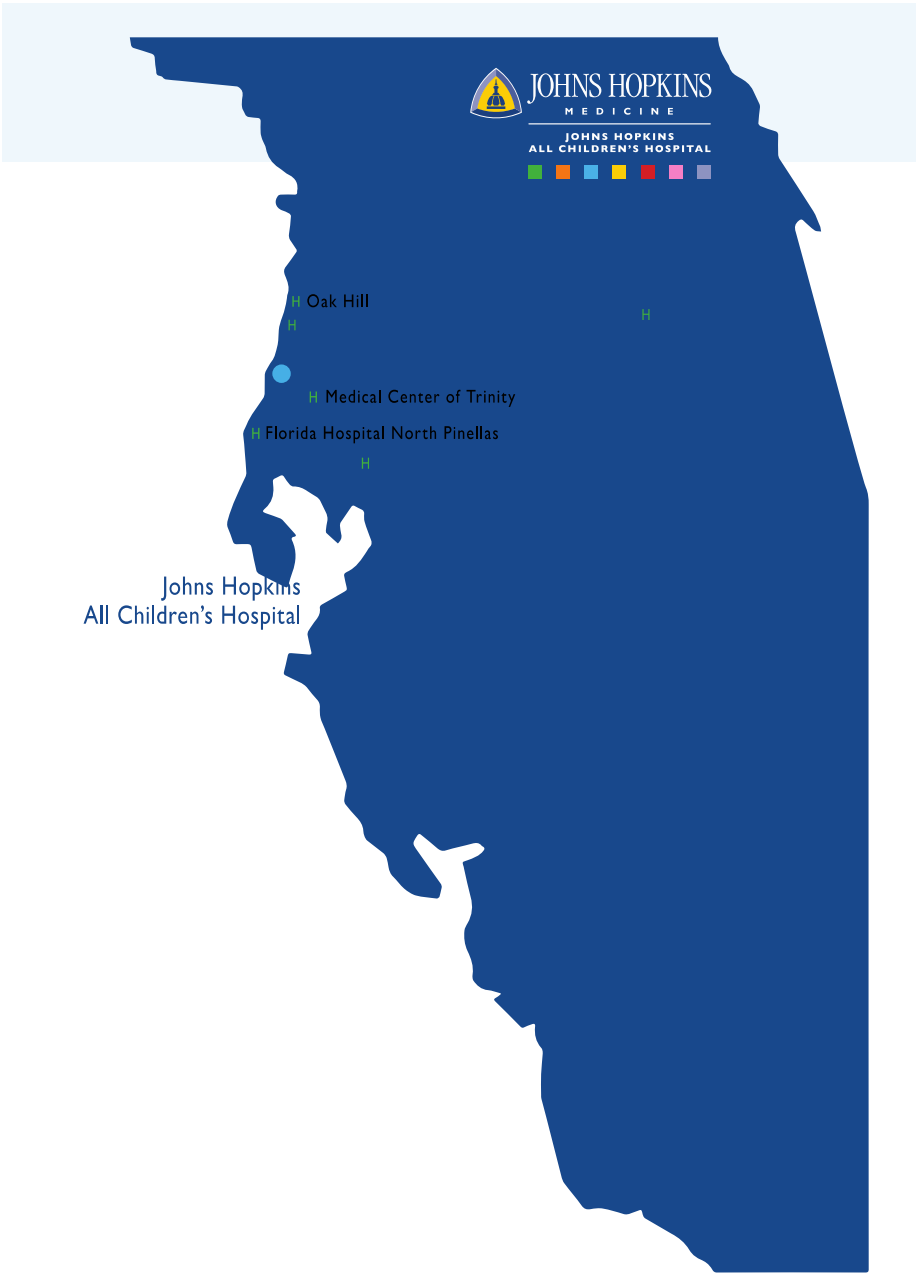
Lakeland

Pasco

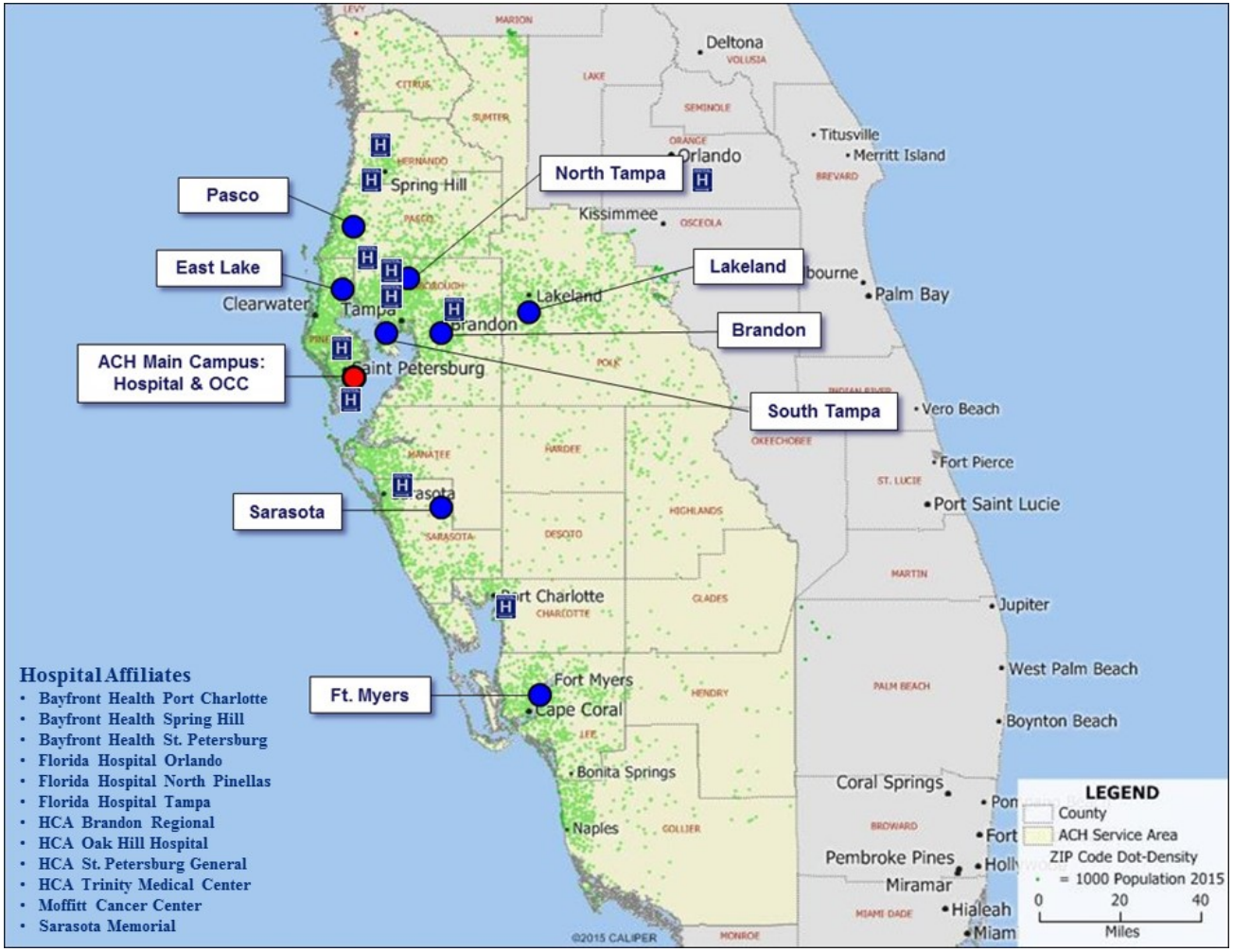
Sarasota

South Tampa

Tampa



# Johns Hopkins All Children's Hospital's Regional Presence



# What is Transformation?

Transformation implies a major change in form, nature, or function.

Merriam Webster's Dictionary defines it as:

Trans.for.ma.tion – *noun* – A **thorough or dramatic** change in form or appearance.

Trans.form – *transitive verb* – To **change in composition or structure**; to change the outward form or appearance of; to **change in character or condition.**

# All good stories require imagination and visioning!

The heart of this story is the desire of a community hospital to imagine a future vision as an academic medical center through restructure, and by innovation and building.

- Common element of all imagination, is envisioning the end result; looking through the obvious to the foundational elements that will ensure good results. i.e. good bones, great reputation, track record, great potential, value proposition with opportunity for innovation.
- Planning is essential to ensure good outcome.
- Enpowerment and Engagement – the secret sauce.
- The unknown factor – opportunities and challenges.

# Value Proposition for Integration of ACH into JHM/JHHS

- Expand the value of All Children's Hospital for the benefit of the children and families of the Tampa Bay region, Florida, and southeastern United States
- Expand the value of JH Pediatrics by creating research, training, and leadership opportunities for faculty of JHSOM Department of Pediatrics and other JHSOM Departments within JH Children's Center.

# JHACH's Vision

- Every child in the region, if not the state, will have access to the highest quality and safest care, have the best patient experience, and receive that care at the lowest cost

# April 1, 2011 – Definitive Agreement signed.

- Leadership – CEO, CAO, SR VP Strategy, CNO, VP Med Staff, President ACSP.
- Minimal physician involvement in decision making
- Employed physician group's organizational structure had no real governance and limited ability to influence in critical decisions of their practice, on resources/systems needed to operate the practice optimally; and had minimal or little involvement in hospital decisions.
- Physician Practice – private physician model; emphasis on clinical service and WRVU's.
- Strong and involved Board of Trustees
- After Definitive Agreement with JHM – two new positions added to the leadership: Vice Dean and Assistant Dean.

# The Story- Prologue

## Our present

## Our Future

# Chapter 1- The Strategic Plan - you need a roadmap

"If you don't know where you are going, you will end up somewhere else"
*Yogi Berra*

# Ten Year Academic Strategic Plan

Hospital and Board commitment of $240M; $160M for academic integration and $80M for Research & Education Building.

**Critical components:**

- Residency Program – 12 slots per year, Tuition assistance for first 3 classes.
- Director and Associate Director, OME
- Core full time faculty (7), Residency Program
- Fellowships ( 3)
- Director, Research
- 2 Institutes – ( CBDI and NS) leadership, core faculty, program support – start up packages 5-8 years, starts staggered over ten years.(10 faculty slots)
- 4 Programs with specific disease focus ( Hearts, Neo, Diabetes-Obesity and Allergy/Immunology. (9 faculty slots)
- 4 Cores – CTRO (Clinical Translational Research Organization), Biorepository, Biomedical Informatics, Metabolic Determinants. (7 faculty slots)
- 2 Physician Scientist recruits, program support for team and start up packages for 5 years. (6 faculty slots).

# Chapter 2 The Residency Program

- Think Tank retreat with national experts in graduate medical education, JHU faculty and ACH executives – tasked in developing innovative Peds Residency curriculum (late spring 2011)
- PIF – completed and submitted to ACGME Oct. 2011
- Director and Associate Director of OME hired ( Nov and Dec 2011)
- ACGME Site visit – Feb. 2012
- ACGME RRC reviews program application and approves it July. 2012
- July 2012 to Oct. 2012 - full court press to advertise new program in national meetings, medical student forums, web and social media presence.
- Oct. 2012 to Feb. 2012 residency candidates interviews, ranking and submission to National Match Program.
- March 23, 2012 – National Residency Match Day – we filled all our 12 slots!!!

# GME Training Programs-today

- Residency Program- full cohort, 35 residents
  - Fellowships – Pediatric Surgery – 2 clinical fellows, 1 research fellow.
  - Fellowships - Palliative Care, Neonatology and Hospital Medicine applications submitted. Critical Care, Emergency Medicine in planning stage.

# Chapter 2 - Faculty Appointments

- Developed JHACH criteria for full versus part-time faculty
- Developed initial considerations for part-time faculty appointments
- Developed faculty policies that apply to full and part time faculty

# Faculty Appointment Criteria

- Full Time
  - A JHU employee
  - Evidence of drive, skills, and experience to advance on promotional track; JHU has only 1 track, tenure.
  - ≥30% of effort is engaged in scholarship (clinician-scientist or clinician-educator)
- Part Time
  - Not a JHU employee (ACSP employee)
  - Strong record of scholarship OR substantial role in teaching mission
  - ≤20% of effort is scholarship

# Faculty Appointments

- JHACH offers full time and part time appointments
- Both types of appointment offer same faculty development opportunities
- All physicians eligible for faculty
- Current status:
  - 61 Part Time Faculty
  - 3 Part Time Adjunct Faculty
  - 22 Full Time Faculty

# Current Faculty Breakdown

**Full Time Faculty**

- 3 Instructors
- 9 Assistant Professors
- 5 Associate Professors
- 5 Full Professors

**Part Time Faculty**

- 26 Instructors
- 30 Assistant Professors
- 2 Associate Professors
- 3 Full Professors
- 1 Adjunct Assistant Professor
- 2 Adjunct Professors

# Academic Process

- Performed as role under the Vice Dean
- Johns Hopkins University process
- All appointments flow through the JHUSOM Department Chair

# Faculty Appointments – not required

A faculty appointment is not required as a condition of employment.

But all employed physicians must support the mission!

# Chapter 3 – Research infrastructure

- ACH IRB transitions to JHU IRB Oct. 2013 and becomes the 7th JHU IRB Committee. Standard format for all JHU IRB's re: conduct of meeting, review, minutes. Legal expert and an ethicist, part of committee.

- Conversion to eIRB, JHU's on line system for entry and tracking of protocols, approximately 1 year later. Enhanced ability to have same study opened in multiple campuses; full review for initial site and expedited review for subsequent sites. Connected the campuses.

- DCRP (Designing Clinical Research Program) first cohort – program led by JHU Baltimore based faculty to mentor physicians at ACH in clinical research. Participants select a project, prepare protocol, initiate and complete study; submit abstract and/or paper for publication.

# Research infrastructure cont'd.

- 4 DCRP cohorts completed, 5th cohort, program transition to a CTRT (Clinical Translational Research Training) with a focus on resident and fellows as the participants.

- JHM & ACH Shared Mission Agreement – overarching agreement that immortalizes our common goals and objectives for the tripartite mission. Under its umbrella multiple addendums including research and clinical services.

- Shared Mission Agreement – allows for ease of collaboration via efficiency in executing agreements between affiliates and the university.

# Research support infrastructure

# Research support units

- Research operations unit – study coordination, research nursing, project management.
- Investigational Drug Services Unit – storage & dispensing.
- IRB Office
- Research Regulatory Affairs – Q/A, internal monitoring, compliance, training.
- IND/IDE – regulatory, filing of forms, training.
- Epi/Biostat – study design and support
- Data management
- Research Administration – pre and post award.

# Research Initiatives

- Biorepository – biospecimen processing and banking, CAP accredited.
- iPics study – 14 disease prospective collection/storage pertinent clinical data and biospecimens in children with pre-specified acute and chronic conditions to determine prognostic relationships. Foundation for faculty recruitment, grant submissions, resident & fellows publications and mentorship. Future research studies.
- Metabolic Determinants Core – focus on proteomics, metabolomics and lipidomics; sample processing and analyses scheduled to start in March 2017.
- Epi/Biostatistical Support – assistance with study designs, power calculations for statistically significant research structure and sample population. Now part of the Health Informatics Core.

# JHAC Research & Education Building

- 230,000 Square Feet
- $95.5 M
- Construction Jobs
  - Minority
  - Local
  - Veteran


Opening 2018

# Research & Education Building

## BUILDING FACTS

- Construction began – early 2016
- Construction complete – 2018
- Approximately 230,000 square feet
- 7 floors
- 250-seat auditorium, simulation lab and flexible spaces for team-based learning
- Research lab space & research offices, expanded pediatric biorepository, and new biomarker research program
- Academic and research offices for institutes focused on key areas of child and maternal health
- Open and flexible design will support collaborative research and education

## THE ECONOMIC IMPACT

- Estimated 300 construction jobs
- Estimated 30 new highly skilled jobs, including faculty, educators, researchers & support staff
- Estimated 200 faculty, educators, researchers, physicians, nurses & support staff will be housed in the new building

# Chapter 4 - Physicians are critical to the mission

- Physician leadership is critical to the development of the AMC.
- The patient is at the core of all roads in the academic medical center.
  - achieving excellence is the driver
  - medical research and medical education need an environment or connection to clinical care.
  - The clinical enterprise  on the other hand can exist without the other two.
- The future of the AMC is secure as long as the interdependence exists.

# Excellence = Survival

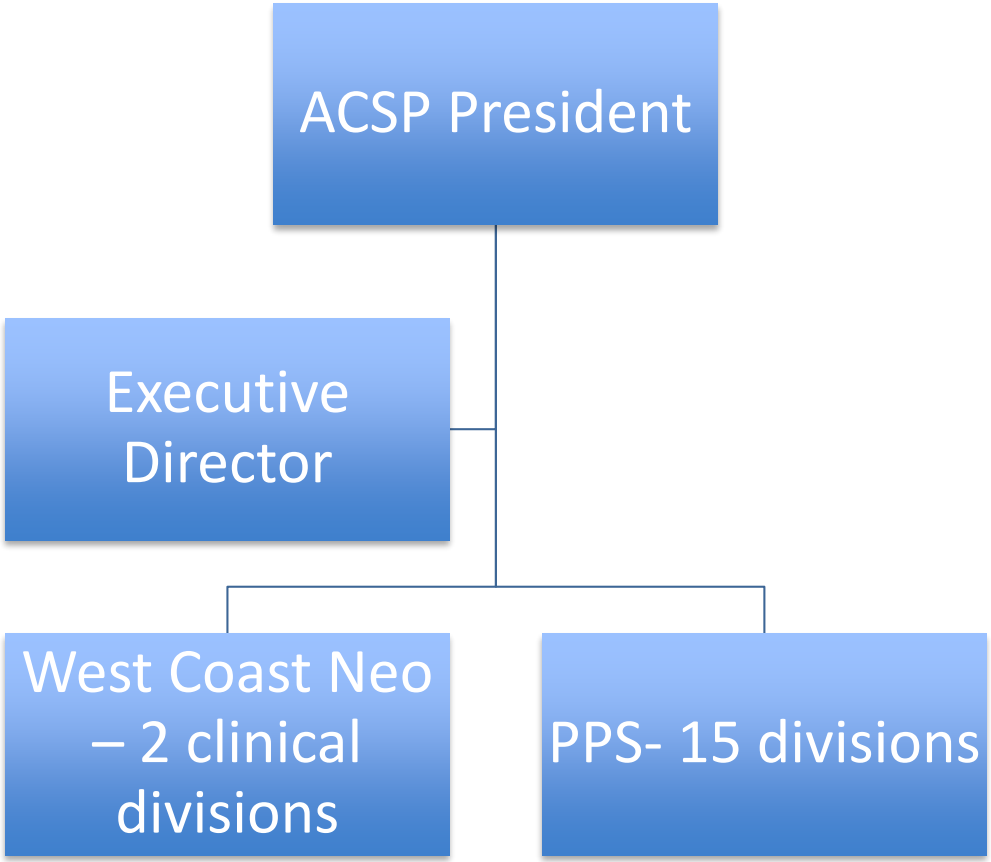
-Clinical enterprise has to rely on excellence (cutting edge, clinical trials, multi-disciplinary care, niche care) in order to attract constant stream of patients.

High cost and difficulties to access services are deterrents

Superior quality has to be the differentiator. Sometimes the AMC is a facility of last resort.

Physician Group's organizational structure must support and not create barriers to achieve the AMC's goals.

