FAIRVIEW HEALTH SERVICES

UNIVERSITY OF MINNESOTA ACADEMIC HEALTH CENTER

AFFILIATION EVALUATION

REPORT OF THE EXTERNAL REVIEW PANEL

MARCH, 2001

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FAIRVIEW-ACADEMIC HEALTH CENTER AFFILIATION EVALUATION

EXECUTIVE SUMMARY

BACKGROUND

In 1996, the University of Minnesota Academic Health Center (AHC) and Fairview Health Services (Fairview) entered into a set of affiliation agreements. The key components of the agreements included (a) the acquisition of the University Hospital by Fairview, (b) an academic affiliation agreement between Fairview and the AHC, (c) an agreement between Fairview and the AHC's faculty practice organization, University of Minnesota Physicians (UMP).

As part of the agreement, a formal external review process after 3 years of the affiliation was stipulated. Dr. Frank Cerra, Senior Vice President for Health Sciences at the University, and David Page, President and CEO of Fairview, initiated this process in August, 2000. The following panel members were chosen to conduct this external review process:

- William Loveday, President and CEO
  Clarian Health Partners
  Indianapolis, IN

- William Peck, M.D., Executive Vice Chancellor and Dean
  Washington University School of Medicine
  St. Louis, MO

- Winston Wallin, Former Chairman of the Board
  Medtronic Corporation
  Minneapolis, MN

SCOPE AND OBJECTIVES

The scope of the external review included the following tasks:

- To assess whether the objectives of each of the organizations are being met as it relates to the affiliation
- To comment on the progress of the merger
- To highlight some of the challenges encountered
- To evaluate the agreements between the organizations
- To recommend methods for accelerating progress toward achieving the goals of the affiliation

PROCESS

The process for the review consisted of extensive data collection and several institutional site visits during which the panel members interviewed stakeholders from the AHC and Fairview, and other community health systems. Included in the interviews were individuals at governance, management and medical staff levels within Fairview and the AHC. Specific physician input was gathered from physicians from the University and the community, with the focus on those who practice at the F-UMC campus.

KEY CONCLUSIONS AND RECOMMENDATIONS

The review panel believes that the affiliation has been vital to Fairview and the University/AHC, and that the organizations should continue to productively move forward together. Virtually all of those with whom the review panel interacted expressed support for continuation of the relationship.

While each organization had several objectives in entering into the affiliation, including mission support, market presence, and economics (see pages 7 and 8), the core goals for each organization can be summarized as follows:

- For Fairview: A bold plan and change was needed to "save" the Riverside campus. Fairview was faced with the potential for major operating losses at Riverside or potential closure of the campus as an inpatient, acute care facility. The addition of the "quaternary" level of service represented by University Hospital was desirable for both Riverside and the Fairview system.

- For the AHC/University: In order to improve the prospects for the Medical School, an affiliation with a system with greater market presence and managed care capability was needed; avoidance of future financial liability for the University related to operation of its hospital and retention of at least some degree of financial support for academic programs from the clinical enterprise was viewed as essential

These core goals have been substantially accomplished, with the notable exception that the prospects for the Medical School have not improved.

Bringing together two organizations with very different cultures, missions, governance structures, histories and physician relationships has been a complex and challenging task.

There is clear need for continued attention to the relationship and its objectives. Toward that end, the review panel's core recommendations are as follows:

1. Presuming the State of Minnesota wants a premier Medical School, the University and the State of Minnesota should provide significant additional financial support to the Academic Health Center and the Medical School.

Enhancement of the Medical School is critical to the future success of the affiliation between the AHC and Fairview, to the University and to all of Minnesota. Over the last five to ten years, the Medical School has experienced significant losses, in terms of reputation, national ranking, faculty members, and financial stability.

The School has dropped from 19th to 27th in Federal research funding; tenured faculty members have decreased by over 80; annual operating losses have been as high as $8 million. The problems are very serious. Fairview alone cannot be the sole solution to the financial and qualitative challenges of the Medical School. The State of Minnesota has to be the key financial resource supporting the renaissance of the School. For a variety of reasons, especially the impact of managed care, the University of Minnesota Medical School has been short of funding, for at least the last decade. The only realistic hope to fill this void is the State of Minnesota, which so far has not responded.

Significant additional financial support for the Medical School is required to return the School to a position of national prominence and to re-position the School as a premier biomedical research institution. The University of Minnesota needs to address this very important issue with the state legislature. The future of the state's public medical school is at stake, and the legislature needs to be keenly aware of the urgency of the situation. The current legislative funding request will allow only for stabilization of the Medical School. With knowledge of what other states are investing in their Medical Schools to position those states for the current revolution in bio-technology, the review panel is of the opinion that substantial ($50-$75M over several years) additional investment will be required to help rebuild the Medical School to its former national and international status. Leadership at the highest levels of the University needs to champion this message. The University and the AHC should be held to the highest levels of accountability for wise investment of new funding received.

Increased state funding for the AHC is important not only to the University, but to the whole of the state. The University should actively reach out to, educate, and enlist the support of other health care organizations in its communication effort with the State legislature. The state's health care system has entered a period of critical health professional shortages, especially in nursing. The AHC , with the support of the State, should be part of the solution to this acute problem.

2. The leadership of Fairview and the AHC needs to jointly reformulate a clear vision for the relationship, a clear role for F-UMC as a teaching hospital serving in a regional referral role, an effective process for alignment of priorities between

Fairview and UMP, and effective bridge-building between UMP and other key Fairview-affiliated physician groups.

There is currently a lack of clarity around the vision for the affiliation relationship, the vision for F-UMC, and the expectations and obligations of both parties. The reformulated vision needs to specifically address the strategic benefits of the relationship, core objectives , and concrete actions planned to fulfill the vision. The vision needs to be clearly, frequently, and passionately communicated throughout the organizations.