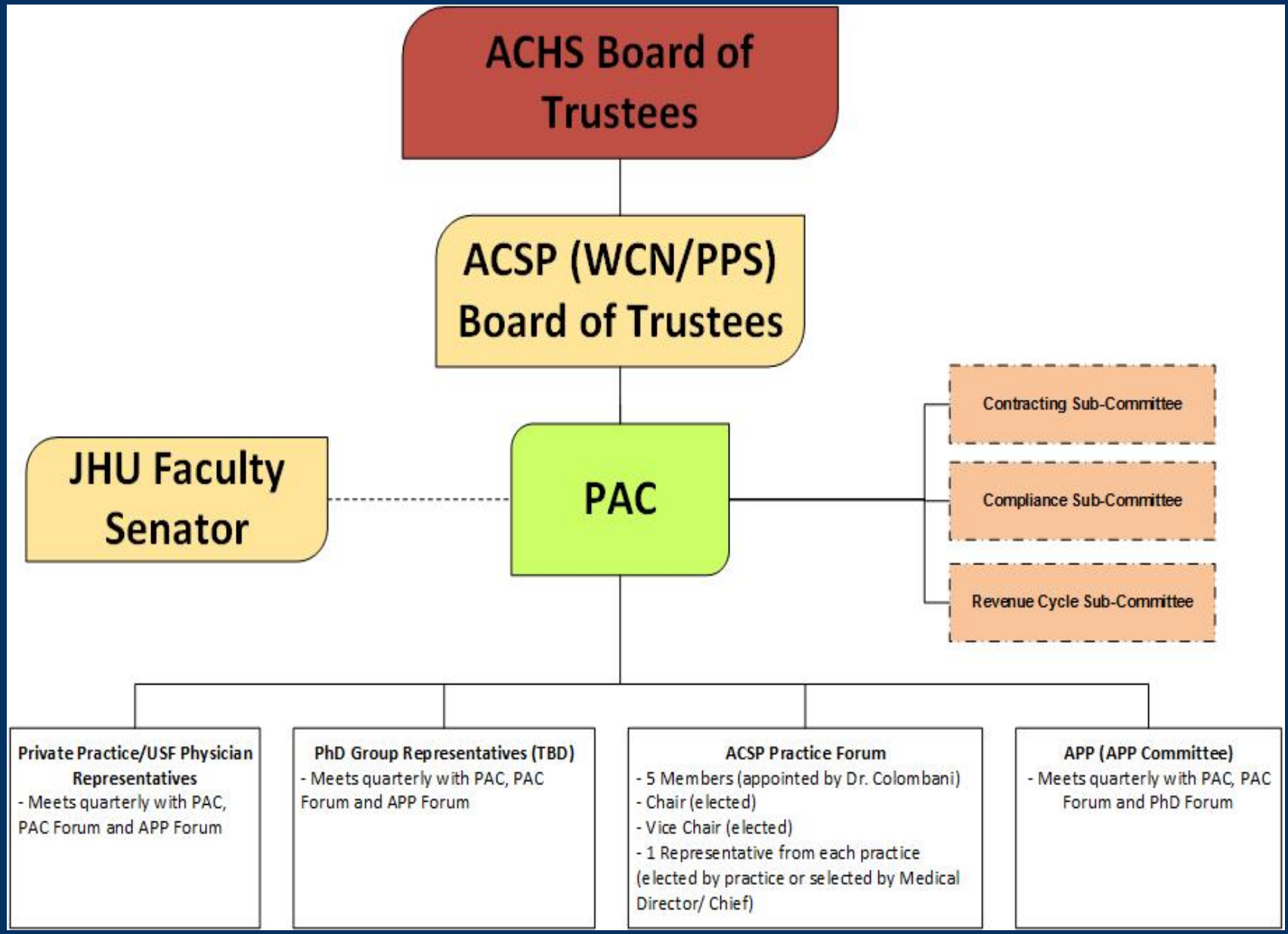
# Physician organization – two corporations, 17 clinical divisions



# Physician Advisory Committee- new concept

- Incorporate physician voice into ACSP governance and encourage collaboration and engagement.
- Integrate multi specialty practices to allow physician input of strategic decisions.
- Develop minimum productivity standards and recommend changes to compensation plans.
- Develop Quality & Safety Standards
- Set guidelines for Accountability for subcommittees or task forces.

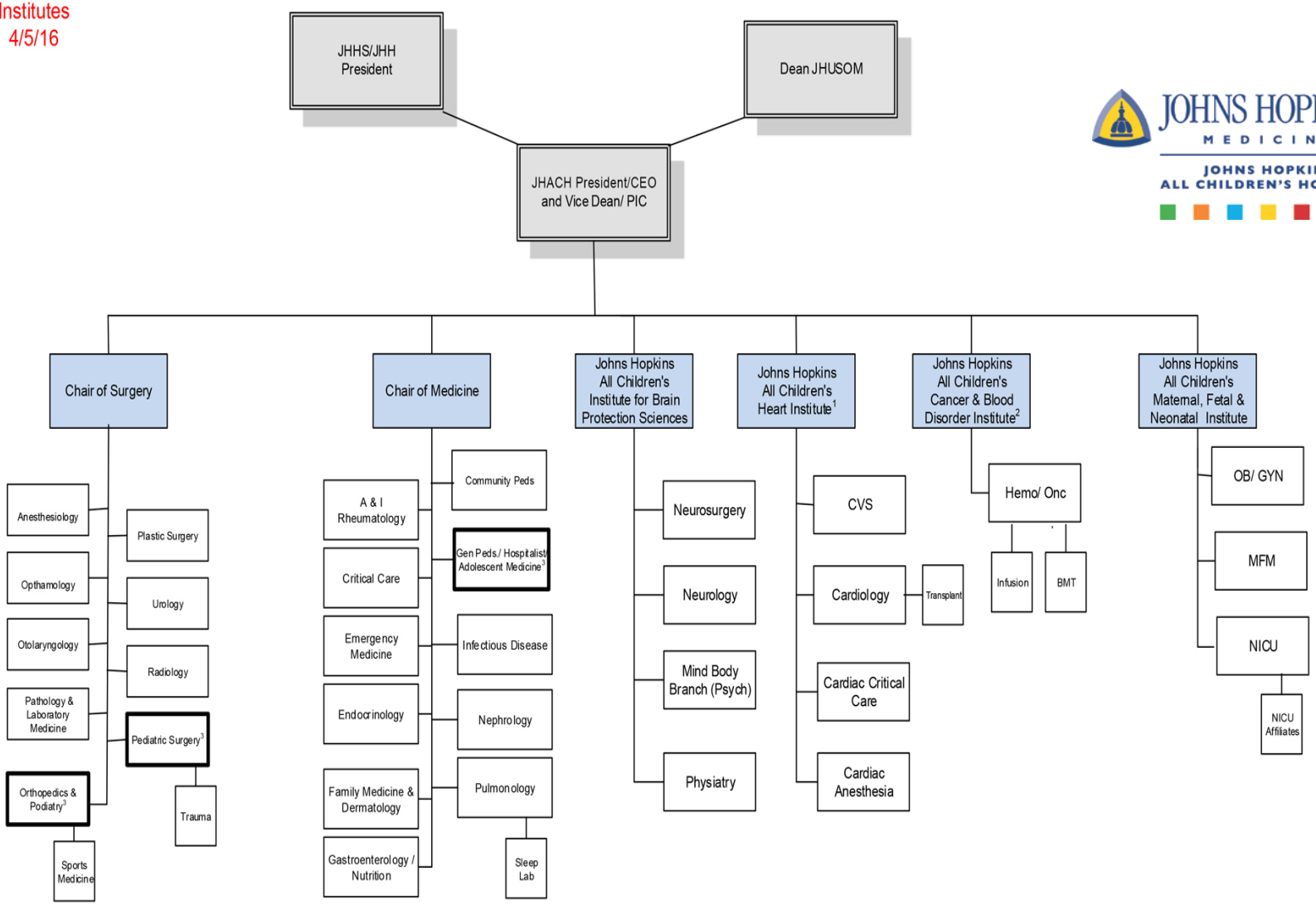
# Physician Group – incorporating a voice in ACSP governance



# Physician Group new organizational structure

- In alignment with Academic Medical Centers structure.
- 2 departments – Medicine and Surgery
- 4 Institutes:
  -Cancer and Blood Diseases
  -Hearts
  - Institute for Brain Protections Sciences
  -Neo/MFM

Institutes
4/5/16




1. Collaborates with and is responsible in part for cardiac anesthesia, CVICU, outpatient cardiology
2. Collaborates with and is responsible in part for infusion center
3. Additional prioritized service lines

# What we've learned: fine tune as needed – good maps have more than one route to final destination.


Rigid roadmap vs. agile development

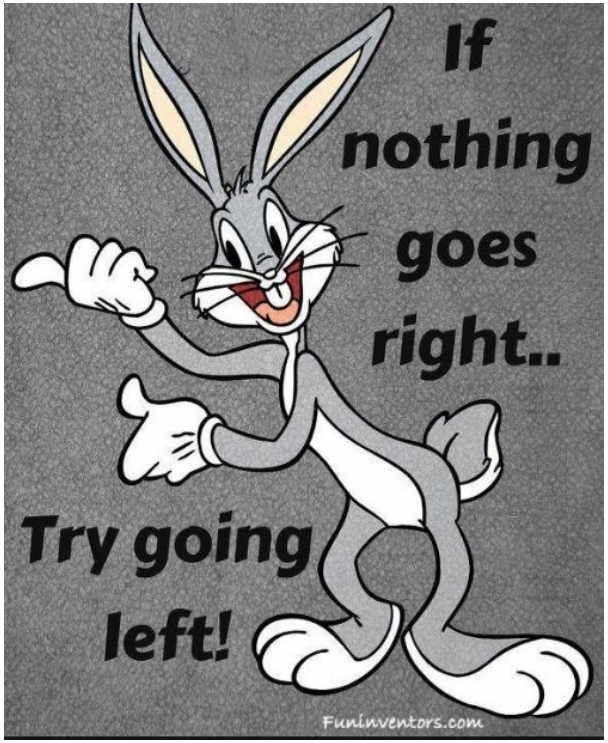
An engaged leadership structure has allowed us to :

- Assess change in the environment and pivot and adjust tactics as needed.
- Recalibrate plans without compromising ultimate goal.

  i.e. changes in recruitment strategies; modified original plan and created 4 Institutes.
- React to opportunities presented; quickly determine value proposition and assess whether to engage or not.

# Recalculating – inertia is fatal

This




Not This

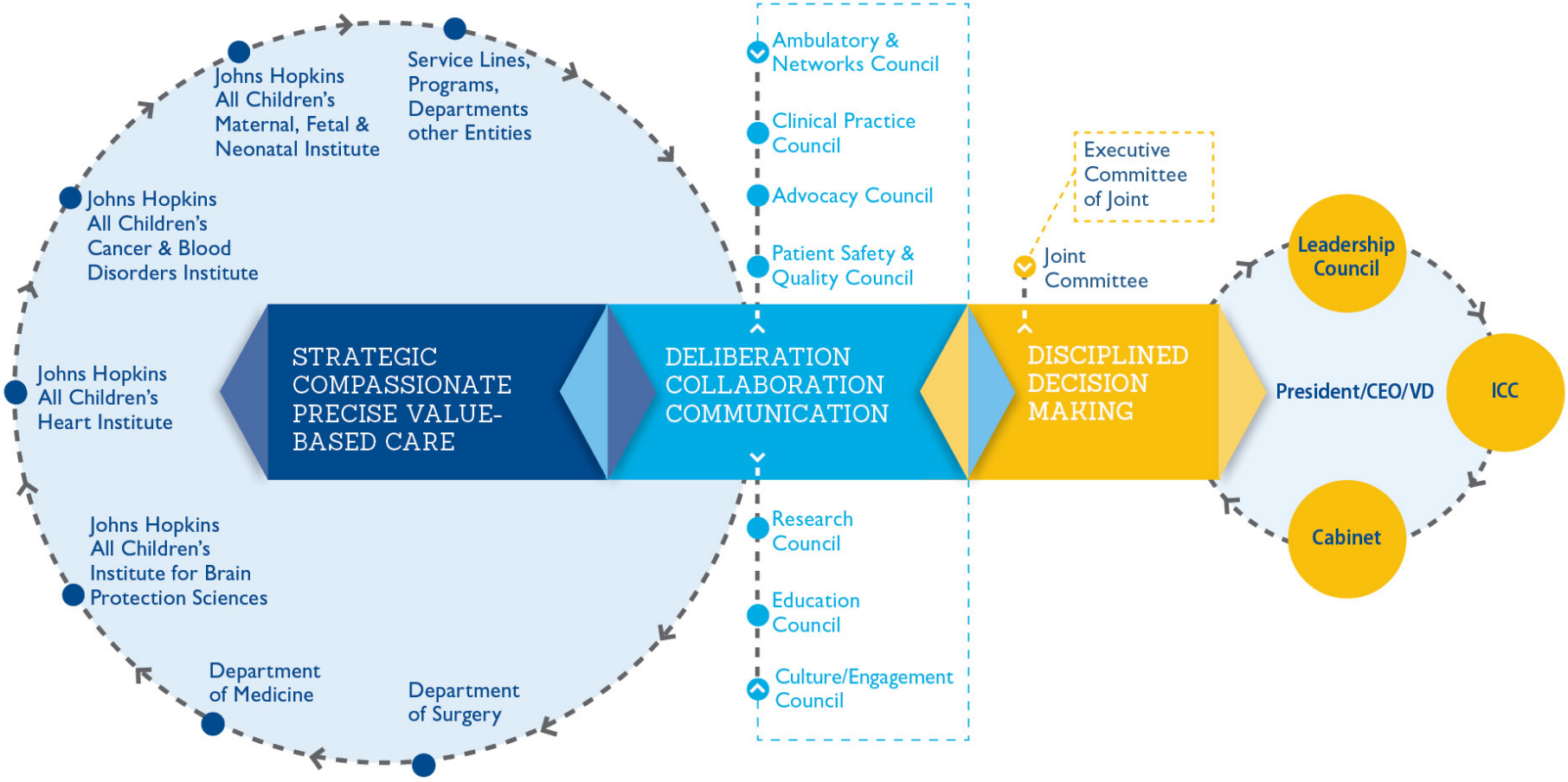

Lack of good planning and deliberate, thoughtful decision making = bad outcomes.

# Strategic Campus Master Plan and Clinical Prioritization

Engaged Flad Architects and KSA – 2014 and 2015

- Master Campus plan 10 year projection
- Incorporated academic strategic plan
- Confirmed understanding of ACH market and competitive
- environment
- Identified service lines/sub-specialites – determined evaluation criteria to be utilized for prioritization of clinical growth.
- Physician involvement in focus groups and leadership group.

# JHACH Leadership Architecture



# Who We Are Today

## Treatment
*Leading Pediatric Care*

- Cancer & Blood Disorders Institute
- Heart Institute
- Institute for Brain Protection Sciences
- Maternal, Fetal & Neonatal Institute
- Departments of Surgery and Medicine

## Education
*Training the Best for the Future of Pediatric Health*

- Accredited Pediatric Residency Program
- Pediatric Subspecialty Fellows
- Collaboration with USF Health Morsani College of Medicine
- Nursing and Pharmacy Residency Program
- Leadership Development and Management Training Programs

## Research
*New Approaches Making Cures Achievable*

- Over 300 IRB approved active studies
- Florida's only accredited pediatric biorepository
- New research building under construction
- Cutting edge clinical, translational and bench research studies

## Advocacy
*Championing Healthy Futures*

- Mission based community health programs such as Healthy Start and Fit4AllKids
- Injury Prevention programs such as Safe Kids
- Community Benefit Community Benefit
- Citizenship
- Legislative: Voice4Allkids

## FY2016 Vital Statistics

| | |
|---|---|
| Licensed beds | 259 |
| Percentage ICU beds | 57% |
| Inpatient admissions | 6,887 |
| Total surgeries | 9,187 |
| Emergency Center visits | 48,835 |
| Outpatient visits | >450,000 |
| Employees | >3,100 |

** July 1, 2015 - June 30, 2016*

# Johns Hopkins All Children's Hospital FY2016 Statistics

| | | |
|---|---|---|
| Admissions | | 6,887 |
| Patient Days | | 58,761 |
| Observation Patients | | 3,510 |
| Average Daily Census | | 161 |
| Average Length of Stay | | 8.5 |
| Case Mix Index (APRDRG) | | 2.26 |
| Surgeries | Inpatient | 1,902 |
| | Outpatient | 6,954 |
| | Cardiac (CVOR) | 331 |
| | Cardiac Transplant | 9 |
| Emergency Center Visits | | 48,835 |
| Outpatient Visits | | 415,824 |


# EnVISION2020

Johns Hopkins All Children's Hospital will be the leading pediatric academic health system in the State of Florida by 2020. *We aim to achieve this internal vision by*

- delivering the highest quality and safest patient-centered care with best possible outcomes from perinatal to adulthood;
- ensuring a strong workplace culture and community citizenship
- using an integrated, coordinated and continuous delivery model involving our main campus, outpatient care centers, home care and collaborations with regional/community providers to create value for families, our system and payers
- teaching future healthcare leaders and advancing research to make cures more achievable
- transforming pediatric healthcare policy through advocacy
- achieving high physician and employee satisfaction and engagement

# Chapter 5

Story To Be Continued…….

# Questions?

Contact Information:  SPowel24@jhmi.edu

**Sylvia R. Powell, M.B.A.**

**Associate Dean for Administration**

**Johns Hopkins All Children's Hospital**

Sylvia Powell joined Johns Hopkins University School of Medicine in the Office of the President and Vice Dean for Johns Hopkins All Children's Hospital in July 2011. She is one of 16 Associate Deans at Johns Hopkins Medicine, and a key force in shaping the education and research programs and leading academic growth at Johns Hopkins All Children's Hospital. Her leadership and efforts were essential in expanding the research and academic enterprise, including the launch of the pediatric residency program, new fellowships, the pediatric biorepository and the four Johns Hopkins All Children's institutes.

Ms. Powell provides administrative oversight of the development and growth of clinical, translational and basic research programs, including the CTRO and the biorepository. She is responsible for academic affairs, including faculty development, fellowships, and the Johns Hopkins All Children's Hospital Pediatric Residency program.

During more than 30 years at the University of Miami, School of Medicine, Ms. Powell held several administrative roles. She was Vice Chair of Administration for the Department of Neurology and previously served in other positions that focused on academic affairs, research administration, professional services and contracting. In 2008, she became the Director of Administration for the Children's Center for Cancer and Blood Diseases at Children's Hospital Los Angeles, part of the Keck School of Medicine at the University of Southern California. In this role, she was responsible for all research, professional practice and service line operations of the Children's Center, overseeing a $119 million budget.

Ms. Powell holds an M.B.A. from the University of Miami.

# Strategies in Affiliations and Collaborations

Jackie Crain, VP, Chief Strategy Officer

January 13, 2017

90 YEARS OF CARE 1926 2016

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

# Roadmap of contents

- “Why” align
- External assumptions
- Start with goals
- Types of agreements
- How to move forward

# The “Why”

- Healthcare is not getting less complex or less costly
- Hospitals and physicians are interdependent for some purposes and competitive in other instances
- Physician employment ≠ Alignment

# Reasons to Align

- Volume based care
- Patient- centric care
- Reimbursement models
- Standardization
- Increased quality/ better outcome
- Patient satisfaction
- Narrow networks
- Operational improvements

# Contractual Relationship vs. Employment

- Continued autonomy
- No changes to payroll or benefits
- Control of staff and office operations
- Flexibility for outside activities
- Little to no investment

# Benefit and Value

- The benefit of alignment is financial
  - Change the payment dynamics for each party
  - Global fee arrangements

- The value of alignment is the relationship
  - Long term trends
  - Impact on both party's patients

# The “Parties”

## Physician

- Values autonomy
- Values quick decision-making
- Seeks consensus with the group

## Hospital Executive

- Values mission and rankings
- Values group thinking, uses deliberate process-based decision making
- Comfortable in hierarchical top-down organization structure

# Start with goals

- Discuss goals upfront
- Ensure a value proposition for each party

# Recognize and discuss the different goals

Sample Goals:

- Money
- Market share/ new service
- Meet milestones
- Regulatory
- Defensive tactic
- Mission
- Reputation/ brand exposure
- Data
- Exclusivity

# Write out the Value Proposition

- Shared goals
- Primary goals
- Secondary goals

**Example:**

The parties will refresh a long standing collaboration to provide a network of care where babies and children will be able to receive the safest/ best care possible, in the right setting.

Party 1-

- Remodel clinical relationship to include greater emphasis on quality and research
- Expand geography
- Partner to increase brand awareness

Party 2-

- Readiness for risk contract
- Increase multi-site research opportunities
- Add exclusivity and telehealth

# Types of Agreements

First

- Consider perspectives, steward the relationships and prepare goals

Then

- Consider the type of agreements

# Agreements

- Medical Director Agreements
- Call / Call – Back Agreements
- Supervision and Teaching Agreements
- Gain-sharing Agreement
- Co- management agreement
- Affiliation Agreements

# How to Move Forward

- Continually review and re-examine goals
- Take the time needed
- Leave time for market analysis by outside vendor
- Ensure legal/ compliance review up front
- Customize the arrangement
- Share leadership for the project; be transparent
- Establish metrics and milestones

# How to Move Forward

- Agree to a principle document (no more than 6-8 bullets)
- Set a target start date
- Agree to the type of agreement

# Examples of Principles Document

Next Steps

1. Define the service line(s)
2. Form a steering committee
3. Sketch baseline metrics
   - Use national benchmarks
   - Ensure you can access the data to measure
4. Define timeline
5. Agree to compensation model
   - If flat fee (not hourly) generally 50% is at risk for performance goals

# Typical Features of a Co-Management Agreement

- Co-management agreement is typically comprised of a base fee and an incentive fee.
  - Unless there are investments and new corporations anticipated
  - To avoid hourly fees and time records

- The co-management agreement will replace any existing medical director agreements.

- The agreement stipulates a listing of core management/ administrative services to be provided by the manager (for which a base fee is paid)
- Metrics and milestones are set forth in advance

# Service Line Co-Management  Agreements

Sample Core Services:

- Clinical improvements
- Workflow process improvement
- Physician and patient scheduling
- Nurse and non-physician clinician oversight
- Patient case management activities
- Credentialing activities
- Materials management
- Medical Staff committee service and leadership

# Sample Metrics

- Patient satisfaction survey
- Percutaneous coronary intervention within 90 mins
- Readmission rates
- AMI mortality (actual vs expected)
- USNWR ratings
- Maintain block-time utilization performance
- 100% first case on-time start for each surgeon presence

# Key Legal Issues

- Anti-Kickback Statute Safe Harbors
- Civil Monetary Penalty Statue
- Stark Act
- False Claims Act
- 501 (c)(3) Tax Exempt Issues
- Provider based Status Rules
- Fair market value and commercial reasonableness

# Sample weighting/ calculation

**Sample 1** – (10% of performance based compensation)

- Maintain block time utilization performance of 75% or higher as set by the hospital's Block Time Scheduling and Utilization Policy.

**Scoring**

Percent of block time utilization:

- 73% - 76%= 2 points
- 77% or higher = 3 points

**Sample 2** – USNWR (25% of performance based compensation)

- Achieve ranking in USNWR = 1 point
- Achieve ranking between 40 and 50 in USNWR = 2 points
- Achieve ranking better than 40 in USNWR = 3 points

# Potential Problems

- Failure to define service lines that are subject to co-management
- Failure to include a process to change leadership / director role
- Failure to actively manage and document metrics / milestones
- Failure to appoint a committee (not hospital executive) to evaluate performance

# Before you Finalize

- Re-review goals/ value proposition
- Consider approvals (Boards, Medical Staff)
- Consider FMV & Legal review
- Communicate specifics (exclusivity, brand)
- Set a frequent schedule to meet about scores, metrics, opportunities

# Disclaimer

The views and opinions expressed herein are those of the presenter and do not necessarily reflect the views of Johns Hopkins All Children's Hospital, its affiliates, or its employees.

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**Jackie Crain, J.D., M.B.A.**

**VP, Chief Strategy Officer and Sr. Legal Counsel**

**Johns Hopkins Health System**

Jackie Crain serves as Vice President, Chief Strategy Officer and Senior Legal Counsel of Johns Hopkins All Children's Hospital. In this role, she oversees the areas of business services including strategic planning, business development and affiliate programs, as well as overseeing the areas of legal affairs, corporate governance, risk management, claims management, licensure/regulatory affairs and local compliance.

Mr. Crain was named Senior Counsel, Johns Hopkins Health System, in January of 2012, with oversight responsibility at Johns Hopkins All Children's Hospital, where her experience spans more than a decade through her service as in-house counsel for All Children's hospital as a representative of the law firm retained by the health system.

She has been a strong advocate for patients, their families and the hospital, and champions the unique health care needs of children and Johns Hopkins All Children's vital role as an essential provider of pediatric services for children from across the state of Florida and beyond.

Ms. Crain graduated cum laude from Florida State University and earned her M.B.A and J.D. cum laude from Stetson University College of Law in St. Petersburg, Florida.

# Co-Management Agreements: Physician-Hospital Alignment and Integration

## "When the Dust Settles"

**Anthony Napolitano, MD**

**January 13, 2017**

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# LET THE CELEBRATION BEGIN !!!

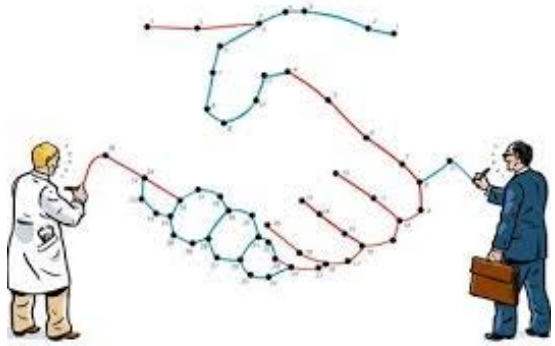


# WHAT HAPPENS NEXT ?

# DUST SETTLES:  CLARITY ?

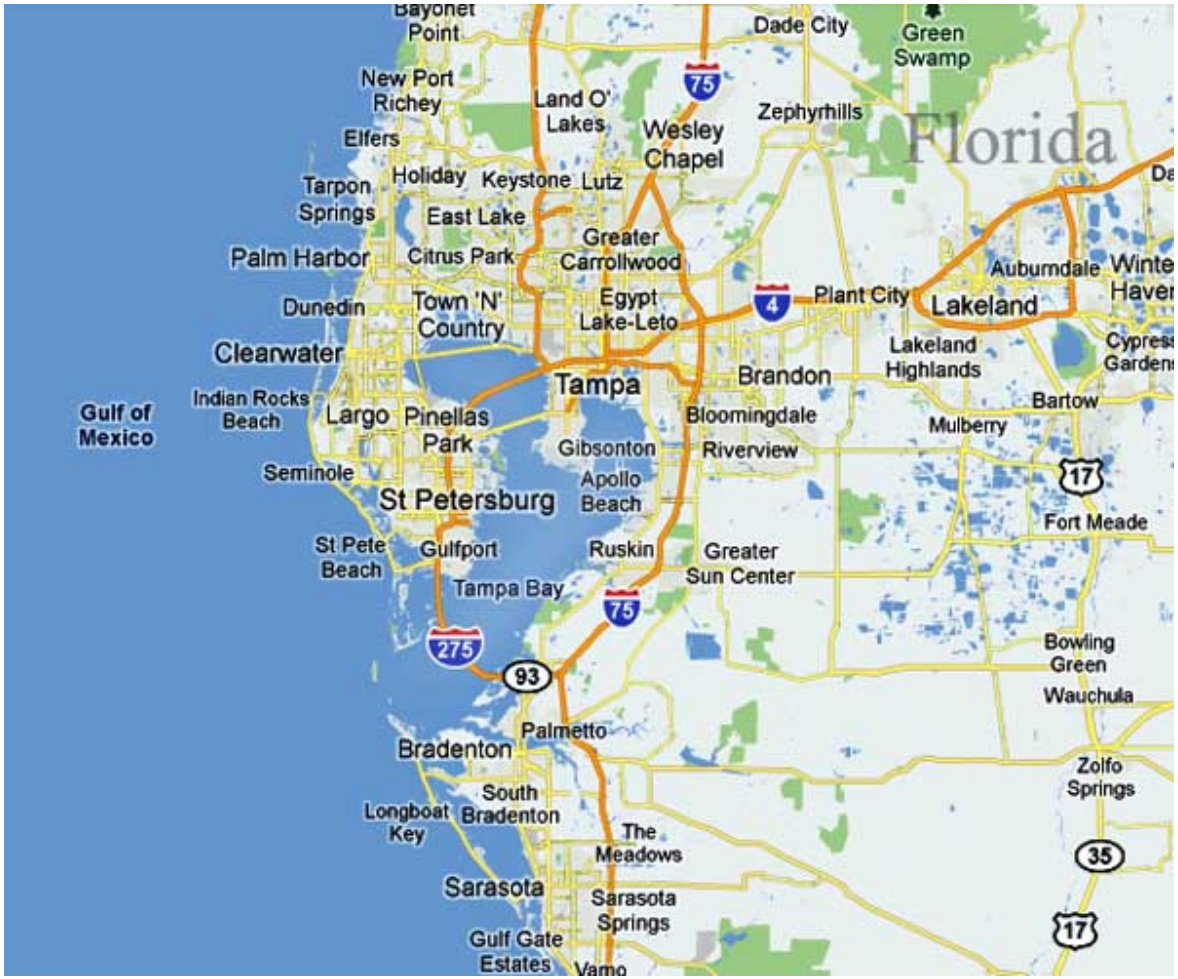

# DID WE GET IT RIGHT ?

- **Physician-Hospital Alignment: “All In”**
  - Not just about Physicians
  - What is the Focus: The Patient?



# LOCATION, LOCATION!

# Tampa Bay, Florida



# PEDIATRIC ACADEMIC MEDICAL CENTER PROSPECTIVE (What can we offer?)

- Increase the depth and breath of Pediatric Care
- Best Practice
- Quality and Safety of Care
- Efficiency (Cost)
- Teaching
- Branding
- (Research)

# "COMMUNITY" HOSPITAL (What can they offer?)

- Patients
- New/Increase Market Share
- Local Access to care
- Potential Network
- Care Transition
- Efficiency & Economic
- (Education)
- (Research)

# TYPE OF AGREEMENT

**AFFLIATION** ⟷ **CO-MANAGEMENT**

# AFFILIATIONS vs CO-MANAGEMENT

## Affiliations

- Lose agreements: (+/- alignment)
  - Academic Medical Center strategies
  - Affiliate Strategy
- Medical provider support
  - Physician
  - APP
  - Nursing
- Goals
  - Academic Medical Center: referrals
  - Affiliate: new service line
- Best Practice
  - Variable
- Quality Metrics
  - Assess the relationship
  - Volume > Value?
- IT Support: Variable

## Co-Management/Hub

- "All in" Agreement:
  - Alignment of common strategies
    - Agreed Upon (Global)
  - Individual strategies
- Medical Provider:
  - Physician, APP
  - Integration
- Goals:
  - Agreed upon alignment
- Best Practice:
  - Expected
    - Pathways (guidelines)
    - Patient/Family Centric (driven)
- Quality Metrics:
  - Common Dashboards
  - Outcomes
- IT Structured Support
  - Connection

# FRAMEWORK FOR SUCCESS: Before and After

1. **Aim: Clarity on the objectives**
   - Why (Vision, Mission, Strategy)
2. **Elements:**
   - Affiliation
   - Co-management
3. **Know & Understand your Partner**
4. **Strategy ⟺ Operations: What will it take?**
   - Program: (Impact at both sites)
     - Workforce
     - Resources

# FRAMEWORK FOR SUCCESS: Before and After

5. **Accountability:**
   - Medical Center
   - Hub/Affiliate
6. **Education:**
   - Provider
   - Nursing/RT/Ancillary
7. **Metrics:**
   - Organization
   - Local

# FRAMEWORK: Aim or "Why"

- **Academic Organization**
  - Vision
  - Mission
  - Strategic Plan
- **Regional/Statewide (National/International) Reputation**
  - Experts
- **Organization Communication**
  - Leadership to Front Line Staff

# FRAMEWORK: Elements

- **Affiliate**
  - Physician coverage model
- **Co-Management**
  - Program
    - Medical team
    - Best Practice pathways
    - Outcomes
      - Metrics
      - Quality
    - Education
    - Research
    - Efficiencies

# FRAMEWORK: Community Hospital (Homework Pays Off)

- **Overall Operations**
  - Similar philosophy (profit/non profit)
  - Reputation
  - Market position and strategy
  - Location
  - The “want and why!
- **Current Program model**
  - Staffing
  - Operations
    - Metrics:
      - LOS
      - Infections
      - Patient Experience
- **Objectives/ Aims**
- **Service Line**
- **Network**
- **Resources**

# Community Hospital: What you should know

- Volumes
- Patient Days
- Length of Stay
- Average Census
- Ventilator Days
- Acuity (CMI): Staffing Resources
- Patient Experience
- Diagnosis
- Current Medical staffing Model
- Quality Metrics
- Sub-specialty coverage
- IT support/ bandwidth

# FRAMEWORK: Accountability (2 components)

- **Academic Main Campus**
  - Leadership:
    - Strategy
    - Operations
  - Dashboards with agreed upon metrics
- **Community Site (Affiliate/Hub)**
  - Leadership Oversight
  - Local Pediatric Physician Governing body: (Medical Care Committee)
  - Interaction with Hub Leadership
  - Dashboards with agreed upon metrics

# STRATEGY TEAMS: Rides off into the Sunset!!!

- **First to be called…..**
- **Transition to who?**

# ACCOUNTABILITY: Presence

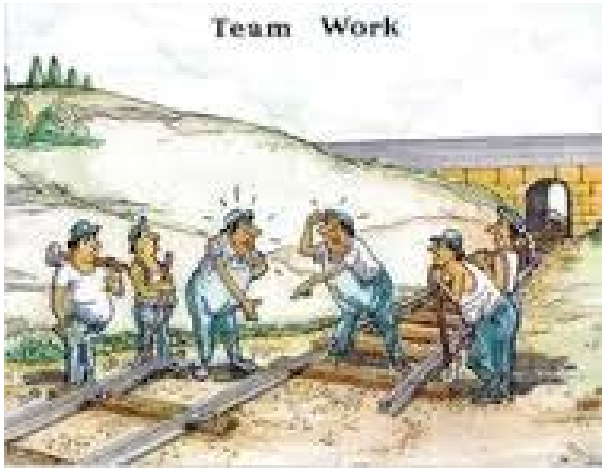
- **Regular presence on site**
  - Team
  - Community Site (Affiliate/Hub)
    - Leadership
    - Ancillary Support
    - Non related Programs (Radiology, Anesthesiology)
- **Ongoing Communication**
- **Variances**
  - Important to recognize
  - Easy to overlook

# FRAMEWORK: Workforce

- **Staff**
  - Physician
    - Current physicians
      - Contracted
      - Employed
    - New Hires
  - Advanced Providers
  - Nursing
  - Ancillary
- **Onboarding (Investment)**
  - Main Campus
  - Community Site (Affiliate/Hub)

# MEDICAL TEAM MATCH

- **Right fit**
  - Experience
  - Degree of independence
- **Skill sets**
  - Leader
  - Team player
  - Communication
  - Public relations




# YOUR TEAM vs LOCUMS: Trade Off!

## Your Team

- Known
  - Skill sets
- Knowledge of program/system
  - Hub
  - Main Campus
- Engaged
- Relations
  - Staff experience
  - Patient/family experience

## Locums

- Unknown
  - Skills sets
- Not familiar with program/system
  - Hub
  - Main Campus
- Less/Lack of Engagement
- Relations
  - Staff experience
  - Patient/family experience
- Cost

# RELATIONSHIPS KEY TO SUCCESS !

- **Building the Team**
  - Right Fit
  - Public Relations builder
- **Linkage to Main Program**
  - Rounds & Conferences
    - Bi-directional
  - Telehealth
  - Best Practice
  - Shared position
- **Avoid Isolation**
  - “Them”
  - “We're different”

# FRAMEKWORK: Community Site (Affiliate/Hub)

- Regional Demographics
- Volume and Acuity
- Referral patterns
- Network
- Current program
- Aims
- Staffing Model
- Adult/Pediatric outside services
- Resources

# FRAMEWORK: Education

- **What is the investment**
  - Increase the depth and breath of Pediatric Care
  - Best Practice
  - Quality and Safety of Care
  - Efficiency & Cost
- **Staff**
- **Supporting Services**
- **Patients/Families**
- **Community**
- **(Resident/Fellow education opportunity)**

# FRAMEWORK: Education

- **Onsight (Hub) forums**
  - Grand rounds
  - Conferences
- **Main Campus experience**
- **Simulation**
  - Local
  - Main Campus
- **Telehealth**
  - Provider to Provider
  - Remote education opportunities

# FRAMEWORK: IT

- **EMR**
  - Access
  - Interoperability
    - Share data
    - Patient information (transfer)
- **IT Bandwidth**
  - Telehealth
- **IT Support**
  - Mutual relationship

# FRAMEWORK: Metrics

- **Outcomes: Dashboards**
- **Pathways, Care Bundles**
- **Reporting Structure**
- **Information Confidentiality**

# ALLIGNMENT and INTEGRATION

- **Not just the Physicians**
- **Whole Program**
  - Global Shift
- **Relationships Building**
- **Authority to Direct the program granted by Hub**
  - Accountability

# BRANDING: When the signs go up, are you ready?!

# ARE YOUR REALLY READY ?

- **Direct Impact**
  - Volume
  - Throughput
  - Staffing
  - Identification
- **Indirect Impact**
  - Main Campus
  - Other “affiliate/community” sites
  - Competitive Programs

# WHAT WILL YOU MONITOR

- **Patient Care**
  - Patient/Family Experience
- **Physician**
  - Engagement
  - Onboarding process
    - Initial
    - First Year
- **Staff**
  - Satisfaction
- **Metrics**
  - Reviewed at defined intervals
- **Organizational Goals**

# COMMUNICATION: Ongoing

- **Main Campus**
  - Internal team
- **Affiliate/Hub**
  - Internal team
- **Community**
  - Community physicians
  - Patients
  - Community

# Thank you

**Tony Napolitano, M.D., F.A.A.P**

Dr. Tony Napolitano currently serves as the Chairman of the Department of Medicine, Medical Director for Strategic Business Services, and Medical Director of Lifeline Critical Care Transport Program at Johns Hopkins All Children's Hospital. In addition he also serves as Medical Director for the NICU at Sarasota Memorial Hospital. In his Strategic Business role, he is responsible for the clinical relationships for regional networks and affiliate programs throughout the west coast of Florida.

After receiving his medical degree from the University of Brussels, Dr. Napolitano completed his pediatric residency and neonatology fellowship at the Medical College of Virginia, where he remained as an attending neonatologist and assistant professor for pediatrics. In 1988, Dr. Napolitano joined the neonatology program at All Children's Hospital. He is an Assistant Professor of Pediatrics at Johns Hopkins University School of Medicine and Associate Professor of Pediatrics at University of South Florida. He is a fellow of the American Academy of Pediatrics and a member of the sections of Perinatal Pediatrics and Transport Medicine. He has served as a member and past president of the Florida Society of Neonatology.

Dr. Napolitano's clinical research interests include the treatment of persistent pulmonary hypertension of the newborn, nutrition in premature infants and Neonatal Abstinence Syndrome.

Dr. Napolitano has been honored by the State of Florida EMS, the Florida Healthy Mothers, Healthy Babies Coalition of Pinellas County and Tampa Bay March of Dimes.