The absence of a clear vision and operating model for F-UMC has been a detriment to achieving the goals of the affiliation. F-UMC has been operated as part university hospital and part community hospital; both roles have been compromised as a result. F-UMC should be viewed and operated as a teaching hospital serving a regional referral role. Marketing efforts for F-UMC should reinforce this role. The emphasis should be on advancing the distinctive role of the University Hospital and its centers of excellence, integrated with the other strengths of the Fairview system and supported by the AHC and community physicians who are attracted by the environment of a teaching hospital setting. Continued attention to improving operations at F-UMC should also be a high priority.

There is not yet sufficiently effective, outcome-oriented joint strategic planning and prioritization effort involving Fairview and University of Minnesota Physicians. Aligning priorities and planning processes between these two organizations is critical to the success of the affiliation and should be a high priority for the leadership of Fairview, the AHC, and UMP. The Coordinated Management Council is moving in this direction. A critical element of joint success between these two organizations is building and strengthening UMP' s outreach activities to other physicians and communities served by the Fairview system. If F-UMC is to succeed as a tertiary referral center, UMP's commitment to outreach and referring physician support is essential.

Community physicians who have historically practiced at the Riverside campus (previously Fairview Riverside Hospital) have found the new organization to be a difficult place to practice. The large majority of community physicians have chosen to either move their clinical practice to another Fairview facility, or to a competing facility in the market place. Community physicians continue to question the value of the relationship between Fairview and the AHC. Fairview has recently put in place a new Vice President for Medical Affairs for F-UMC, whose role will be to define the value proposition for the physicians working at F-UMC. The vision and role for the F-UMC campus described earlier will hopefully bring clarity to the physicians regarding F-UMC's role within the Fairview system, along with clarity of opportunity for those interested in practicing in that setting.

Fairview and the AHC should facilitate an ongoing forum targeted at "bridge-building" between UMP and other key Fairview affiliated physician groups. Overlapping Board attendance between UMP and FPA at UMP and FPA Board meetings may also help to better link these two physician groups, both integral to the success of the affiliation.

3. Fairview and the AHC should implement aggressive internal and external marketing and communications plans clearly expressing and supporting the reformulated vision and role for F-UMC.

During the interview process the review panel heard substantial lack of clarity from both inside and outside Fairview and the AHC regarding the role and distinctive capabilities of F-UMC. Communication of the re-formulated vision will be particularly important to internal stakeholders. Externally, the relationship of Fairview and the AHC will require on-going clarification and communication. Further, from an external perspective, marketing of the special expertise at F-UMC will be a key ingredient to future success.

4. A 3-5 year budget for targeted recruitment support for new academic clinical leadership should be jointly developed. The panel would recommend that agreement on funding levels be reached and a significant funding amount be allocated by Fairview as quickly as possible.

Based on opinions expressed to the review panel and knowledge of recruitment packages put together elsewhere, the panel would anticipate that the funding allocation will need to be in the $2-$5 M range per year for the next several years.

The Medical School will need to recruit into several important clinical academic leadership roles in the near future. While the Medical School should have primary responsibility for the support of the new leaders, Fairview should participate in the financial support for these recruitments, which will be important to the future of F-UMC and the Fairview system. A 3-5 year budget for targeted recruitment support should be developed and monitored jointly by Fairview and the AHC. Fairview should be actively involved in the search, recruitment and monitoring processes.

5. Fairview and the AHC should create meaningful cross-participation in the executive and policy "cabinets" of each organization, in order to build a broader base of understanding and ownership of each organizations' cultures, resource allocations, and priorities.

The affiliation agreements created meaningful integration at the Fairview governance level, and the CEO's of the organizations clearly share a common vision. That vision has not, however, been translated into effective, consistent inter-organizational behavior. Better understanding of cultural differences and priorities, along with better blending of

the cultures and priorities, will improve inter-organizational behavior. Organizational behavior patterns should be changed to facilitate better mutual understanding.

Toward that end, additional overlap and integration of leadership between the two organizations is strongly recommended. Cross-participation in each of the organizations' executive/policy "cabinets" should be initiated. People and resources specifically dedicated to implementation of critical joint initiatives should be identified by both the AHC and Fairview. It is also recommended that the University President serve as a member of the Fairview Board, at least during the next several, critical years.

CLOSING

The AHC and Fairview have much to be proud of, including the courage shown by both organizations to be innovative in their joint commitments to patient care, education, and research. No relationship involving universities, faculties, physicians, and hospitals is ever perfect or not in need of improvement, even those that have existed for decades. It is not a surprise to the review panel, and likely is not to the leadership of the AHC and Fairview, that the full potential of the affiliation relationship has not yet been reached. After three-four years, one can only expect to find a work in progress.

The review panel believes that acting on the conclusions and recommendations outlined in this report will substantially increase the probability that continued progress will be made.

The members of the review panel are hopeful that their work will assist Fairview and the AHC in moving forward in reaching their mutual important goals.

FAIRVIEW HEALTH SERVICES

UNIVERSITY OF MINNESOTA ACADEMIC HEALTH CENTER

AFFILIATION EVALUATION

REPORT OF THE EXTERNAL REVIEW PANEL

I. INTRODUCTION AND BACKGROUND

The evolution of the health care marketplace nationally has caused enormous change to the role and configuration of community health systems and academic health centers. In the past, the role of a community health system was to provide primary and secondary care – perhaps with a limited commitment to medical education; academic health centers served in a tertiary referral patient care role in order to support their core missions of education and research. Those roles began to evolve, with more overlap, in the 1980's and early 1990's. Even more dramatic change occurred in many communities in the mid-1990's, with multiple major organizational combinations occurring among community health systems, academic health centers, and national for-profit systems.