# Marketing and Branding for Affiliations and Collaborations

## Association of Administrators in Academic Pediatrics Winter Regional Conference

January 13, 2017

Sylvia Ameen
Vice President, Marketing and Communications
Johns Hopkins All Children's Hospital

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# Who We Are

# Who We Are

| | |
|---|---|
| **Treatment**<br>*Leading Pediatric Care* | Cancer & Blood Disorders Institute |
| | Heart Institute |
| | Institute for Brain Protection Sciences |
| | Maternal, Fetal & Neonatal Institute |
| | Departments of Surgery and Medicine |
| **Education**<br>*Training the Best for the Future of Pediatric Health* | Accredited Pediatric Residency Program |
| | Pediatric Subspecialty Fellows |
| | Collaboration with USF Health Morsani College of Medicine |
| | Nursing and Pharmacy Residency Program |
| | Leadership Development and Management Training Programs |
| **Research**<br>*New Approaches Making Cures Achievable* | Over 300 IRB approved active studies |
| | Florida's only accredited pediatric biorepository |
| | New research building under construction |
| | Cutting edge clinical, translational and bench research studies |
| **Advocacy**<br>*Championing Healthy Futures* | Mission based community health programs such as Healthy Start and Fit4AllKids |
| | Injury Prevention programs such as Safe Kids |
| | Community Benefit Community Benefit |
| | Citizenship |
| | Legislative: Voice4Allkids |

## FY2016 Vital Statistics

| | |
|---|---|
| Licensed beds | 259 |
| Percentage ICU beds | 57% |
| Inpatient admissions | 6,887 |
| Total surgeries | 9,187 |
| Emergency Center visits | 48,835 |
| Outpatient visits | >450,000 |
| Employees | >3,100 |

** July 1, 2015 - June 30, 2016*

# Outreach Centers, Affiliates & Collaborations

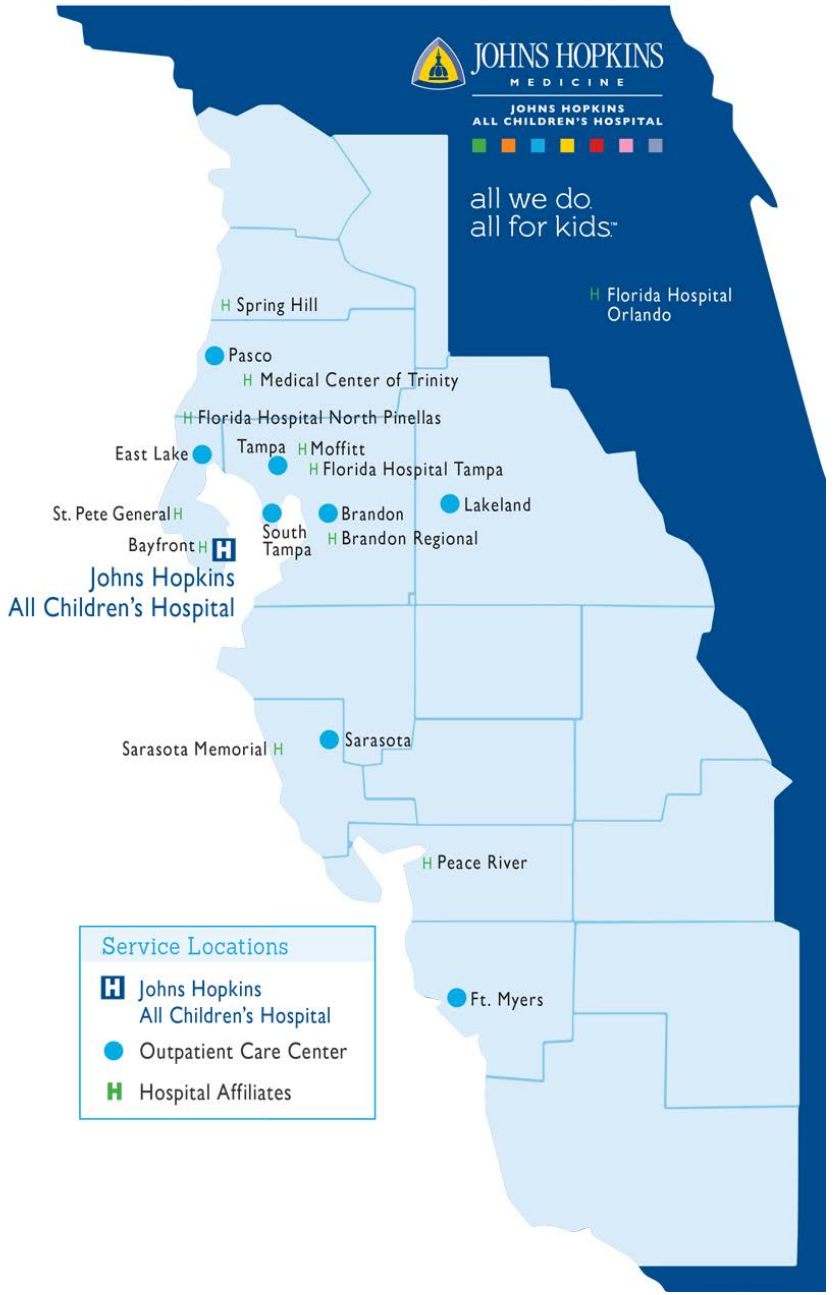
**Primary Service Area:** West Central Florida
- Total Population: **5.5 Million**
- Total Population Age 0-17: **1.2 Million**

## Outpatient Care Centers

Brandon • East Lake • Ft. Myers

Lakeland • Pasco • Sarasota

South Tampa • Tampa

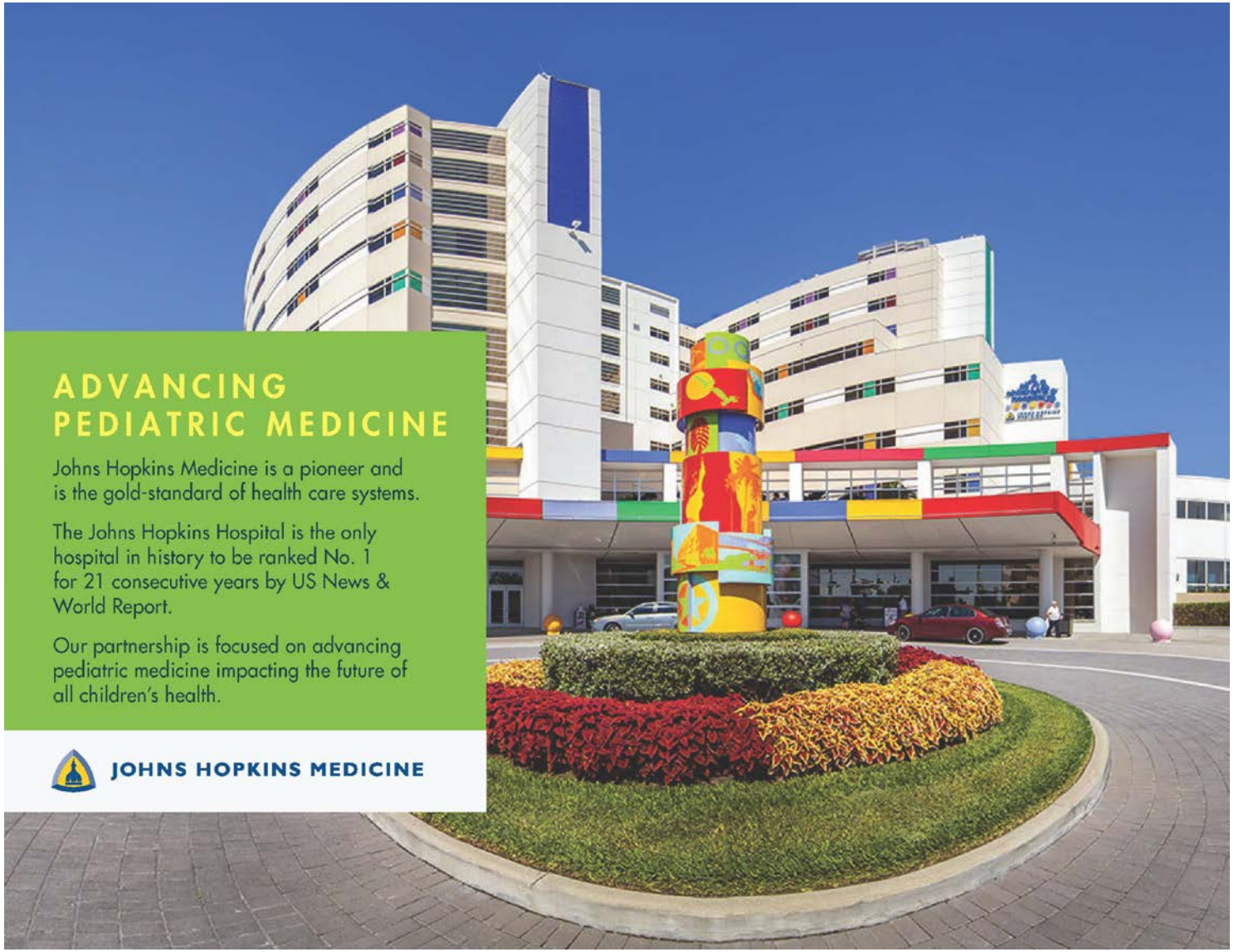


# Why Affiliate?

- Open doors to better serve patient families by leveraging All Children's clinical and pediatric specialty strengths with Johns Hopkins Medicine's global reputation for research and medical teaching, as well as their fundraising and philanthropy prowess

- Join Johns Hopkins Medicine as a national leader in pediatrics, providing our hospital with:
  - Research opportunities through NIH and other federal programs
  - Stronger financial security through philanthropic donations
  - National recognition

# Integration with Johns Hopkins Medicine



# What is a Brand?

# Brand Campaign 2011

Together We're Better Campaign


# Brand Campaign 2013-2015

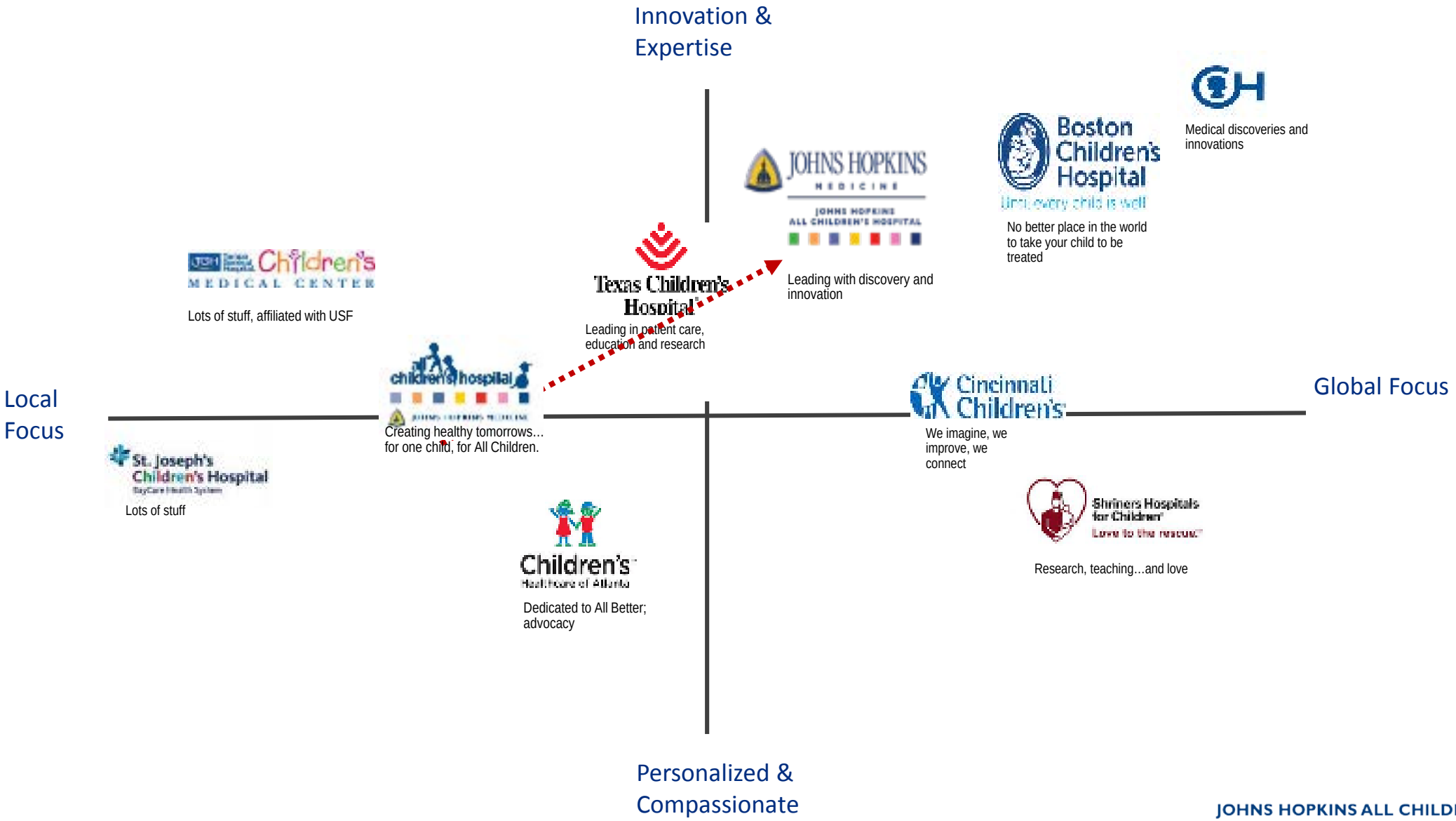
all we do. all for kids.™


# Why Rebrand?

## Value Proposition

- Changing the name firmly messaged and established that we are indeed a Johns Hopkins pediatric health system and we deliver Johns Hopkins quality care to children.
- Captures conceptual real estate in the minds of donors, families, community, and internal audiences of who we are.

# Brand Transformation Opportunity



# Key Consumer Survey Findings

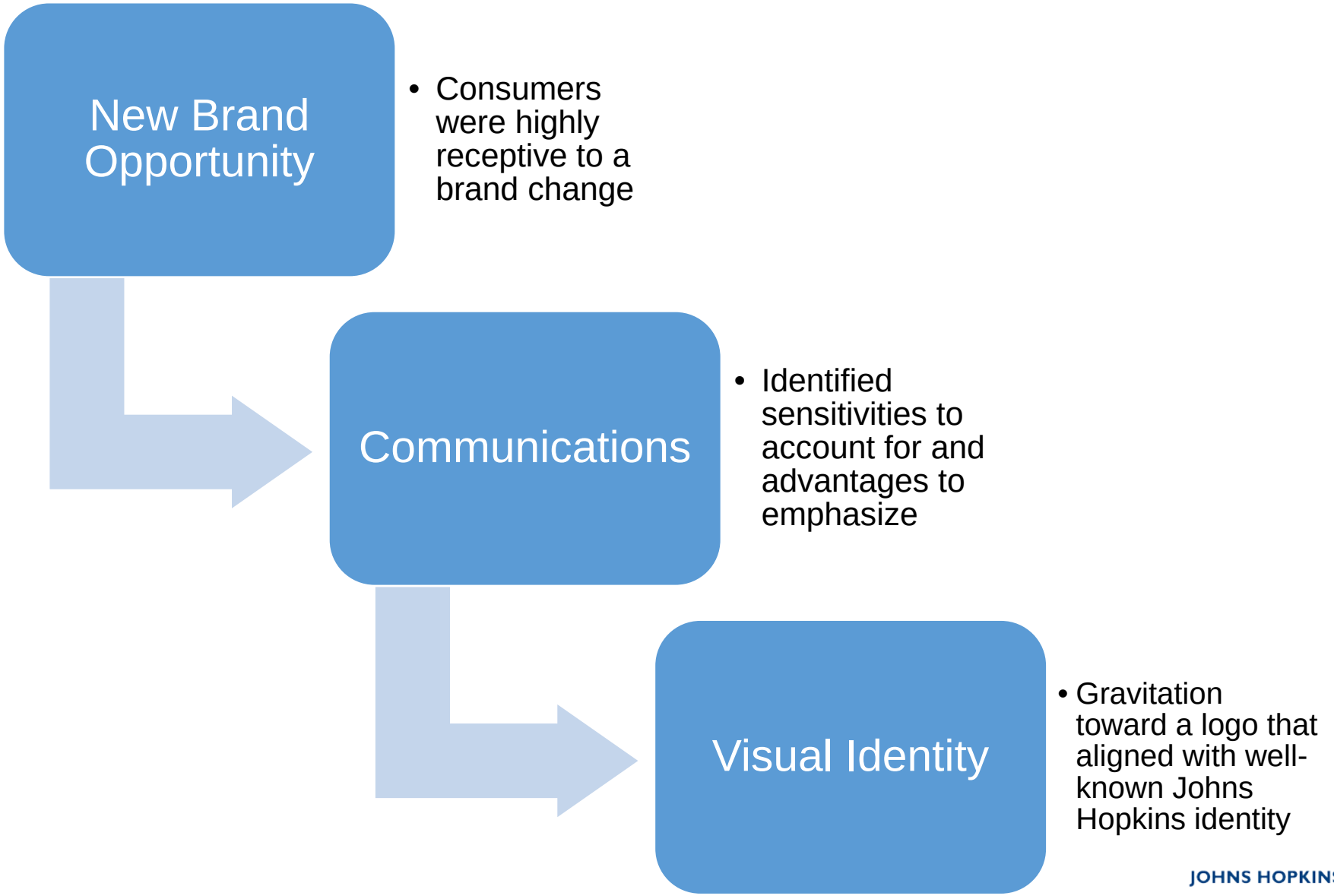
**All Children's Hospital known as…**

- The leading children's hospital on Florida's west coast
- A premium brand for children's healthcare
- Customer-centric
- Clinically excellent

**Other Findings**

- Johns Hopkins brand enhances perception of clinical excellence
- Consumers care about the BENEFITS of academic medicine
- Consumers wary that academic medicine loses sight of customer-centered care

# Key Consumer Survey Findings

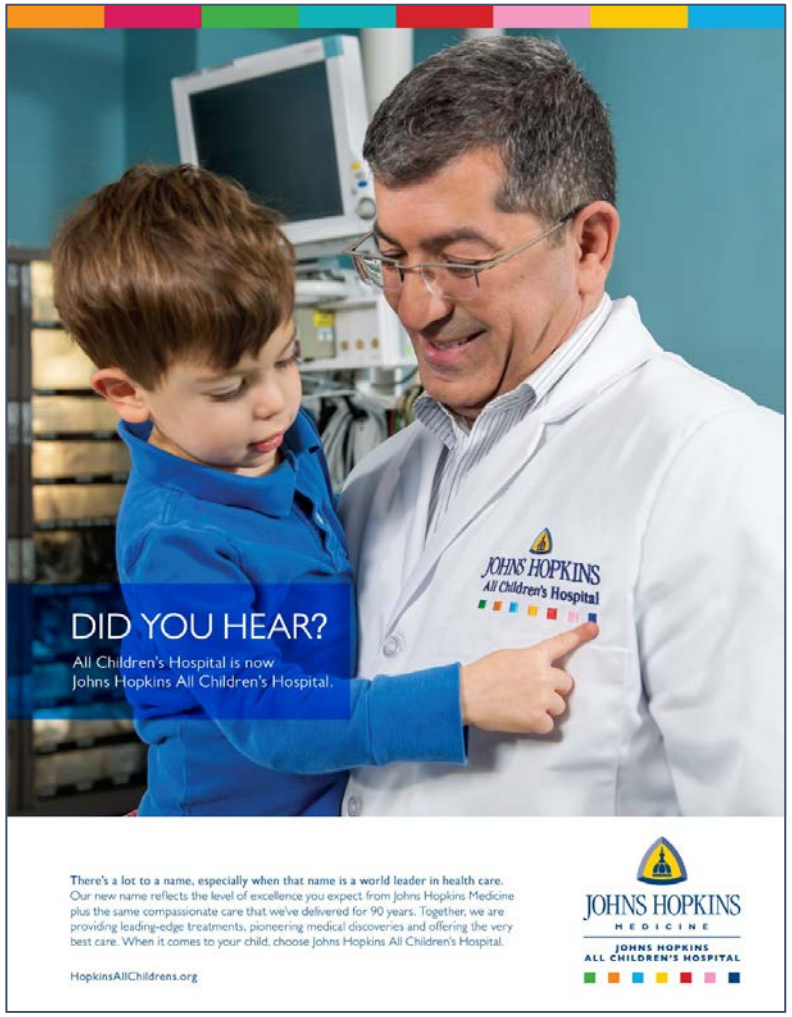


# Brand Logo Evolution



# New Brand Campaign 2016

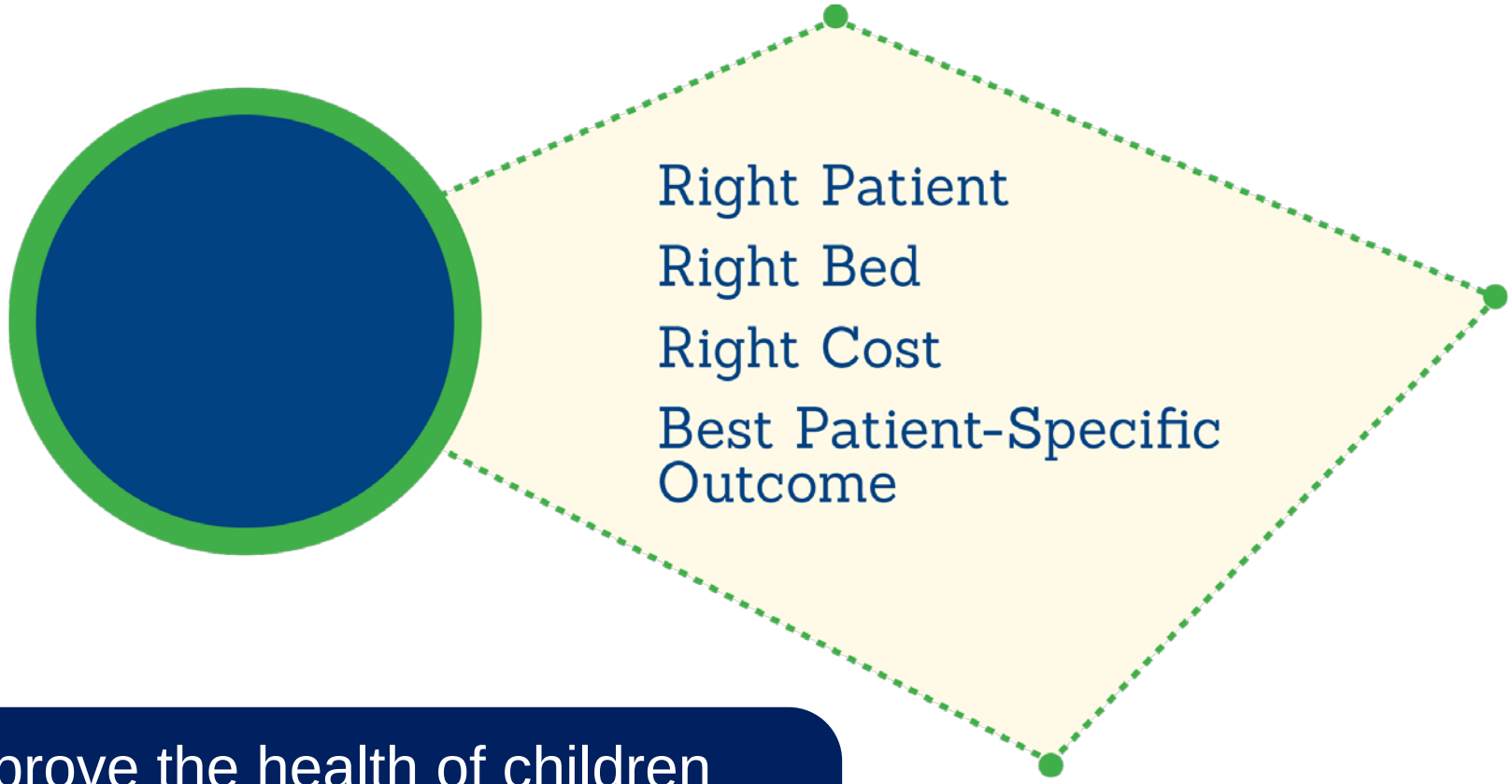
## There's a Lot to a Name





https://youtu.be/0fPTwOnktL0

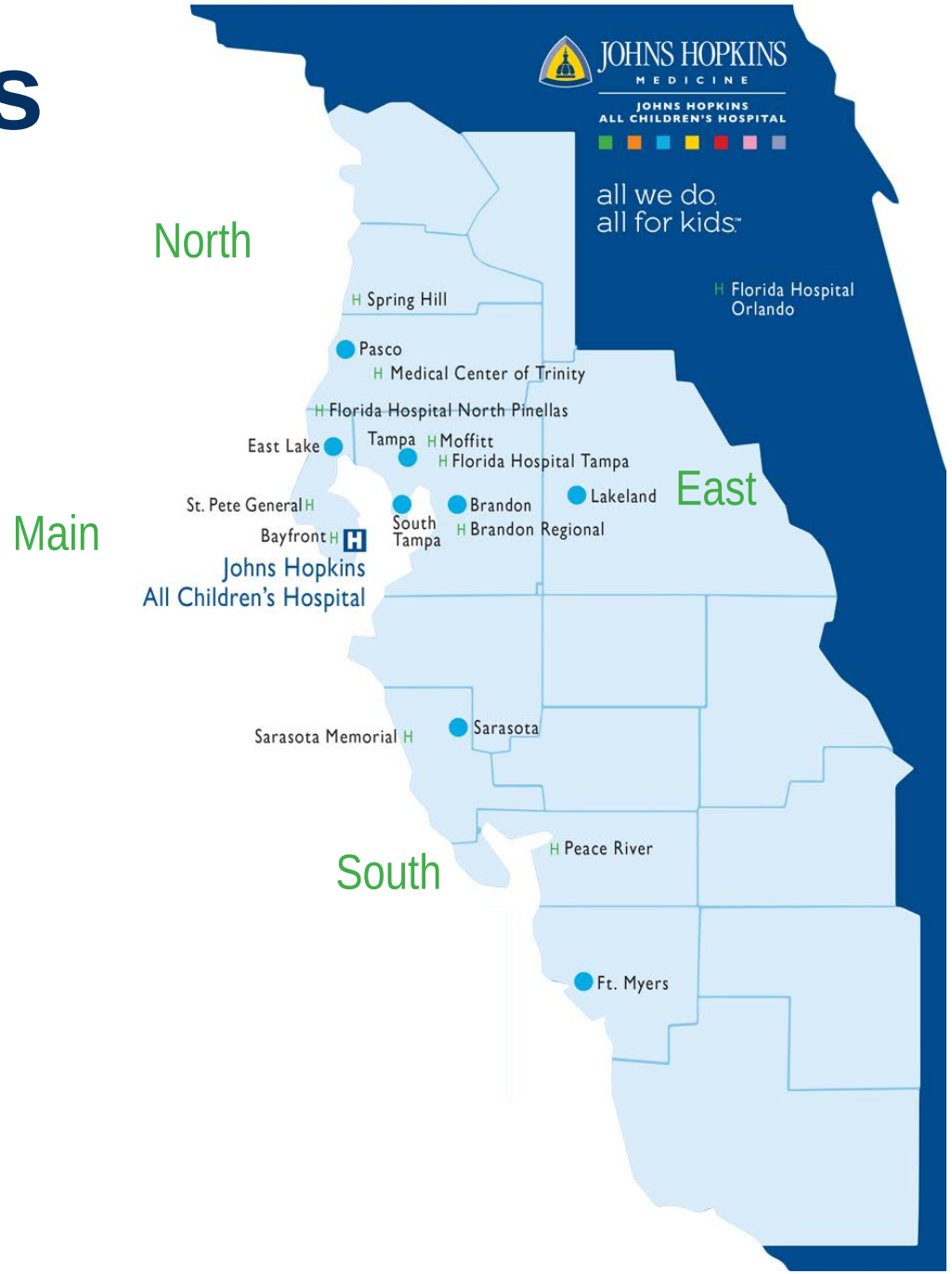
# From Hospital to Health System




Mission: Improve the health of children

- Care
- Education
- Research

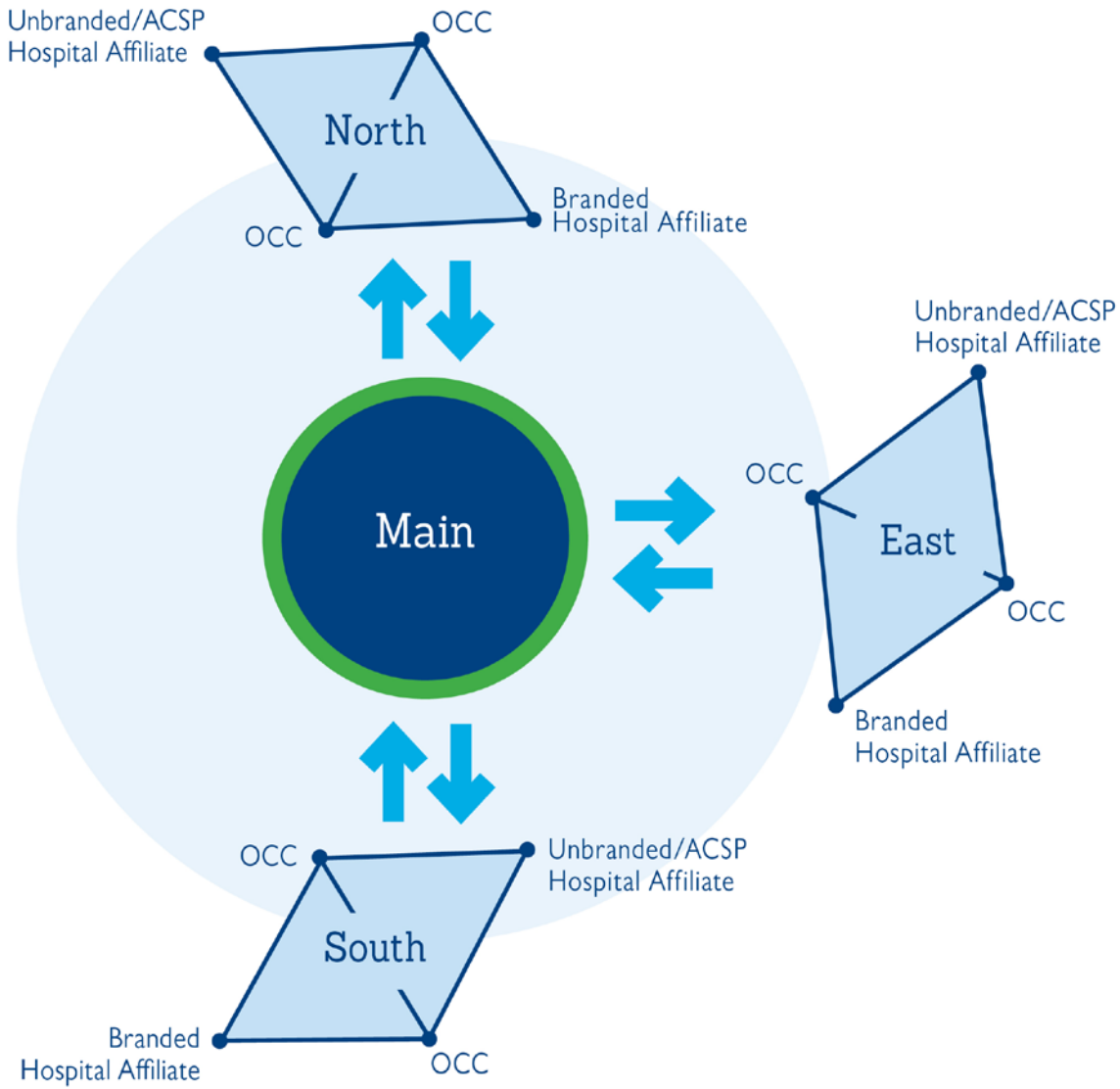
# Johns Hopkins All Children's Regional Network



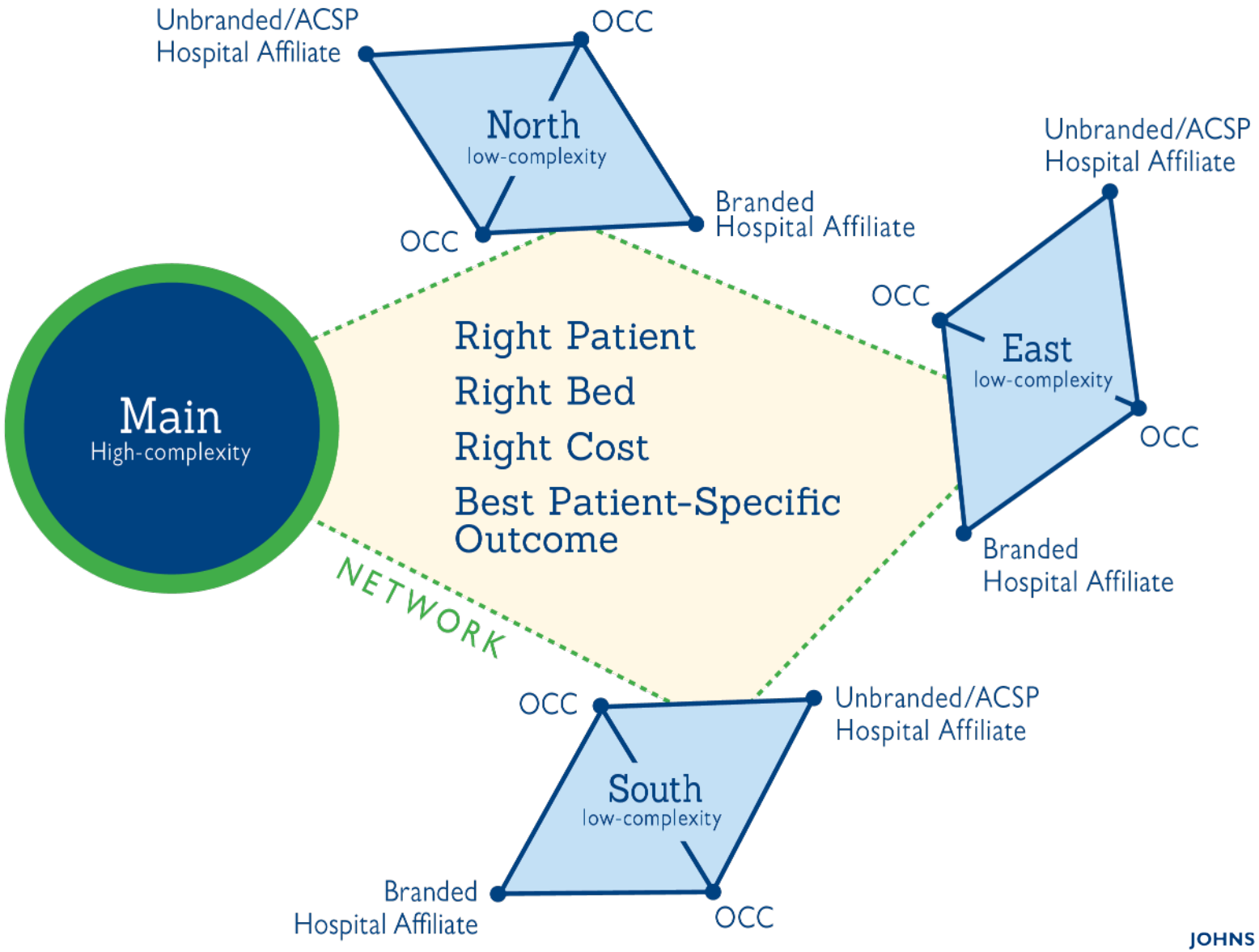

Service Locations

- H Johns Hopkins All Children's Hospital
- Outpatient Care Center
- H Hospital Affiliates

# Hub & Spoke Regional Architecture



# New Regional Hub Architecture



# Brand Application in Hub Model

## Affiliation



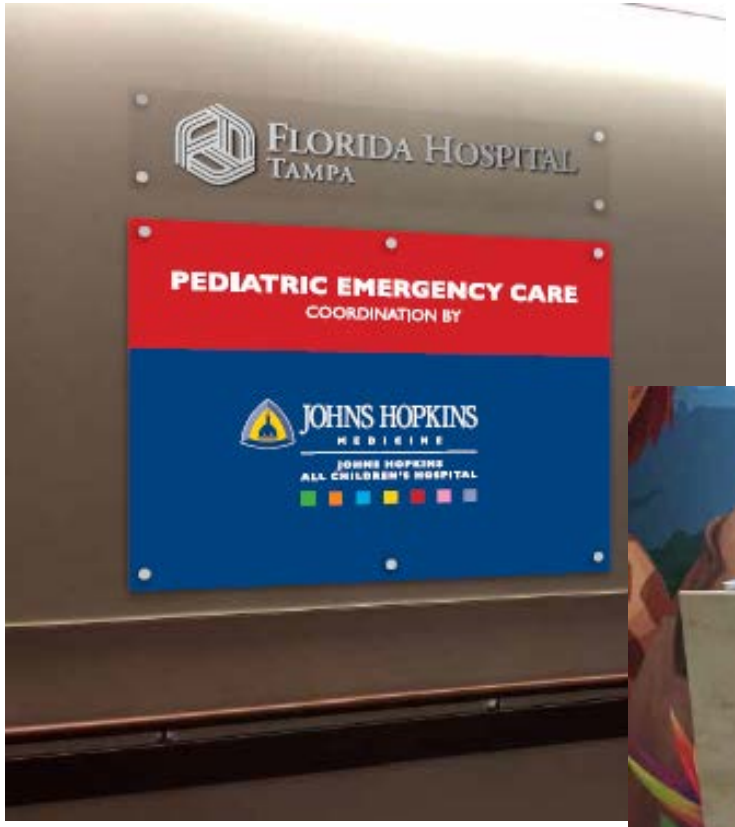
## Collaboration

# Conditional Use of Brand

- Affiliation agreement to combine the strength of two brands in order to increase consumers to a single product.

- Factors involved include JHACH:
  - Managing all administrative and operational functions for the entity and has a vested interest.
  - Overseeing quality of clinical programs.
  - Monitoring quality indicators, clinical standards & performance measures.
  - Medical services backed by JHACH administration.
  - Operating hospital systems: safety, quality, education, research, training, public health, accreditation: joint commission international.
  - Managing resource deployment.
  - Ensuring that contractual management is long term (5 to 10 years) & developing the standards.

# Affiliation (Branded)





# Collaboration (unbranded)



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# What’s Next?

- Keep the fidelity of the brand.
- Control the package.
- Each relationship is different
- Not all worked out.

# Marketing Strategic Journey

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**Sylvia Ameen, C.F.R.E.**

**Vice President, Marketing & Communications**

**Johns Hopkins All Children's Hospital**

Sylvia Ameen serves as the Vice President, Marketing & Communications, for Johns Hopkins All Children's Hospital. In her role, Ms. Ameen is responsible for the oversight of all marketing and communications operations at the hospital, including internal hospital communications to employees and physicians as well as external marketing strategy. Her purview includes all marketing strategies, media relations, creative development, crisis communications, internal and external communications, hospital events, brand use, culture and employee engagement.

Ms. Ameen also serves as a member of the hospital's executive leadership team. She works collaboratively with her colleagues on transforming Johns Hopkins All Children's Hospital into a leading academic and research institution focused solely on improving health outcomes for children.

Ms. Ameen joined the All Children's Hospital Foundation in 1989. There, she was responsible for a principal gift portfolio, board engagement and campaign management. She also directed the $75 million capital campaign for the construction of the new All Children's Hospital, which opened in January 2010. Her leadership skills and fundraising ability have raised significant philanthropic support for Johns Hopkins All Children's during her 27-year tenure with the hospital.

Ms. Ameen holds a B.A. from Eckerd College and is a Certified Fund Raising Executive (CFRE). Throughout her career, she has been active in the Association for Healthcare Philanthropy, the St. Petersburg Suncoasters and Ronald McDonald House Charities of Tampa Bay. Most recently she joined the board of the St. Petersburg Downtown Partnership to focus on economic development for her favorite city.