The progression of the Twin Cities health care marketplace, and the evolution of the University of Minnesota Academic Health Center (AHC) and Fairview Health Services (Fairview), were such that in 1996 the AHC and Fairview established a new, highly integrated relationship. The key components of the affiliation between the AHC and Fairview involved (a) the acquisition by Fairview of the former University Hospital and subsequent integration of that facility with the former Fairview Riverside Hospital to form Fairview-University Medical Center, (b) the establishment of an academic affiliation agreement between the two organizations, and (c) the establishment of an agreement between Fairview and the AHC's faculty practice organization, the University of Minnesota Physicians (UMP).

The primary motivations for establishment of the affiliation, from Fairview's perspective, included:

- Community interest – Fairview has a long held belief in the importance of the

Academic Health Center to the health care system of the community and state. The Fairview Board leadership articulated the view that supporting the AHC through this transaction was the "right thing to do for the community."

- Competitive dynamics – The University had made it clear in 1995 that it intended to align its hospital with one of the major community health systems; Fairview was desirous of adding the tertiary care capability represented by the AHC/University Hospital to Fairview's portfolio. Fairview would then have a full continuum of acute care service offerings, complemented by its ambulatory, behavioral and seniors programs.

- Internal dynamics – Fairview's Riverside Campus was about to lose a major payor's volume; the future of the Riverside Campus was in doubt and a new initiative was needed to redefine the future of this important part of the Fairview system.

From the University perspective, the motivations behind the establishment of the affiliation included:

- Avoidance of financial liability – There was concern and evidence on the part of the University that the University Hospital would generate operating losses which would harm the University's financial status, and that "stand alone" status in the marketplace would produce this result. There were, and have since been, a number of examples nationally where financial challenges in the clinical enterprise have harmed the University's financial status and credit rating.

- Access to patient base – The Medical School and faculty practice organization needed access to a larger patient base than the University was able to generate as an "independent" health care system.

- Enhancement of the Medical School – The University wanted to focus its management attention on the academic units most central to its mission; improvement of the core teaching hospital's performance was seen as an essential link to improved academic performance.

With these motivations, the two organizations signed the enabling documents in December, 1996, establishing the affiliation between Fairview and the AHC.

As part of the agreements, the two organizations planned a formal external review of the affiliation after three years experience with the new relationship. This external review process was commissioned, per the agreements, by David Page, President and CEO of Fairview, and Dr. Frank Cerra, Senior Vice President for Health Sciences at the

University, in August, 2000. An external review panel was formed, consisting of:

- William Loveday, President and CEO
  Clarian Health Partners
  Indianapolis, Indiana
  (Clarian is a product of the merger of Indiana University Hospitals and Methodist Hospital in Indianapolis)

- William Peck, M.D.
  Executive Vice Chancellor and Dean
  Washington University School of Medicine
  St. Louis, Missouri

  (Washington University has a close affiliation relationship with the rapidly growing BJC Health System)

- Winston Wallin
  Former Chairman of the Board
  Medtronic Corporation
  Minneapolis, Minnesota

  (Mr. Wallin has been very active in the Minnesota health care, business, and education communities throughout his distinguished career)

The review panel was charged with the following tasks:

- To assess whether the AHC and Fairview's separate and joint objectives are being reached

- To review the progress of the affiliation

- To highlight some of the challenges encountered

- To evaluate the reciprocal agreements between the organizations

- To recommend methods for accelerating progress toward achieving affiliation goals

The review panel emphasized the latter task in particular in its work, recognizing that prospective advice is more valuable than retrospective data analysis and critique.

The review panel gathered extensive background documentation relative to the affiliation, and reviewed current and past results from financial, market, education, and research perspectives.

Most central to the work of the review team was a series of interviews with key stakeholders, conducted over five days of interviewing from September – December, 2000, and several telephone interviews in January and February, 2001. A listing of the individuals who participated in the interview process is attached as Appendix A.

This report is organized in two sections. The first section is an overview, from the review panel perspective, of the results of the affiliation to date. The second section represents the key conclusions and recommendations from the review panel, with a focus on the priorities for moving the relationship forward toward the goals expressed at the time of the affiliation.

II. KEY FINDINGS

A. PROGRESS: CHALLENGES, COMPLEXITY, AND CULTURE

The challenges associated with the creation of an affiliation between an academic health center and a community health system are enormous. Fairview and the AHC are part of an important and current national health care "experiment", testing whether new forms of relationship will advance the organizations' missions of patient care, education and research. Some involved with that experiment elsewhere have seen positive market and academic impact (Partners, BJC, Clarian); some have unwound their relationship (Penn-State – Geisinger, UCSF- Stanford); none have declared total success; and others are moving forward, learning from both progress and mistakes. The Fairview – AHC affiliation falls in the latter category.

The complexity of forging a new future for two very different organizations cannot be overstated. Different core missions, governance structures, cultures, histories, physician relationships, finances, and roles mean progress will be slow, mis-steps will be taken, people will change, and conflict will be evident. Hopefully, these challenges can be overcome by commitment to the long term good envisioned for the relationship. All of this has been evident in the relationship between Fairview and the AHC.

Progress has been made, even in an environment where Fairview (like other systems) has experienced greater than expected financial challenge from the marketplace, and the AHC has experienced greater than expected financial challenge in the Medical School and its faculty practice organization. Continuing tension, disappointment with the pace of progress, and open conflict at some levels are also evident, meaning much of the

potential for the affiliation is yet to be realized. Perhaps most important, leaders at both organizations continue to express a commitment to "make it work".

B. Core Goals Accomplished

The primary motivations underlying the affiliation for the AHC and Fairview were described earlier in the report. The essence of those motivations for each party can be summarized as follows:

- For Fairview: A bold plan and change was needed to "save" the Riverside campus. Loss of two major "customers" for the Riverside campus was imminent. Fairview was faced with the potential for major operating losses at Riverside or potential closure of the campus as an inpatient, acute care facility. The addition of the "quaternary" level of service represented by University Hospital was desirable for both Riverside and the Fairview System.

- For the AHC/University: In order to improve the prospects for the Medical School, an affiliation with a system with greater market presence and managed care capability was needed; avoidance of future financial liability for the University related to operation of its hospital and retention of at least some degree of fund flow for academic support from the clinical enterprise was viewed as essential.

If these were the core objectives of Fairview and the AHC, they have largely been accomplished. F-UMC is a "going concern"; while not without its operating or financial challenges, discussion of closure of Riverside is no longer on the table. The University is not exposed to potential hospital deficits and the fund flow to the Academic Health Center has been maintained. Importantly, in combination, both the AHC and Fairview are stronger, especially in terms of market presence in a heavy managed care environment.

In sum, the review panel would conclude that both the AHC and Fairview made the right judgement in entering into the affiliation.

If there is a disappointment in terms of core goals, it is that the above accomplishments have not resulted in enhancement, or even stabilization of the financial status, faculty, and reputation of the Medical School, even recognizing that such enhancement was not a direct "responsibility" of the affiliation. This subject will be addressed as a priority in greater depth later in the report.

C. Specific Complexities and Circumstances

As the following observations are made relative to outcomes yet to be accomplished,

additional commentary on context is important. The affiliation between Fairview and the AHC has not followed a straight line path of progress. These relationships never do, but several events and circumstances in this case are noteworthy as complicating factors:

- Turnover at the leadership level at both organizations has been a detriment to progress. The departure of Dr. William Brody and the CFO at the AHC and Richard Norling as CEO of Fairview took the original visionaries and champions for the relationship out of the picture. Despite the best efforts of many others, leadership turnover clearly had an important impact in dampening implementation progress.

- The Medical School has experienced large losses, both in terms of faculty numbers and financial performance. The loss of faculty has been caused by many forces, including events that preceded the Fairview relationship.

- The Twin Cities healthcare marketplace has deteriorated, in terms of financial performance, in the last three years. Fairview has not been immune to the effects of the marketplace. Fairview's financial performance has diminished, with operating margins decreasing from 2.3% to less than 0.4% on a system wide basis, from 1995 to 1999. While some may blame the affiliation for this outcome, there are clearly deeper marketplace forces at work.

  The review panel noted that there is a credible plan by Fairview to return to historical financial performance levels, with recognition that the plan will take 3-5 years to fully execute.

- Capital expenditures required for infrastructure support, especially Y2K and other system conversion, were far greater than anyone could have anticipated in 1996. Fairview invested $40M+ in this regard, the benefit of which is measured in terms of maintenance, not advancement.

- The staffing shortage for health professionals in the Twin Cities and elsewhere has impacted capacity and operations.

- The University faculty practice organization has been in a re-organization mode through much of the short history of the affiliation, drawing attention away from an external and market focus for the UMP-Fairview dimension of the affiliation.

While neither Fairview or the AHC offer the above as "excuses" for lack of progress on some fronts, these circumstances are viewed as highly material by the review panel.

D. WORK IN PROCESS

While substantial progress has been made, the review panel clearly heard and perceives that much remains to be accomplished if the full potential of the relationship is to be reached. Key findings in this regard follow; conclusions and recommendations relative to some of these findings are described later in the report.

The Academic Affiliation Agreement included a set of "Reciprocal Commitments of the Parties." These serve as a useful paradigm for describing some of the work in process.

"Flagship" and "World Class" Commitments

As committed to in the agreements, the AHC has certainly continued to use the F-UMC campus as the principle site for its academic and patient care programs. The AHC's educational programs appear not to have been clearly positively or negatively impacted by the affiliation, as measured by applicant numbers and quality, residency match, or accreditation outcomes.

On the other hand, the Medical School is slipping from "world class" status, as measured by sponsored research rankings in particular. The Medical School has dropped in national rankings of Federally sponsored research from 20th in 1995 to 27th in 1999, having been ranked 19th in 1990. Similar "softer" rankings of Medical Schools show similar results. While the AHC may not necessarily have fallen short of its reciprocal agreement in the affiliation documents, it clearly is falling short of where it wants to be and where it should be by other measures. The review panel also believes it is falling short of what clearly is in the best interest of the State of Minnesota. The review panel would emphasize this trend as its most important finding, to be addressed again later in this report.

For Fairview's part, there remains much consternation and disappointment about the "flagship" and "world class" commitments. The two parties have not come to a common understanding of these terms, which is reflective of continued disconnect around the vision for F-UMC campus. The causes of this lack of mutual understanding are multi-factoral. In some cases, expectations on the part of the University were unclear or unreasonable. In other cases, Fairview's performance has fallen short of the mutually desired outcomes.

A number of Medical School faculty expressed the belief that Fairview had committed to, was obliged to, could, or should "deliver" increased clinical activity to the University campus and faculty, in some cases through the vehicle of system wide centers of excellence being created only or predominantly at F-UMC The faculty interviewed indicated that this belief grew from both explicit and implicit statements by Fairview and AHC leaders. This belief is not consistent with the documented agreements, however.

On the other hand, some elements within Fairview, outside of top leadership, have been and continue to be conflicted about the role of F-UMC as a tertiary care center within the broader Fairview system. This conflict is addressed later in the report.