# Creating Partnerships to Optimize Physician Engagement

**Gregory A. Hale, MD**
**Professor of Oncology and Pediatrics**
**Johns Hopkins All Children's Hospital**
**St. Petersburg, FL**

# Engagement among physicians is very low


**SAMPLE:** 2,011 physicians surveyed on Epocrates.
**SOURCE:** athenaResearch

# The Age of Engagement

We are Entering the
"Age of Engagement"
In Healthcare

- Patient Engagement
- Physician Engagement

# Enhancing Physician Engagement

- **Develop clear and effective communication channels**
- **Build trust, understanding and respect**
- **Clearly delineate common goals and responsibilities**
- **Identify and develop physician leaders**

# Managers and Physician Cultures

| Area | Manager | Physician |
|---|---|---|
| View of work | Make a living | Work is living |
| Loyalty | Organization | Patient |
| Responsibility | Shared | Personal |
| Ambiguity tolerance | High | Low |
| Patient focus | Broad | Narrow |
| Timeframe for action | Middle-long | Short |
| View of resources | Limited | Unlimited |
| Knowledge base | Social/management | Biomedical |
| Exposure to others | Little | Great |
| Relationships | Hierarchical | Collegial |
| Career | Hierarchical | Achievement |
| Vocabulary | Cost, benefit, revenue | Quality, Patient outcomes |

# Communication styles

- **Physicians may not be trained to communicate well and that their authoritarian style and limited listening skill hinder information exchange with managers**
- **Managers should work with physicians to help them develop their communication and confrontation abilities**
  - **Active listening, checklists, structured dialog, appreciative inquiry.**

# A Lack of Physician Engagement is Emerging as the Key Barrier to Driving Value-based care

## Hospital Systems

- Physicians not leading the value enhancement efforts.
- Weak relationships between administration & physicians
- Lack of perceived incentives for physicians to enhance value

# Gaps in perception

| Statement | % MD agreeing | % Execs saying MD agree |
|---|---|---|
| Hospital name trusted | 62 | 81 |
| Hospital treats MD fairly | 46 | 68 |
| Hospital treats MD W/respect | 48 | 78 |
| Hospital delivers on promises | 45 | 66 |
| Physicians have support/staff | 42 | 60 |

**Jackson Healthcare 2016**

# What is Physician engagement?

- **Energetic state of involvement with personally fulfilling activities that enhances one's sense of professional efficacy (Maslach and Leiter)**
- **The experience that some physicians have as being actively interested in the quality of their workplace and are motivated to take an active leadership role in helping to improve that workplace (Snell)**
- **The active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organization which itself recognized this commitment in supporting and encouraging high quality care (Spurgeon)**
- **Opposite of burnout**

# Industry Pursuing Dual Strategies

## ABSS Physician Engagement and Alignment Indices

**Relationship-Based Metrics**

**Employed** ⟵ ⟶ **Independent**

### Engagement Index

- This organization inspires me to perform my best
- I am willing to put in a great deal of effort to help this organization succeed
- I would recommend this organization to other clinicians as a great place to practice
- I am likely to be practicing at this organization three years from now

### Alignment Index

- I prefer to admit and/or refer my patients to this organization
- I would recommend this organization to other clinicians as an excellent place to refer and/or admit their patients
- I am willing to serve in non-clinical roles such as positions on hospital committees

Source: Advisory Board Survey Solutions' national physician engagement database, 2014

# Engagement Matters

- **75-85% of the decisions that drive quality and cost are determined by physicians**
- **United States leads world in healthcare spending**
  - **18% of US GDP**
- **Value based healthcare focus**
  - **Challenge to provide higher quality healthcare with decreased costs and improved outcomes**
- **Gallop study: there is a 26% increase in productivity for engaged physicians compared to non-engaged physicians.**

# The realities of engagement

- **The physician is at the center of health care delivery.**
  - **Ordering drives most health care actions**
  - **Physician engagement is a key component to successful QI projects.**
- **The physician's focus is primarily on their own practice or quality of care.**
  - **The physicians goals and hospitals goals and incentives may not be aligned.**
  - **Lack of commitment to system improvements.**
- **Personal responsibility for quality is powerfully engrained in physicians.**
- **Primary care physicians more likely to be engaged than specialists.**

# Systems Issues

- **Physicians are too busy**
- **Physicians are not compensated for their help**
- **Poor knowledge and management support**
- **Lack of meaningful measurements**
- **Poor data analytic support**

# Levels of physician engagement

- **AAPL surveyed 1,666 physicians**
  - **All felt that engagement is extremely important to their job satisfaction.**
  - **On a 10-point Likert scale the an average score of 7.7 for work engagement and 6.4 for organization engagement**

**<u>Levels of Engagement</u>**

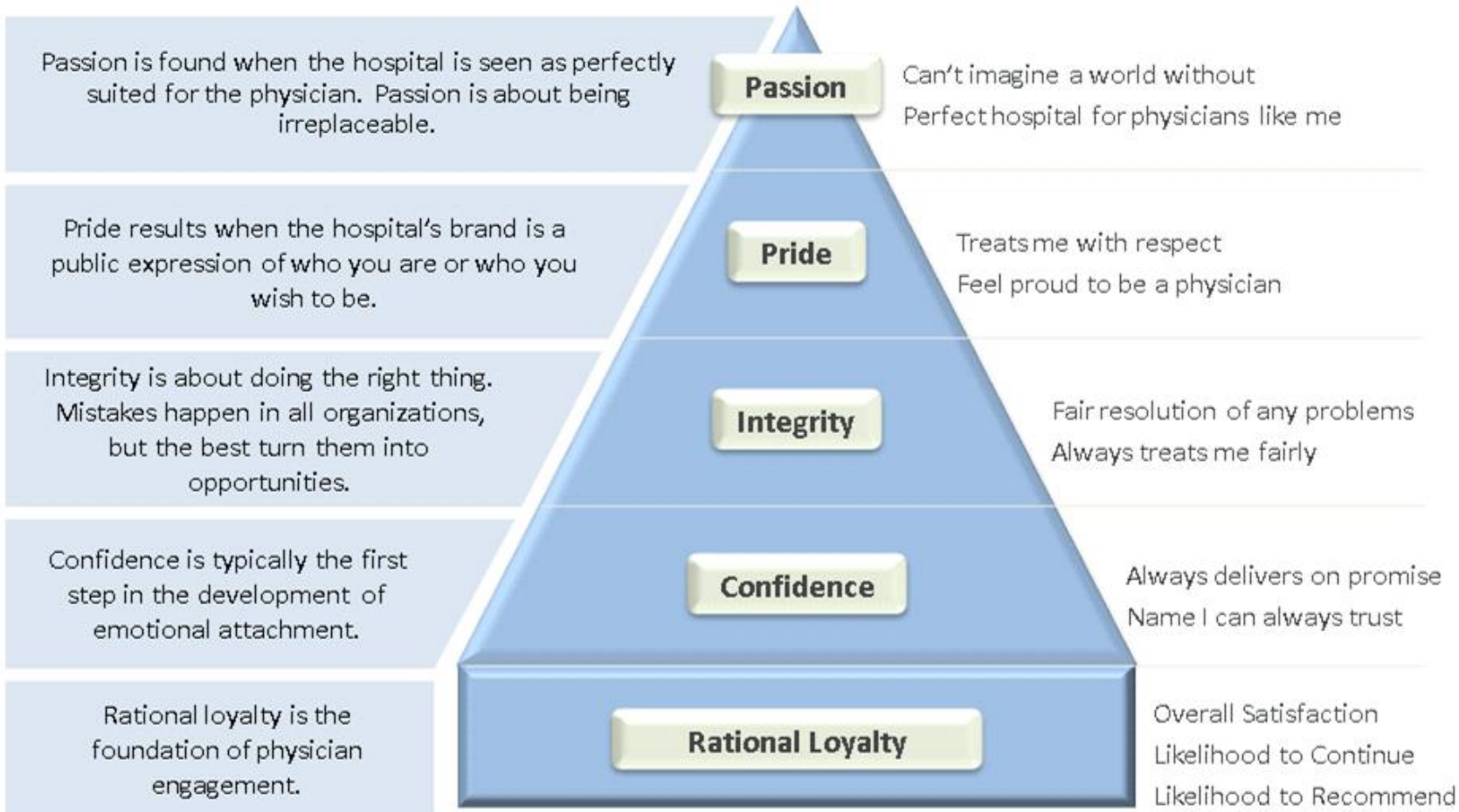
**Aversion**

**Apathy**

**Engaged**

# Levels of physician engagement

- **Confidence: Believe hospital can always be trusted to deliver on its promises**
- **Integrity: Believe hospital always treats them fairly and will resolve any problems that occur**
- **Pride: Feel good about using the hospital and hospital use reflects upon them**
- **Passion: View hospital as irreplaceable and as an integral part of their lives and their practice of medicine**


Passion is found when the hospital is seen as perfectly suited for the physician. Passion is about being irreplaceable.
Pride results when the hospital's brand is a public expression of who you are or who you wish to be.
Integrity is about doing the right thing. Mistakes happen in all organizations, but the best turn them into opportunities.
Confidence is typically the first step in the development of emotional attachment.
Rational loyalty is the foundation of physician engagement.
Passion
Pride
Integrity
Confidence
Rational Loyalty
Can't imagine a world without
Perfect hospital for physicians like me
Treats me with respect
Feel proud to be a physician
Fair resolution of any problems
Always treats me fairly
Always delivers on promise
Name I can always trust
Overall Satisfaction
Likelihood to Continue
Likelihood to Recommend

# Characteristics of engaged physicians

- **Feel respect and credibility toward the personalities and qualities of those they interact with**
- **Attracted to strong visions that are clear and challenging**
- **Value relationships with others that are based on integrity, honesty, fairness and consistency**
- **Are more open-minded, enjoy intellectual challenges and risks and are self-directed learners.**
- **Strives to achieve above and beyond what is expected in daily role.**

# Physician perspectives: important factors

- **Respect for my competence and skills (9.2)**
- **Feeling my opinions and ideas are valued (9.1)**
- **Good relationship with my physician colleagues (9.1)**
- **Good work/life balance (9/1)**
- **A voice in how my time is structure and used (9)**

# Physician perspectives: Gaps

- **Feeling my opinions and ideas are valued**
  - **Leadership and decision-making**
- **Voice in clinical operations and processes**
  - **Resources and support**
- **Voice in how my time is structures and used**
  - **Schedules and time management**
- **Fair compensation for my work**
- **Good work/life balance**
  - **Personal health and well-being**

# Determinants of physician engagement

- **Experiences within organization**
  - **Functional: reflects a perceived partnership between the physician and an organization that is build and strengthened through reliable efficient delivery of high quality products and services**
  - **Personal: emotional bonds that form and mature between a physician and organization**
- **Job resources**
  - **Autonomy in role**
  - **Task identity**
  - **Variety of skills required**
  - **Significance of tasks performed**
  - **Feedback from supervisors and colleagues**
- **Personal resources**
  - **Self-efficacy**
  - **Self-esteem**
  - **Personal optimism**

# Barriers

- **Bureaucratic processes**
  - **More paperwork, preauthorization**
- **Hospitals have misconception that financial compensation is the primary driver for securing alignment**
- **Decreased autonomy**
- **Physician response**
  - **Feel overwhelmed and ill-equipped to effect change**
  - **Lack understanding of healthcare waste and inefficiency**
  - **Physicians are risk averse and have poor understanding of the risk-based payment model.**
- **Lack of compensation for engagement activities**
- **Managers not valuing physician leadership**
- **Poor organization communication practices**
- **Conflicts**

# Why Are Engagement Efforts Coming Up Short?

**Barriers to Physician Engagement**

## 1 Historical Distrust

- Lack of meaningful follow through on prior engagement initiatives
- Embedded skepticism undermining future efforts

## 2 No Reliable Measure

- Flawed methodology for surveying mixed medical staff
- Forced reliance on general impressions for key strategic investments

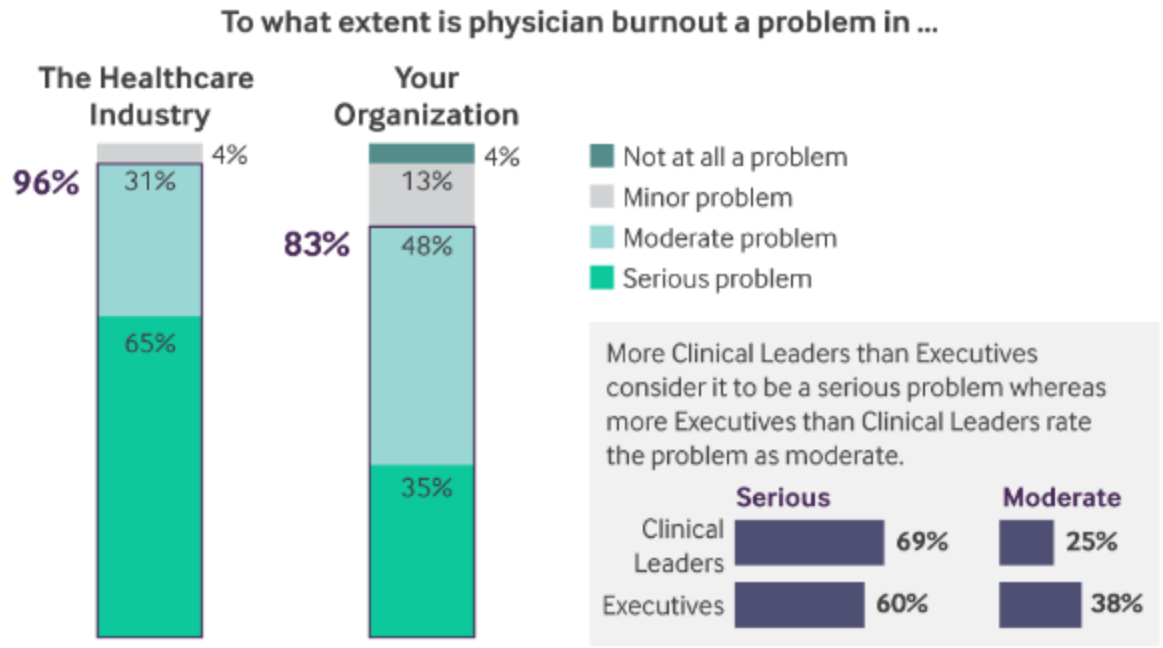
## 3 Overly Broad Plan

- Unclear direction on what to do next to drive physician engagement
- Confusion over how to balance long-term goals with short-term goals
- Lack of clarity on whether to invest in enterprise-wide efforts or "hot spots"

## 4 Insufficient Resources

- Lack of dedicated personnel to execute on vision
- Limited funding to launch and support ongoing investments in outreach
- Engagement one of multiple strategic priorities

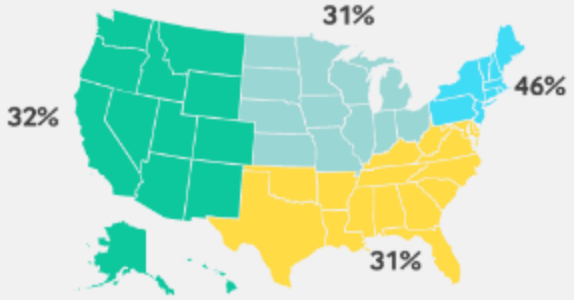
# The Physician Burnout Problem Is Perceived to Be Larger Outside of One's Organization




More Clinical Leaders than Executives consider it to be a serious problem whereas more Executives than Clinical Leaders rate the problem as moderate.

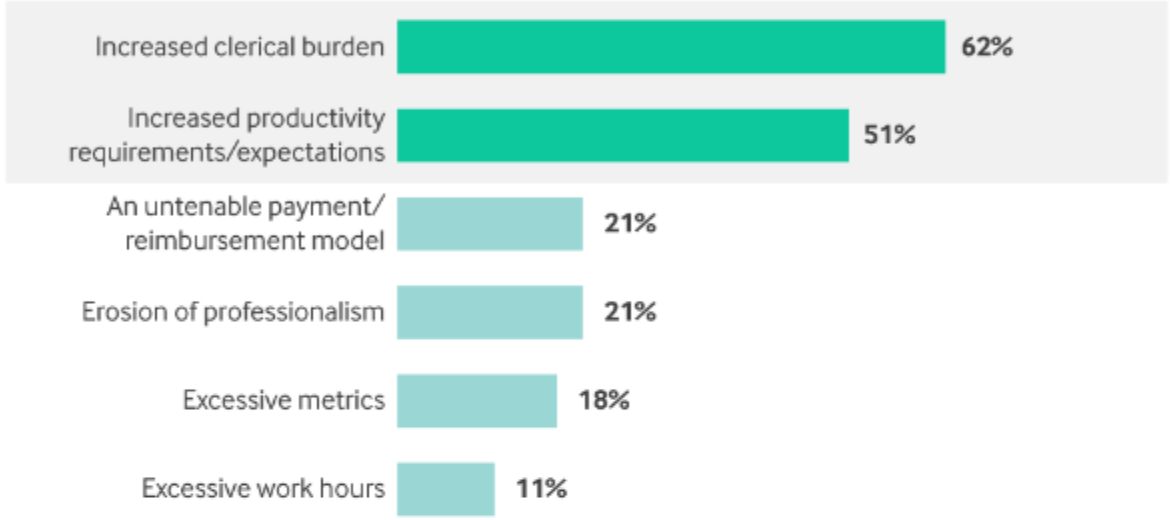



Council members from the Northeast (46%) rate the industry burnout problem as more serious than their counterparts from the West (32%), Midwest (31%), and South (31%).



# Increased Clerical Burden and Productivity Requirements/Expectations Produce Physician Burnout

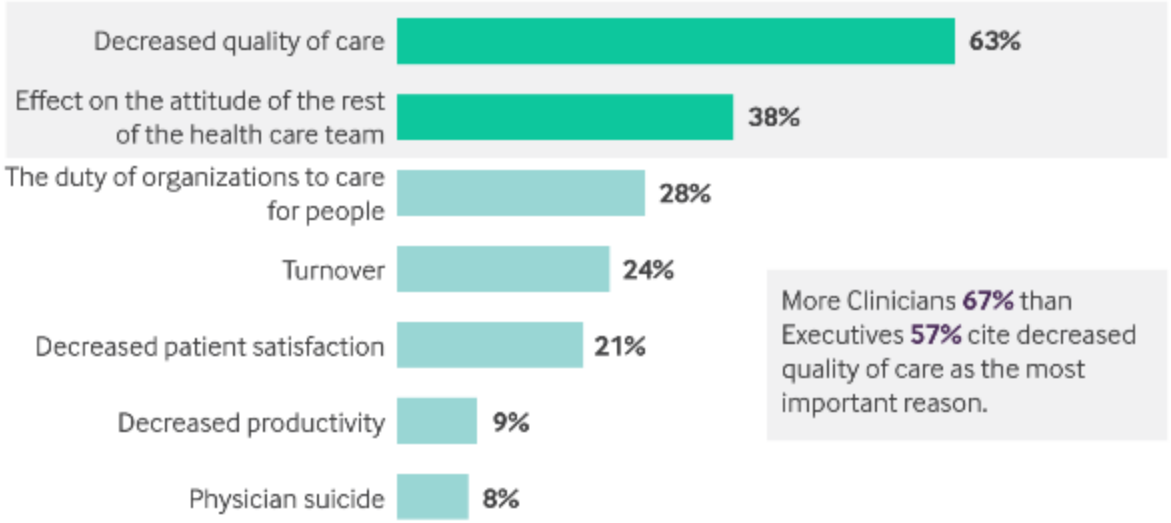
**What are the top two factors contributing to the increase in physician burnout?**




A higher percentage of Executives than Clinical Leaders and Clinicians cite increased clerical burden as a top factor in increased physician burnout.

# Decreased Quality of Care Is the Top Reason to Address Physician Burnout

**What are the top two most important reasons to address physician burnout?**




More Clinicians **67%** than Executives **57%** cite decreased quality of care as the most important reason.

Base = 570 (multiple responses)

# Levels of Physician Engagement

- **Individual**
  - **Open door policy, personalized letters**
- **Group**
  - **Team building sessions, leadership meetings**
- **Organization**
  - **Medical staff involvement, communication**

# Domains of physician engagement

- **Administration**
  - **Experiences physicians have with administration**
- **Organization**
  - **Experiences physicians have regarding the state of the organization, especially its strategic direction**
- **Department**
  - **Experiences physicians have with key departments**
- **Staff**
  - **Experiences between physicians and staff and how these experiences contribute to patient care.**

# Measures of physician engagement

If you can't measure it, you can't improve it. - *Peter Drucker*

- MES (NHS)
  - 18 item instrument or a 30 item instrument
  - Reliable and valid
  - Quick and easy to administer and complete
- Morehead Associates Physician Survey
  - Newer
  - Validity and reliability not known
  - Proprietary
  - Based on the 4 domains mentioned earlier

# Measures of physician engagement: MES

- **Meta-scale 1: Feeling valued and empowered**
  - **Subscale 1: Climate for positive learning**
  - **Subscale 2: Good interpersonal relationships**
- **Meta-scale 2: Having purpose and direction**
  - **Subscale 3: Appraisal and rewards effectively aligned**
  - **Subscale 4: Participation in decision making and change**
- **Meta-scale 3: Working in an open culture**
  - **Subscale 5: Development orientation**
  - **Subscale 6: Commitment and work satisfaction**

# Measures of physician engagement: Morehead Drivers of engagement

- **I have confidence that this organization will be successful in the coming years**
- **This organization cares about its customers**
- **I am satisfied with the teamwork demonstrated between the OR services nursing staff and technical staff**
- **I am satisfied with the overall performance of hospital administration**
- **This organization's patients are satisfied with the quality of care they receive**
- **The CME offered by this hospital for physicians is useful**
- **Overall I am satisfied with the performance of the nursing staff**
- **This organization cares about quality improvement**
- **This hospital treats physicians with respect**

# Outcomes of physician engagement

- Organizations with more engaged clinicians and staff achieve better outcomes and experiences for
  - NHS high performing hospitals had higher levels of engagement (4 vs 2.5) than lower performing hospitals and higher percentages of engaged physicians (44% vs 17%)
  - Engaged physician reduce unjustifiable variation in patient care (US)
  - Engaged physicians less likely to make mistakes (Dutch)
  - Engagement scores on MES correlate with improved patient mortality, reduce reported incidents and higher levels of service and compliance (Spurgeon)
- Stoll: “without medical engagement, care continues to be delivered in isolated clinical pockets preventing coordinated action to produce system improvements, let alone better population health outcomes.”