Sufficient opinion and evidence has been presented to the review panel to persuade the panel that substantial improvement in performance relative to the F-UMC's role as a regional referral center is needed. The panel certainly notes multiple successes: Pediatrics, Psychiatry, Clinical Laboratories, and others. Despite these successes, the predominant sentiment of both University physicians and community physicians (for different reasons) is that the vision for F-UMC is unclear, important operating functions need to be improved, capital investment is needed, and decision-processes need to be accelerated. Provision of a technologically superior, highly effective patient care operation at the F-UMC was a core commitment made by Fairview. Fairview leadership acknowledges the importance of these commitments and the work that remains in this regard.

One of the key ingredients in F-UMC's success will be flexibility and commitment on the part of the faculty to embrace both campuses of F-UMC within the scope of their clinical practice.

Marketplace Commitments

Fairview's marketshare has remained roughly constant over the past three years (24.8% in 1997; 24.1 % in 1999). The objective of attracting "sufficient patient care volumes", as defined in the reciprocal agreements, to F-UMC is perhaps best measured by one outcome: F-UMC is frequently at capacity. While staffing shortages have impacted capacity, both the AHC and Fairview have fulfilled their commitments to this mutual marketplace development. The affiliation appears not, however, to have made major market impact, suggesting its real potential has not yet been reached.

The affiliation has better positioned both the AHC and Fairview in the marketplace, from a managed care participation and pricing perspective. Large market shifts cannot be expected in the short term, however.

Non-Exclusivity Commitments

The review panel believes these commitments and expectations have been met by both parties appropriately.

System Financial Integrity and AHC Academic Integrity

Fairview's decreased financial performance and the AHC's diminished academic standing have already been noted earlier in the review panel's findings. The review panel could not judge either outcome as reflecting a lack of ongoing commitment to the reciprocal agreements made by the AHC and Fairview. It does appear that Fairview's long term capital plans if executed as outlined are on the aggressive end of the scale, given Fairview's fiscal position.

Joint Commitments: Agreements to Cooperate

The parties agreed to cooperate across a broad range of topics in the affiliation agreement. Joint efforts in nearly all of the areas noted are evident. However, the ability of the two organizations to truly collaborate and cooperate has been limited, in the review panel's judgement, by two critical factors:

- Continuing lack of clarity around vision, expectations, and obligations in several important areas

- Lack of overlap and integration of some of the applicable management structures and processes across Fairview and the AHC

These limiting factors are addressed further later in the report.

To summarize the review panel's basic findings:

The affiliation, while difficult, has represented the right strategic partnership for both the AHC and Fairview. Attention should continue to focus on acceleration of progress toward the objectives for the partnership. Specific conclusions and recommendations in that regard are outlined in the next section of the report.

III. Key Conclusions and Recommendations

A. The Medical School: A Core Value

Although not assumed as a direct responsibility of both parties in the affiliation, both Fairview and the University went into the affiliation relationship recognizing the importance of enhancing the Medical School. The Medical School is essential to the community and the State, and had slipped in ranking and reputation in the mid 1990's.

The review panel has come to recognize that the goals for the affiliation will not be completely fulfilled without a renaissance in the Medical School, and that the

advancement of the Medical School is highly dependent on the future success of the affiliation. The affiliation alone, however, is not the sole solution to continued "turnaround" of the fortunes of the Medical School, as Fairview's financial support

cannot be expanded in major ways beyond current levels. The University and the State must play larger roles in that regard.

The review panel is deeply concerned that the Medical School continues to operate with substantial operating deficits, continues to lose faculty, and continues to slide in national rankings of sponsored research funding. These outcomes all negatively impact the State of Minnesota. While the Fairview affiliation can impact these trends to a limited degree, there is greater potential that these trends will affect the future of the Fairview – AHC affiliation. The Medical School, the AHC, the University and the State must take aggressive action to reverse these trends.

The Medical School has lost as much as $8M per year on an operating basis in the recent past, with its reserves and endowments diminishing by $67M since 1992. Tenure track faculty members have decreased form 532 in 1995 to 448 in 1999. The School, once rated number 14 in NIH funding, has now fallen to number 27.

These losses and diminished performance have occurred during a period in which federally sponsored funding for biomedical research has been increasing dramatically. A golden opportunity has been missed to date.

B. FINANCIAL SUPPORT FOR THE MEDICAL SCHOOL AND ACADEMIC HEALTH CENTER

As noted earlier, the review panel is deeply concerned about the continued downward trend in the Medical School's national research rankings, the loss of large numbers of faculty, and a continued diminishment in national reputation. It is important to the future of the affiliation that these trends be reversed. While this outcome will not be immediate or easy, it is important that continued deterioration not be allowed to occur.

While the competitive environment for many academic health centers has been challenging across the country, it has been brutal in Minnesota. The review panel does not wish to repeat what has been an already well chronicled set of events at the University of Minnesota AHC over the past decade. These things are apparent to the review panel:

- The AHC has new leadership and a new strategic plan which should be supported

- The Fairview relationship can be a part, but only a part, of the renaissance of the Medical School

- The University and State of Minnesota must assume much greater responsibility for supporting the Academic Health Center, especially the Medical School

- Time is of the essence

The review panel met with the President of the University of Minnesota and has reviewed the supporting material for the increased funding request from the State Legislature for the AHC. The review panel was impressed with the depth of knowledge and support on the part of President Yudof for the AHC. It is clear that the current biennial funding request is a very high priority for the University. Leadership at the highest levels of the University needs to continue to champion this request and the need for greater funding for the Medical School and AHC.

At the same time, the panel is concerned that the current biennial funding request does not represent the full scope of what the Medical School will need from the State in order to put the School on a clear upward trajectory. If the goal of the State is that the Medical School return to its former stature, the two-year funding request is only a start toward achievement of that goal. Additional, more substantial funding beyond the two years will be needed. Most of the requested new legislative funding for the next two years will merely allow the School to move from a deficit position to break-even. There is only a moderate request for new funding available for faculty and program investment ($10 million over the biennium). With knowledge of what other states are investing in their medical schools to position those states for the current revolution in bio-technology, and to receive their share of anticipated major increases in support for biomedical research, the review panel believes the request to the legislature is far too conservative. The approximate $13M per year made available from the legislative request is barely above the amount needed to keep the School operating at current levels without deficits; it is only the beginning of what will be needed if the goal is to put the Medical School back on the path toward re-establishing the national prominence which the University and State should desire and deserve for the Medical School.

The AHC has formulated a six-year estimate of the additional funding that will be needed from the State for the Medical School. The review panel believes this six year estimate to be more reflective of what the School will need, contrasted with current biennial request. Even the six year estimate, however, may understate the Medical School's needs, especially in terms of timing.

The review panel's conclusions are based on the following considerations:

- The Medical School has operated at recent operating deficits as high as $ 8 M per

year; a request is made to return the School to "breakeven" status through appropriation of this amount.

- In addition, the AHC's current request is for $10M in additional funding over the next two years and $44M over the next six years to support recruitment and to re-establish the prominence of the school.

- The Medical School has targeted recruitment of 100 new faculty over the next 6 years. The review panel concurs that something approximating this number is needed, and that growth in federal research funding should allow these people to be self-sustaining over time. Therefore the critical infusion of cash is time limited over the next 4-5 years.

  Research funding productivity is driven by numbers of quality faculty. Per-faculty member research funding at the Medical School is respectable. More faculty members are needed to meaningfully increase total research funding.

- Multi-million dollar recruitment packages (which are support related, not individual salaries) for leading scientists are now common across the country; the Medical School will need to recruit 10-15 lead people with financial support in this range in order to re-establish itself on a competitive national basis.

- The request for funding should therefore be in the range of $50-75M, which is in part "start -up" funding, spread over 4 to 6 years, with much of the funding coming in the first four years. Recruitment of new faculty and availability of new research space also needs to be carefully coordinated.

Other states have allocated very large amounts to position their academic health centers as economic development engines for decades to come. Given those efforts elsewhere, the University of Minnesota Medical School will only slide further without aggressive intervention and investment by the State.

The panel would note two positives. First, the Minnesota Medical Foundation has been very effective in its philanthropic work on behalf of the Medical School. Second, there is clearly a foundation of many quality faculty and programs to re-build around at the Medical School.

Minnesota is at an important decision point relative to the future of its Medical School. A state with a history of a Medical School in the top 10-20 in the nation could see its resource drop into third-tier status in the near future without action. Top flight faculty will leave in increasing numbers, recruitment will be problematic, reputation will fall further, high caliber student applicants will look elsewhere, research funding and ranking will diminish, and the state will ultimately lose the qualitative and economic development

value of a top flight, research oriented Medical School. State and University leadership will need to act aggressively, decisively, and with vision is this outcome is to be avoided. High levels of accountability for improved performance should also be communicated by the University as part of the plan for increased funding.

Beyond (but including) the Medical School, the Academic Health Center plays a crucial role in the production of new health professionals for the state. Health care provider organizations across Minnesota are facing acute shortages of health professionals, especially nurses. The State should be aware of the importance of this issue as it considers future funding for the AHC and its health professional schools, and the AHC should reach out to the state's provider community to understand the role the AHC can best play in addressing the health professional shortage crisis.

Similarly, the AHC should reach out to the health care community to educate and enlist their support in the University's legislative communication efforts. Active involvement of interested, external parties will help the effectiveness of the University's work in the legislature.

C. Vision: Reformulation Required

The review panel was struck by the extent to which many of the individuals interviewed were not able to articulate a clear vision and direction for the Fairview-AHC affiliation relationship. While there is a consistently expressed commitment to keep the relationship together, there is not a consistently expressed statement of "in order to . . . . "

The causes of this phenomenon are several: marketplace and financial pressures experienced since 1995, the pace of progress hindered by the complexities referenced earlier, turnover in leadership at both the AHC and Fairview, and perhaps lack of sufficient clarity at the initiation of the affiliation. Regardless of the causes, this is clear to the review panel:

- The AHC and Fairview need to reformulate the vision for the relationship
- Core objectives supporting that vision also need to be re-formulated
- The vision and core objectives need to be actively, passionately, and frequently communicated throughout the organizations
- The resources needed to create consistent, tangible progress toward the vision need to be committed by both organizations

In particular, the role of the F-UMC campus remains to be clarified. The multiple "operating models" considered for the F-UMC campus demonstrate a willingness to be

innovative and creative. Unfortunately, the consideration of multiple options has added to the sense of dissonant vision for the campus and the relationship more broadly. As part of the expression of a reformulated vision for the relationship, a clear statement of the role and operating model for the F-UMC Campus within the Fairview system needs to be made.

The review panel heard some indication that the nature of and vision for the relationship is not well understood by others in the health care community. There is a degree of anxiety that long-standing AHC relationships may be vulnerable as Fairview and the AHC move closer together. This anxiety should be addressed as the vision for the relationship is reformulated.

D. Vision: F-UMC, "Flagship" and "World Class"

The terms "flagship" and "world class" appear prominently in the affiliation agreement documents. The vision embodied in these terms formed the basis for much of the initial excitement for the affiliation relationship, within both Fairview and the AHC. These terms also symbolize much of the tension, conflict, and sense of disappointment which has occurred over the past several years.