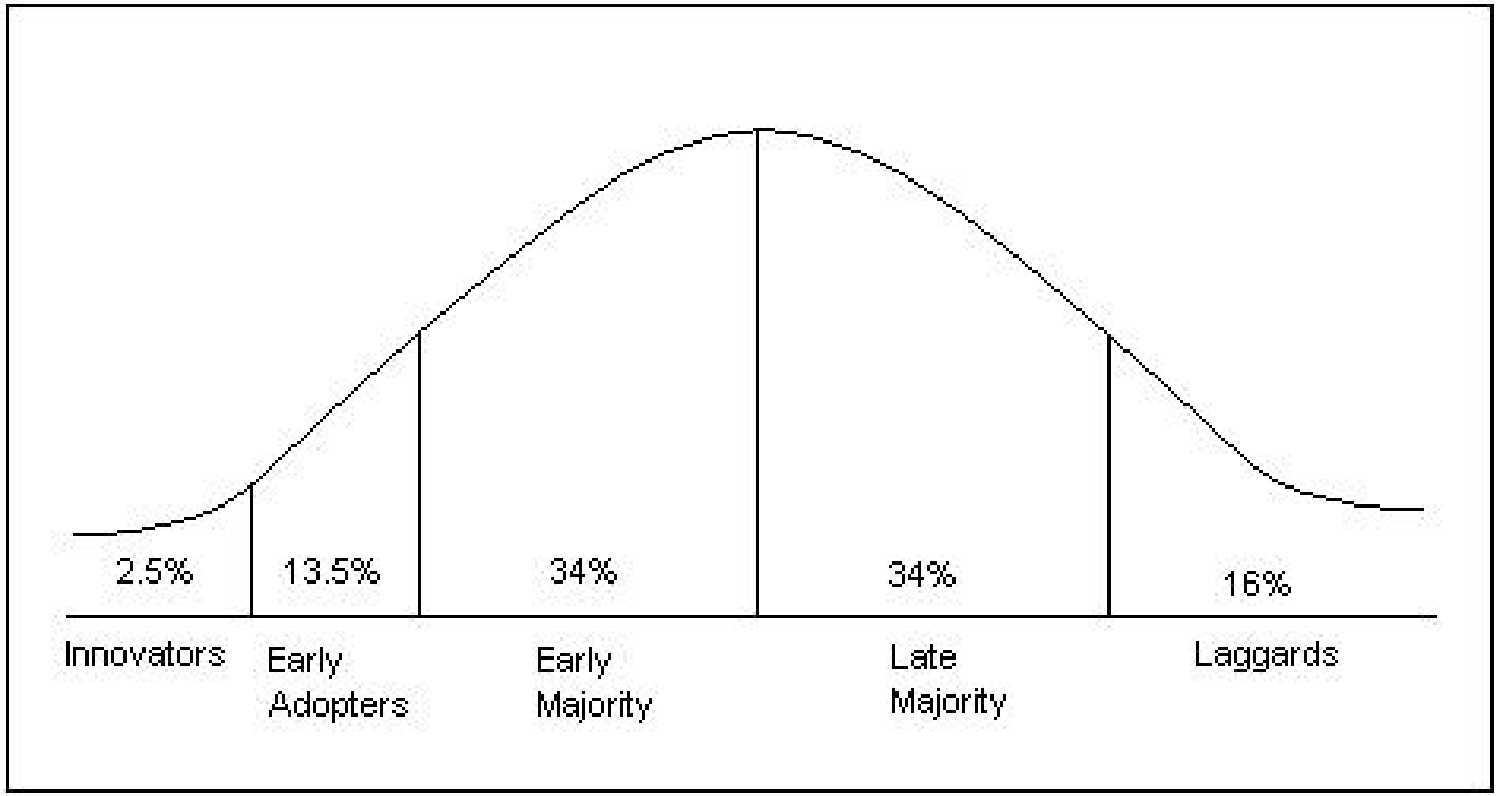
# Physician engagement: ROI

- **6,000 staff at multi-facility health system**
- **Low engagement levels admitted 10-25 patients per year to hospital; $420,000/year**
- **Medium engagement levels admitted 51-75 patients per year to hospital; $1.5 million/year**
- **High engagement levels admitted > 100 patients per year to hospital; $2.5 million/year**
- **12,000 physicians at children's hospitals in US**
  - **Highly engaged physicians admitted 76-100 patients per year with a contribution margin o f $3.4 million/year**

# Encouraging physician engagement

- **MESSAGE: Focus on improving patient care**
- **This message has more value than reducing cost and waste**
- **Message must be clear and consistent**

# Roger's Adopter Categories
# Diffusion of Innovation



# Enhancing Physician Engagement: Institute for Healthcare Improvement


- **Discover common purpose: improve outcomes and efficiency**
- **Reframe values and beliefs: make physicians partners**
- **Segment the engagement plan: fine tune engagement to reach different types of staff, identify champions, educate leaders**
- **Use engaging improvement methods: Use date to encourage buy-in**
- **Show courage: support physician leaders**
- **Adopt an engaging style: involve doctors from the beginning**

# Enhancing Physician Engagement: Liebhaber study

- **Employ physicians: achieve economic alignment**
- **Use credible data that are external, risk-adjusted, and bench-marked**
- **Provide visible commitment by hospital leadership by involving the board**
- **Use of physician champions**
- **Communication and education of physicians**

# Enhancing Physician Engagement: Morehead

- **3 best practice themes based on 300 hospital clients in the US**
- **Communication**
- **Building trust**
- **Partnering and aligning with physicians**

# Enhancing Physician Engagement: NHS

- **Hospital leadership sets expectations, lead by example and be visible and available.**
- **Work with physicians to be future focused and outward looking cultures.**
- **Physicians are increasingly required to be engaged in the wider environment beyond their direct clinical areas.**
- **Select physician leaders based on ability, open competition and attitude rather than seniority**

# Enhancing Physician Engagement: Canada (Snell)

- **Formally recognize the role of the physician leader by**
  - **sponsoring learning opportunities,**
  - **implementing recognition programs,**
  - **providing compensation for time spent on leadership activities, and**
  - **develop meaningful roles for physician leaders**
- **Streamline bureaucratic processes,**
- **Managing physician meeting efficiently,**
- **Supporting innovation, and**
- **Ensuring role expectations, deliverables, and lines of authority are communicated**

# 8 Key principles of physician buy-in

- **Treat a physician like they would treat a patient: listen and emphasize.**
- **Solicit physician input through interviews and focus groups.**
  - **Adopt a problem-solving mentality**
- **Respect physicians time.**
  - **Meetings early, at lunch or end of day**
- **Make it quantitative.**
  - **Physicians respond well to data.**
- **Link the work to performance and quality programs so there is no disconnect.**

# 8 Key principles of physician buy-in

- **Communicate frequently about a project's intent and progress so physicians understand what is happening and what is needed from them next.**
- **Address the skepticism head-on.**
  - **Deal with concerns directly and honestly.**
- **Reward and recognize physician contributions.**

# Enhancing Physician Engagement

- **Create a managerial culture where physician leaders are consulted and supported with explicit expectations of their performance**
- **Intermountain Healthcare and University College Hospital NHS Trust Fund**

# Do and Don’ts for effective engagement

- **Identify and develop physician leaders**
  - **Provide administrative support, data analytics and reporting, and the training needed for improvement**
- **Create a focus for a shared vision**
- **Build trust, understanding, and respect with physicians**
- **View problems as challenges**
- **Be a partner with the physician**
  - **Don’t simply create leadership appointments**
  - **Don’t rely primarily on financial incentives**
- **Clear communication**
  - **Regular contact: face to face meetings**
  - **Manager presence/rounding**
  - **Listen to physicians and address their concerns**
  - **Don’t rely on inspirational speeches**
- **Ensure physicians are involved in decision-making at every step**

# Translating Survey Data Into Action

## Three Key Questions

**Where should I focus my efforts?**

**What should I work on?**

**What should I do?**

# Narrowing Your Focus

**Comprehensive List of Top Opportunities**

**2-3 Most Promising Drivers**

**Additional Filters**

1. Baseline Performance Sufficient
2. Outsized Investment Required
3. Executive Support Needed

# Evaluating Two Possible Options

| Enterprise-Wide | | Hot Spots |
|---|---|---|
|  |  |  |
| Addresses top system-wide opportunities | *Focus* | Addresses top opportunities for most concerning groups |
| Broad | *Scope* | Deep |
| Centralized | *Resources* | Decentralized |
| Requires executive sponsor | *Leadership* | Gives local physician leaders control |

# Comparing Our Two Proven Approaches

## "Top Opp" Approach to Driving Engagement and Alignment

1. Conduct physician survey
2. Identify best improvement opportunities
3. Pursue responsive tactics

## Cultural Approach to Driving Engagement and Alignment

1. Define market vision
2. Define unique culture to advance vision
3. Determine approach to ingrain culture
4. Pursue proactive tactics
5. Conduct physician survey



Source: Advisory Board Survey Solutions interviews and analysis.

# Go Big or Don't Go

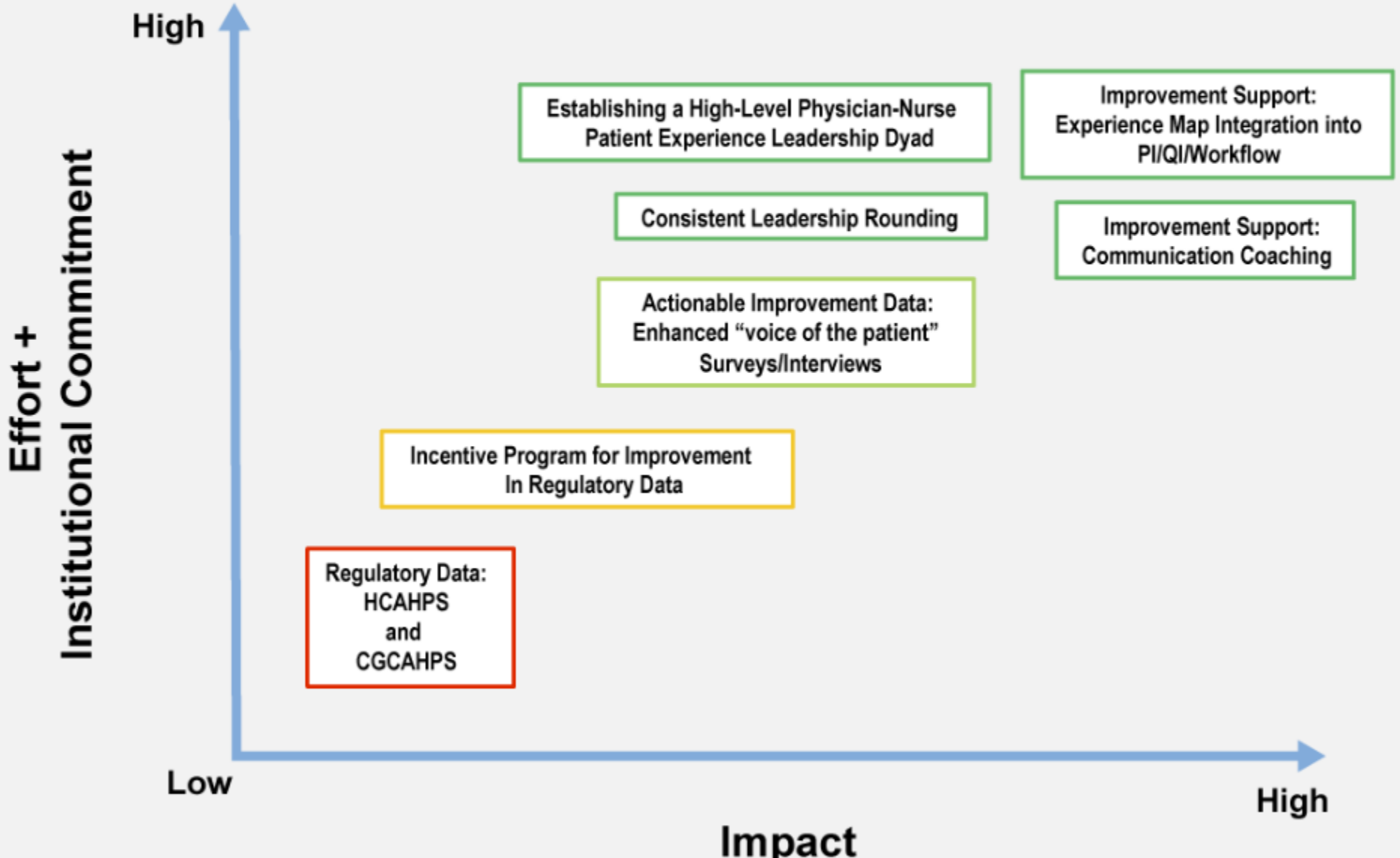
## Cultural Approach Not for Everyone

| Pocket Readiness Audit for Cultural Approach | |
|---|---|
| ✓ | Has your institution successfully met physicians' basic needs (equipment, compensation)? |
| ✓ | Does your institution have a clearly defined market vision? |
| ✓ | Has your institution defined its culture? |
| ✓ | Will your organization be able to dedicate resources needed to pursue initiatives? |
| ✓ | Is your organization prepared to dedicate resources to ingrain and sustain culture? |



Source: Medical Group Strategy Council Interviews and Analysis

# Engaging Physicians in Patient Experience Improvement



# Key Points

- **The fundamental purpose of a health car organization is to support the willing, competent and engaged clinician's interaction with each patient.**
- **Engaged physicians are essential for high-functioning health care organizations but he process of engagement must be supported by an organizational culture of openness.**
- **The engagement process has to be reciprocal with the organization recognizing, and supporting the clinician's needs and vice versa.**

Gregory Hale, MD is a Professor of Oncology and Pediatrics at All Children's Hospital Johns Hopkins Medicine in St. Petersburg, Florida. In 2008, Dr. Hale came to All Children's Hospital as Medical Director of the Hematology/Oncology/BMT program. Subsequently he continues to provide care for patients with both solid and hematologic cancers and non-malignant diseases, with a focus on bone marrow transplantation. Previously he worked for 11 years at St. Jude Children's Research Hospital, where he served as Clinical Director of the Blood and Marrow Transplant Program, was director of the BMT Fellowship program, and was an active member of the Developmental Therapeutics, Solid Tumor, Neurobiology, and Hematologic Malignancies Programs. He presently serves as the institutional investigator for the Children's Oncology Group, Therapeutic Advances in Childhood Leukemia and Lymphoma (TACL) and Neuroblastoma & Medulloblastoma Translational Research Consortium (NMTRC). He is presently a Co-Chair of the Cancer Working Committee of the Center for International Blood and Marrow Transplantation Registry (CIBMTR). His research interests include cellular therapies from alternate donors, especially in the treatment of both hematologic and solid malignancies. He has received grant support from the V Foundation, the American Cancer Society, and the Hyundai Hope on Wheels. He is actively involved in both therapeutic, supportive care and biology clinical trials and has authored over 170 peer-reviewed publications, 95 abstracts and 7 book chapters. He is currently on the Graduate Medical Education Committees for the pediatric residency programs for the University of South Florida and All Children's Johns Hopkins Medicine. He has been active in community educational programs for patients and families through the Aplastic Anemia MDS Foundation, and the Leukemia Lymphoma Society. He is a certified physician executive through the Certifying Commission in Medical Management.

Dr. Hale has served on the boards of directors for international organizations such as the National Marrow Donor Program and the Foundations for the Accreditation of Cellular Therapies. He has served as an invited member of the HPV Advisory Committee of the American Academy of Pediatrics and the Centers for Disease Control. He was an invited member for the Cellular, Tissue, and Gene Therapies (CTGT) FDA Advisory Committee for licensure of cord blood. Dr. Hale serves on the boards of the Suncoast Make a Wish Foundation and the local chapter of the Sickle Cell Disease Association. Dr. Hale received his undergraduate degree in chemistry and his medical degree from Marshall University in Huntington, WV. He completed his residency in pediatrics at Children's Hospital of Pittsburgh and his fellowship in pediatric hematology oncology at St. Jude Children's Research Hospital. He is currently enrolled in the MBA program at University of Massachusetts Amherst.

# Academic Transformation

## Managing Change

Paul M. Colombani, MD, MBA, FACS, FAAP

January 14, 2017

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
ALL CHILDREN'S HOSPITAL

# Healthcare in Transition

- Pay for performance
- Quality vs. quantity
- Corporate control of care
- Price gouging by Big Pharm and device manufacturers
- Time of high anxiety for front line providers


JOHNS HOPKINS
All Children's Hospital

# Historical Background

- All Children's Hospital
- Pediatric Practices
- Residency Programs
- USF Connection

# Proposal

- All Children's Hospital joins Johns Hopkins Health System
- JHU Sponsoring Medical School
- Deliverables
  - Residency Programs
  - Research Programs

# Starting Point

- Community focus on routine care
- Private practice outlook
  - Some exceptions
- Employed MDs (private practice model)
- Minimal teaching
- Modest research
  - Local funding
- Referrals out of area frequent for complex cases
- Hospital census: ⬇ acuity/Medicaid patients

# Ending Point

- Academic Medical Center
  - Clinical care
    - All Service Lines
    - Most complex cases
    - Care for community
  - Teaching (full array of residency/fellowships)
  - Research (clinical translational research)
  - Advocacy (state, regional and national voice)

# Negative Forces

- USF residency/faculty (transition)
- Medicaid payments
  - For profit HMOs
- Florida legislature
- Lack of research infrastructure/leadership
- Unclear/lack of focus on service lines/centers of excellence

# Negative Forces

- Lack of physician leadership
- Misalignment of hospital/physician goals/objectives
- JHU faculty unengaged

# Where do you start?

# Back to Basics

- People
- Vision
- Mission
- Culture
- Empowerment/Trust
- Program Building

# People

- Vice Dean for Academic Affairs
- Associate Dean for Academic Affairs
- Inaugural Chairs in Medicine and Surgery
- VPMA/Safety Officer
- Turnover/reorganize administration
  - COO, CFO, CIO, Chief Strategy Officer
- Recruitment of Institute/Division Chiefs
- Hospital Board/Strategic Planning

# Vision Statement

- Top Children's Hospital in Florida and beyond

# Mission Statement

- Encompass clinical care, teaching, research, advocacy
- Family centered care

# Culture Statement

- Signed by all
- Stress common goals
  - Teamwork
  - Professionalism
  - Trust

# Empowerment/Trust

- Administration Team
- MDs, APPs
- Nursing
- Support staff

# Program Building

- Reorganize finances, contracting, revenue cycle, foundation
- ID and fund Institutes/Departments
- Fund service line centers of excellence
- Recruit expertise

# Partnership

- Align administration/MD staff/Hospital staff
  - Leadership development
  - Career development
  - Move from clinical-only focus to all areas

# How are we doing?

# Accomplishments

- MD CEO
- C Suite 100% commitment
- Departments/Institute leadership on board
- Residency programs expanding
- Research infrastructure in place & expanding
- $100m research building under construction
- Case mix rising rapidly/ALOS ⬇
- Approaching full service children's hospital

# New Research Building

# Ongoing Issues

- Payment in Florida
- Developing skills/careers for existing MDs, APPs
- Overcoming culture shock
- Changing focus of recruitment
- Team is more than clinical coverage
- Teaching/research needs must be met

# Conclusion

- Academic Transformation
  - Complex Process
  - Continuous/ evolving
- Managing Change
  - Transparencies
  - Dialogue with stakeholders
  - Mutual trust

all we do.
all for kids.™

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## Paul Colombani, M.D., M.B.A., F.A.C.S., F.A.A.P.

Dr. Colombani chairs the Department of Surgery at Johns Hopkins All Children's Hospital and is President of All Children's Specialty Physicians. He is a Professor of Surgery, Pediatrics and Oncology at the Johns Hopkins University School of Medicine and the Robert Garrett Professor (Emeritus) of Pediatric Surgery.