The review panel cannot serve as a "scorekeeper" relative to whether the expectations and commitments relative to "flagship" and "world class" have been met. Several observations are important, however:

- The absence of a clear operating model for F-UMC, with associated capital commitments, has been a hindrance to translation of expectations to reality.

- The absence of a strategic vision for the F-UMC campus, in terms of market position and synergy within the Fairview system, has been a significant difficulty.

- The overlap in specialty services between F-UMC, Fairview-Southdale, UMP, and other Fairview-affiliated physicians has apparently been even more complex than anticipated.

- The capital associated with enhancement of the role of a tertiary referral center is very significant; Fairview's plans and capabilities in that regard need to be clarified, even at the cost of creating disappointment.

All of these observations are subsidiary to a more fundamental conclusion: the need for clarity. Plans for clinical program development, capital commitments, the role of F-UMC, revenue and expense synergies, and management priorities all need to be expressed as a function of the broader reformulated vision for the relationship. While that reformulation should reinforce the intent behind "world class" and "flagship", those

adjectives have likely lost their value. The reformulated vision needs to be tangible, actionable, inspirational, and clear.

Part of the lack of clarity relates to multiple variations of operating models which try to balance F-UMC as both a teaching hospital and a community hospital. The attempt to create such a balance has led to neither role being played as effectively as it could be. University of Minnesota Physicians and community physicians express analogous confusion over "what we are trying to be ".

Fairview's top management is working hard to resolve this confusion, with a much clearer emphasis of late on F-UMC's role as a teaching hospital and regional referral specialty hospital. The review panel would strongly support this new emphasis. Communication of this clarified role is essential, as the review panel heard significant dissonance from physicians regarding the role of F-UMC.

Relative to F-UMC's role as a teaching hospital , to the extent that programs have been or can be established which involve both academic and community physicians, so much the better (for example, OB/NICU, Behavioral Health, Orthopedics). The emphasis should be on advancing the distinctive role of the teaching hospital and its centers of excellence.

Toward that end, the distinctive identity of "The University Hospital" should be emphasized from internal and external marketing perspectives. To the extent to which the market will be responsive, system-wide centers of excellence would logically be based at "The University Hospital." A much more clear role and more aggressive market positioning for F-UMC as "The University Hospital" needs to be established, not as the former University Hospital pre-Fairview, but as the new University Hospital, integrated with the rest of the strengths of the Fairview system and supported by the AHC and community physicians who are attracted by the environment of a teaching hospital setting.

E. PHYSICIAN RELATIONSHIPS: UMP

The panel recognizes that some of UMP's clinical activity is conducted at other (non-Fairview) facilities, based on education program and other needs. Similarly, the review panel recognizes the obligations that Fairview has to non-UMP physicians within the Fairview system. Despite these other relationships, the overlap of interests between UMP and Fairview is substantial.

The review panel has been struck by the extent to which the strategic plans and priorities of UMP are not formulated in synch with those of Fairview. This is a critical success factor for the future of the affiliation relationship.

There are certainly many causes of this lack of synchrony. Regardless of the causes of

the current situation relative to UMP's sense of frustration with the relationship, common ground must be found. UMP's desires to conduct the core of its clinical activity in a facility with the characteristics of a university hospital are very appropriate and central to the mission of an academic clinical faculty. In order to achieve that outcome, UMP needs to emphasize the critical importance of the Fairview relationship in UMP's strategic planning, program development, recruitment, and operations efforts. Some of the UMP leadership express skepticism about such emphasis, given current and past difficulties and conflicts with the Fairview relationship.

The review panel is not sufficiently knowledgeable about local dynamics to be specifically prescriptive as to how best to bridge the gulf that has evolved between UMP and Fairview. Although the review panel was not exposed in detail to the Coordinated Management Council during the interviews, this group appears to be evolving into a more effective joint planning vehicle. Some of the organizational changes recommended later in the report will at least partially address this issue, as will the reformulation of the vision described earlier. Substantial management attention, from Fairview, from the AHC, and from UMP leadership must be committed to aligning the strategic and programmatic futures of UMP and Fairview.

A critical area in which there should be a solid, joint understanding is that of planned and desired capacity for UMP. If UMP does not have or plan to create the physician capacity to meet certain patient care needs on the F-UMC campus and elsewhere within the Fairview system, Fairview needs an understanding accordingly and should seek out other resources. On the other hand, to the extent that UMP has growth objectives in terms of clinical capacity, Fairview's program planning would ideally support such objectives. This joint understanding of planned UMP capacity also relates to joint recruitment planning, addressed later in the report.

The review panel was struck by the extent to which UMP is not yet perceived as a "referring physician friendly" academic group practice. It was reported that the emphasis and priority on outreach and referring physician support has decreased or become more variable than in the past. While this is understandable given the pressure on academic physicians, if the characterization is accurate it should not be acceptable to AHC and UMP leadership. "World class" should also characterize the level of service and outreach to community physicians. This is a critical variable and needs to be a high priority for the AHC and UMP if the full potential of the affiliation is to be realized.

F. Physician Relationships: Community Physicians

Balancing the interests and priorities of the physicians who have long-term affiliations with Fairview relative to the interests and priorities of the University faculty now affiliated with the Fairview system, has clearly been a delicate matter for the Fairview

leadership since the merger. This is common in other settings where community health system – academic health center affiliations have been created.

The general sentiment among the specialty physicians within the Fairview system is that the affiliation has created a win – lose situation for them. That is, the new addition to the Fairview family has created more mouths to feed with the same resources. This is an accurate, although incomplete, perception. The operation of a tertiary referral center is capital intensive, and that operation does create a degree of competition – especially for capital resources – within the Fairview system.