A graduate of the University of Kentucky College of Medicine, Dr. Colombani completed his general surgery residency at George Washington University Hospital in Washington, D.C. Upon completion of his pediatric surgery residency at Johns Hopkins in 1983, he joined the Hopkins faculty. In 1991, he was named the Children's Surgeon-in-Charge at The Johns Hopkins Hospital and Chief of the Division of Pediatric Surgery; he also directed the Pediatric Transplant Program at Johns Hopkins Hospital. He is a fellow of the American College of Surgeons and a member of the sections for Surgery and Critical Care of the American Academy of Pediatrics. His research has focused on pediatric transplantation, transplant pharmacology and immunology, chest wall reconstruction and hepatobiliary surgery.

Dr. Colombani holds an M.B.A. from Johns Hopkins University. He has been a consultant and/or committee member for the U.S. Food & Drug Administration, US Pharmacopoeia, United Network of Organ Sharing, and the Residency Review Committee for Surgery of the Accreditation Council on Graduate Medical Education. He is a fellow of the American College of Surgeons and the American Academy of Pediatrics.

# Development and Integration of a Sports Medicine Program

P. Patrick Mularoni MD, FAAP, FACEP, CAQ SM

# What is Sports Medicine?

- A buzz word that means:

" I can take care of athletes."

# Who is Sports Medicine ?

- Orthopedists
- Family Medicine
- Pediatricians
- Physical Therapists
- Athletic Trainers
- Chiropractors
- Massage Therapists

# Primary Care Sports Medicine

- A one year fellowship offered through the American Board of Family Medicine
- Physicians need to be boarded in another specialty
- Family Medicine, Internal Medicine, Physiatry, Orthopedics, Pediatrics
- 122 Family Medicine Sports Medicine fellowship programs
- 16 Pediatric Sports Medicine fellowships

# If Pediatric Orthopedics can see all this then why is it necessary?

- Expanded range of issues treated
- Care Coordination for an ever increasing population of children in sport who have different injuries than they did before
- Education of differing learners
- Opportunities for non-surgical research

# What is the difference between Sports Medicine and Orthopedics?

- Primary Care angle on practice
- Ability to treat concussion
- Treatment of unique issues related to diet and exercise
- Surgical vs Non-surgical

# Where we shine…..

# Gymnast

- 12 years old
- Level 8
- January

# Baseball player

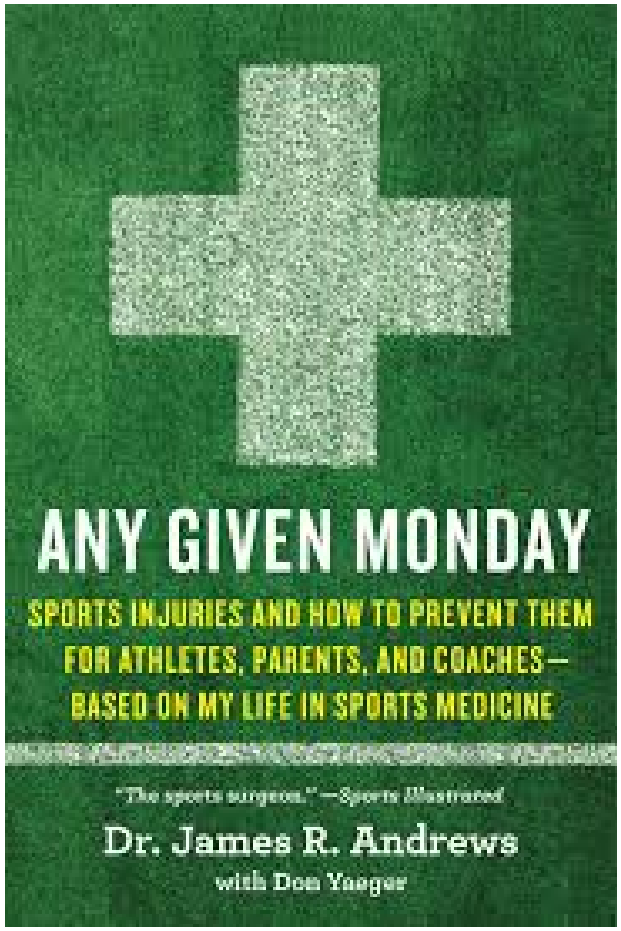
# Baseball player

- Pitcher
- Catcher
- Summer
- 13 years old

# Early Specialization

- There is little data as to the number of athletes that are specializing in sport
- Reasons why we are seeing early specialization in sports
  - Tiger Woods
  - Eastern Block Countries
  - Parents driven by children's success
  - Financial incentives

# Overuse Injury “epidemic”




“ …children are pigeonholed into one sport fairly early on, which means that they have little variation in terms of the muscles and joints employed and skills practiced, which can lead to fatigue and a much higher rate of injury”

# Injuries add up.

- Travel-team parents spend an average of $2,266 annually on their child's sports participation
- Injuries can lead to missed trips tournaments and games

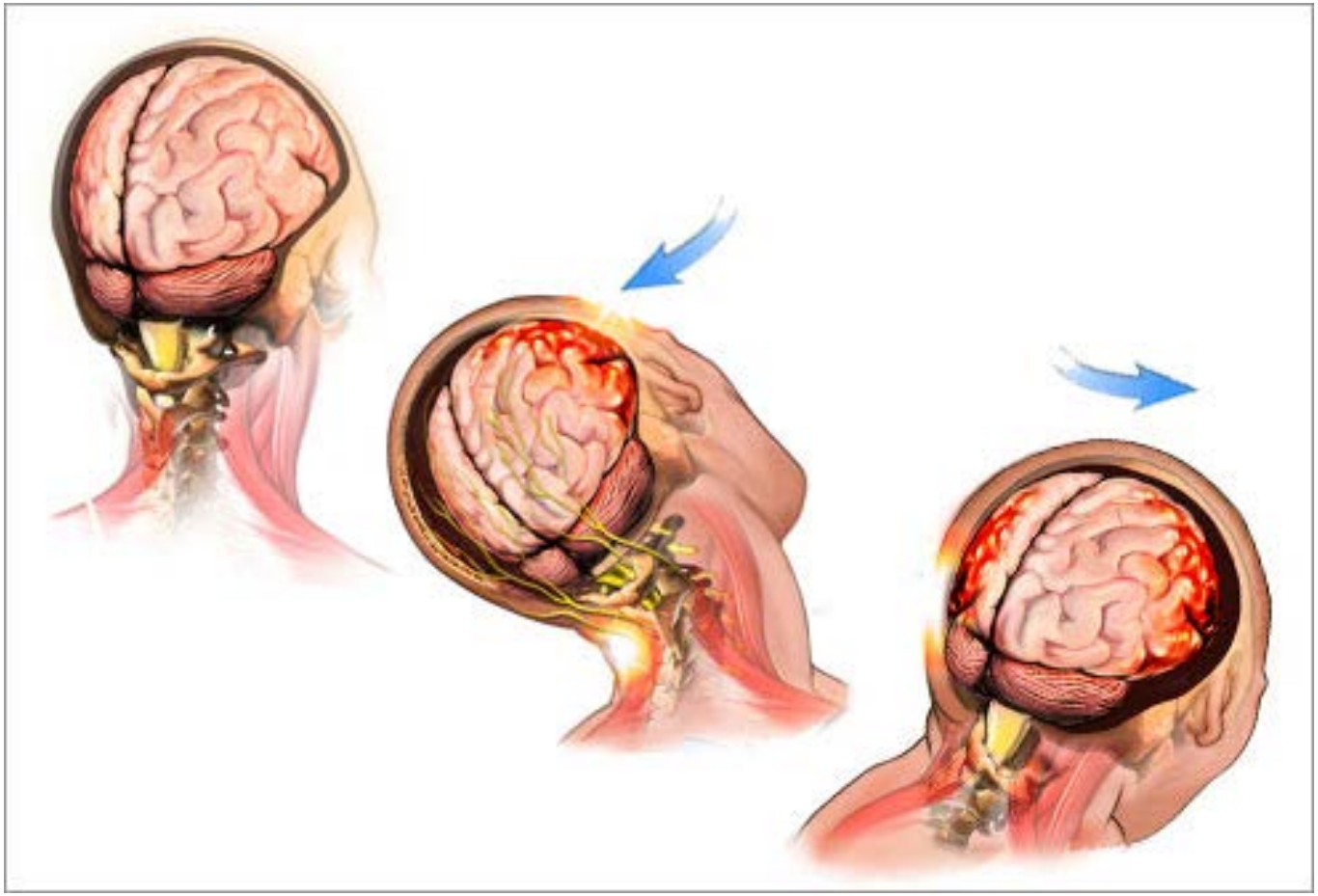
# Epidemiology

- The National Federation of State High School Associations reports that sports participation has surpassed 7.7 million.
- This is a 50% increase from 1993 where 5.4 million athletes competed.

# Children 6 and under

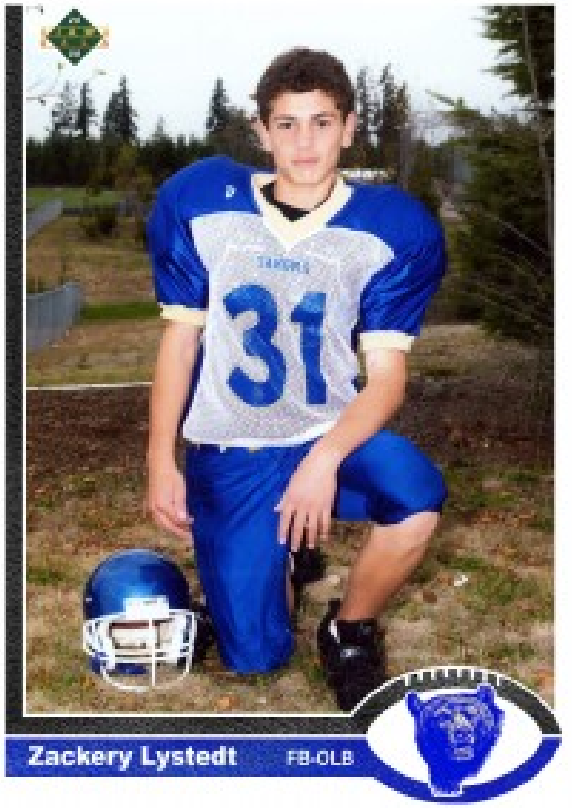
- As a percentage of all athletes less than 18 y/o
  - 1997: 9%
  - 2009: 12%

# Concussion



# Zackary Lystedt

- In 2006 Zack was a 13 year old two-way Junior High player
- In the first quarter he was hit and clutched his head in pain
- He “shook it off” and played with a headache in the second quarter

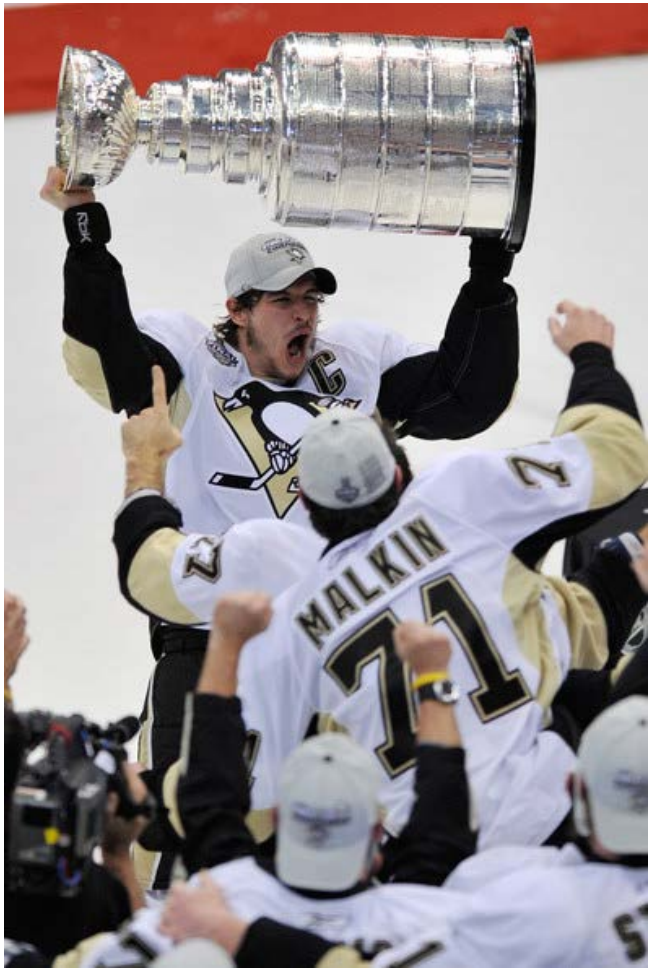


# Zackary Lystedt

- Zach collapsed after the game and suffered from diffuse cerebral edema
- His head injury left him with permanent disability
- May 2009 Washington Governor enacts the Zack Lystedt Law

# Sid Crosby

- Hit in the winter classic January 1, 2011 and was “wobbly”
- Hit by Victor Hedman January 5, 2011
- Three time all star and 2010 goal leader missed the next 11 months



# Concussion Legislation

- Florida House Bill 291 signed into law on April 27, 2012
- Mississippi Law signed in January of 2014
- All 50 U.S. states have concussion laws regarding return to play
- Many have return to learning laws as well

# Concussion on the rise?

- In a 2016 study published in the Orthopedic Journal of Sports Medicine looking at 8.8 million Humana customers
- Concussion incidence increased from 3529 in 2007 to 8217 in 2014. That was a 60% increase
- 32% in the adolescent age group
- Rate of 16.5 / 1000 in males 15-19

# Concussion Rates

- 3.8 million per year
- Higher in High School athletes than college athletes
- More common in girls than boys

# Education

# What do we know

- 1996 archives of Pediatric and Adolescent medicine. 83% of residency programs had less than 6 hours of Sports Medicine lectures.
- 37% had “hands on teaching”

# Pediatrics 2005

- 29% of Pediatric residencies did not have specific musculoskeletal or joint exams in their curriculum
- 23% said they had no lectures on Sports Medicine
- Most teaching on Sports Medicine was reportedly done in the EC and Adolescent rotations

# 2011

- Family medicine residencies that had a Sports Medicine fellowship were 10-15% more likely to identify common sports injuries than those that did not

# Pediatric Education

- More concussions go to their Pediatrician than to the ER
- Over 60% of residents go into Primary Care
- More than 25% of adolescent injury visits to the PCP are from sports injuries
- Yearly physicals are required for sports participation

# Research

- Concussion research has increased exponentially in the past 10 years
- There are research gaps in management of overuse injuries, sports specialization, and concussion

# How did we do it?

- My story…….

Patrick Mularoni MD, FAAP, FACEP, CAQ SM

# Year 1

- Concussion Clinic
- ½ day per week
- Community Coverage (IRCS/Chargers)
- Baseline ImPACT
- Website creation
- Education
  - Lectures
  - TV
  - Radio

# Athletic Trainers in the clinic

- We originally started with typical model of OA, MA, ATC, RN and a Physician.
- Transitioned RN out of practice
- Recognition that Athletic Traners (ATC) can function in many roles in the clinic

# Clinic Design

- Athletic Trainers
  - an allied Health Care profession
  - Bachelors degree but 75% have Masters
  - Can work in both the office and the field

# Athletic Trainers in the Office

- Check in
- Research Enrollment
- ImPACT
- DME/ Casting
- Exercise prescription/ Home PT
- Liason between PT and office
- Interaction with school ATC for return to play

# Year 2

- Growth to 3 clinics per week
- Coverage opportunities
- Grow from within
- Resident Education with Bayfront Family Medicine Residents

# Year 3

- Moved from 3 clinics per week to coverage of 7 clinics per week
- Move to outpatient care centers
- Increased team coverage (Faragut)
- Inclusion of Pediatric Sports Medicine Elective

# Year 4

- Addition of third Physician
- Outreach at 6 OCC's
- Addition of weekly Adolescent Medicine clinic day and expanded Sports Medicine elective availability

# Year 5

- Expansion to 7th outreach as Sports Medicine Physicians at IMG Academy

# Growth

- Between 2012 and 2015 our volumes have steadily increased at a rate of 15-20%
- Month to Month clinic volumes for same location have increased >10% per year
- Growth has shifted with balance towards musculoskeletal injuries

# What are the ingredients

- Orthopedics
- Physical Therapy
- Radiology
- Athletic Trainers
- Neuropsychologists
- Administrative Support

# Navigating the Pitfalls

- Where do you house Sports Medicine?
  - Family Medicine
  - Pediatrics
  - Orthopedics
  - Institute for Brain Protection Sciences
  - Combination

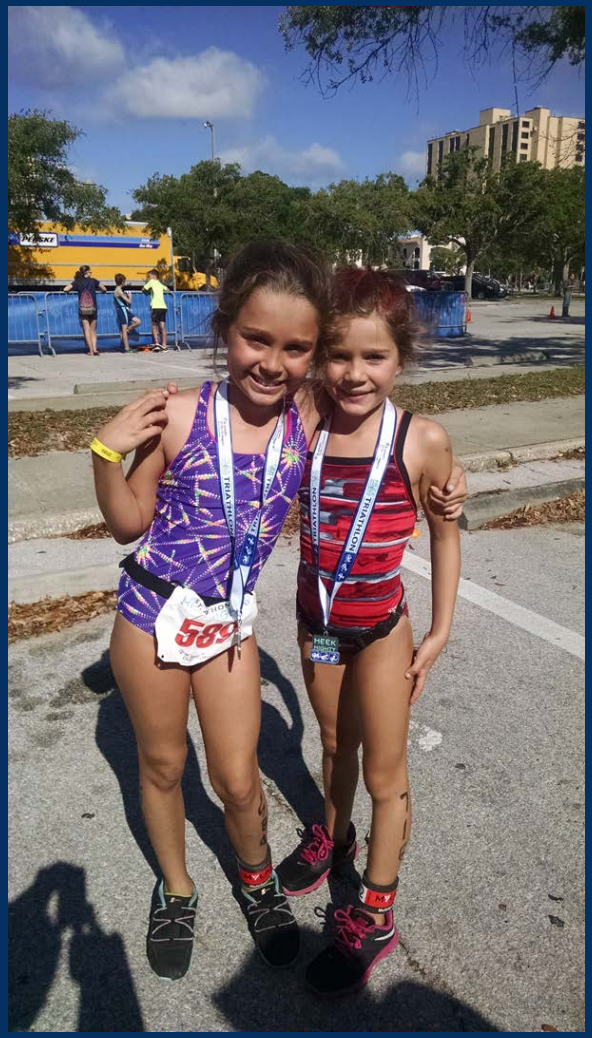
# Navigating the pitfalls

- Turf Battles
  - Orthopedics
  - Neurology
  - Neurosurgery
  - Physiatry
  - General Pediatrics

# Hospital and Community benefits

- Opportunity to interact with the healthy children
- Community outreach
- Partnerships with the schools
- Promotion of healthy lifestyles

# Thank You !



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all for kids.™

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

# Philip P. Mularoni, MD

**Medical Director, Division of Primary Care Sports Medicine**
**Attending Physician, Division of Pediatric Emergency Medicine**
**All Children's Hospital Johns Hopkins Medicine**

Dr. Mularoni graduated from Michigan State University with an undergraduate degree in Biology from the Lyman Briggs College of Science. He completed Medical school at the American University of the Caribbean where he achieved honors in his third and fourth year clinical rotations at Ascension Health Hospitals in Detroit, Michigan. Dr. Mularoni completed his Pediatric Residency at St. John Hospital and Medical Center in Detroit, Michigan. His Fellowship in Pediatric Emergency Medicine was completed in Atlanta, Georgia through Emory University. His Fellowship in Primary Care Sports Medicine was completed in St. Petersburg, Florida through Bayfront Hospital.

While at Emory University, Dr. Mularoni completed research on procedural pain reduction in the emergency setting and was awarded the American Academy of Pediatrics Willis Wingert award for best fellow research. He has continued conducting research at All Children's looking at best practice for procedural sedation in reduction of Pediatric forearm fractures. His current research interests include concussion management and prognosis in patients with mild traumatic brain injuries. He is the chairman of the Medical Emergency Committee. Dr. Mularoni lectures internationally on Pediatric Emergency and Sports related topics and is a regular contributor to Fox television's Good Day show.

Dr. Mularoni is married to Kim Mularoni who is a Pediatrician in St. Petersburg and together they have three children. During free time, Dr. Mularoni competes in running, triathlon and stand up paddle boarding races.