The facts are that Fairview made commitments to the AHC that do require support of F-UMC as the "flagship". The fact that internal competitive dynamics are created within the system does not decrease the obligation to fulfill such commitments.

At the same time, it is in both Fairview's interest and the AHC interest that Fairview be successful from a financial and market perspective. The support of the specialty physician groups traditionally affiliated with Fairview is essential in that regard. Hopefully, the transition which has occurred over the past four years has allowed the perception of competition within the system to have stabilized to a large degree, and that admission patterns have similarly stabilized.

Even with such stabilization, moving forward is important. The re-formulated vision addressed earlier must express and result in the creation of value for the specialty community physicians as part of a more successful Fairview system.

Primary care physicians affiliated with Fairview, especially those at F-UMC, express similarly negative views on the value of the relationship. Their perspective is that they have lost their hospital, lost their specialty consultants, and/or been forced to practice in an inefficient and unfriendly teaching hospital setting. This reaction has been expressed in the relocation of practices both within and outside of the Fairview system. The current situation is such that there is limited community practice at F-UMC, with the important exceptions of the highly regarded programs at Riverside in OB/NICU, Behavioral Health and Orthopedics.

Fairview has recently appointed a full time physician as Vice President of Medical Affairs for F-UMC. This is certainly a positive step. The clarity of vision and role for the F-UMC campus described earlier should become the platform from which the new Vice President operates. In addition, the financial and programmatic benefits created by the "new" F-UMC campus for the Fairview system and its physicians should be actively articulated by the new Vice President and other Fairview leaders.

Fairview and the AHC should facilitate ongoing forums through which key Fairview affiliated physician groups can interact with UMP, as a "bridge-building" effort.

Similarly, overlapping Board attendance by UMP and FPA physicians should be considered at each others' Board Meetings.

G. ACADEMIC SUPPORT: EXPECTATIONS AND OBLIGATIONS

The enhancement of the quality of the academic health center is critical to the success of the Fairview – AHC affiliation, and is an ongoing goal of both parties, expressed in the original affiliation documents and currently by Fairview and AHC leadership.

Fairview should do what it can to provide financial support to the AHC, but Fairview can by no means be expected to be the sole source of financial support for the investment required to move the AHC forward. While Fairview cannot be expected to be the sole, or even a primary, source of support for this purpose, there is sufficient commonality of interest that a degree of financial support and fund transfer from Fairview to the AHC is appropriate.

In the original affiliation agreements, Fairview agreed to a formula payment to the AHC in which operating margin above a given level (3.5%) would be shared with the AHC. Market conditions have been such that Fairview (and the other local systems) has not been able to produce this margin.

Since the time of the affiliation, Fairview and the AHC have conducted a financial analysis relative to the costs and revenues associated with education at F-UMC. The agreement called for a 50/50 sharing of such expenses in excess of revenues. Given the extensive work that has gone into the "Bucket Analysis", the review panel does not presume to be in a position to add value or recommendations in this regard.

AHC leadership indicates that prior to the Fairview affiliation it received $25 M (annual) in fund transfer from the former University Hospital, exclusive of recruitment support. Reconciliation of the AHC-Fairview financial relationships (as described above) is underway. This reconciliation (which should be done at the corporate entity as opposed to sub-entity level), once completed, should produce a clear portrayal of financial support pre –and-post Fairview. The conclusions from this effort should be broadly communicated.

Tentatively, both the AHC and Fairview anticipate that the findings from this financial reconciliation work will indicate similar fund flow results pre-and-post Fairview, with

one notable point of contention between the AHC and Fairview: support for recruitment of new clinical leadership.

The Medical School currently has 8 Clinical Department Head positions vacant or filled on an interim basis. The quality of the individuals recruited and appointed to these and

other clinical leadership positions will be a critical determinant of the quality of the Medical School for decades to come. Some of these individuals will also be a critical determinant of the caliber of the clinical programs of F-UMC into the future. As such,

these recruitments and appointments are of vital importance to both the AHC and Fairview.

The AHC, especially the Medical School, has expressed deep disappointment in Fairview's lack of financial support for recruitment of individuals to fill these academic and clinical leadership roles. The cause of this disappointment is in a mismatch of expectations and obligations. The AHC expects Fairview to provide part of the funding for the package needed to recruit these individuals, as had been the case with the former University Hospital, and is the case at most academic health centers. Fairview, on the other hand, understandably feels its obligations have been met as a result of the commitments described in the preceding paragraphs, as well as with the initial acquisition investment.

This mismatch of expectations and obligations needs to be resolved. The review panel understands that a dialogue between Fairview and the AHC/Medical School has begun. The review panel recommends that the two organizations place very high priority on reaching an agreement on the financial support for recruitment of clinical leadership. On a philosophical basis, the review panel recommends that the AHC adopt the philosophy that the primary financial responsibility lies with the AHC/Medical School, and that Fairview should adopt the philosophy that the clinical program enhancement opportunity created by the Medical School's recruitment of outstanding clinical program leaders is of value to Fairview, and that assistance with recruitment of such individuals based upon this value is an appropriate role for Fairview to play. This philosophy should be translated into a specific plan for joint funding of some of the new clinical department and program leaders. It is recommended that such a plan be expressed in the form of a prospective 3-5 year budget for recruitment support, with clear annual commitments and limits, and with priorities within that budgeted allotment to be reviewed on a "rolling" basis between Fairview and the AHC. This funding should be for a fixed term and specifically tracked by Fairview and the AHC. The review panel would estimate that the funding allocations will need to be in the $2-$5M per year range for the next several years. The review panel would recommend that agreement on funding levels be reached and funding allocations be made for this purpose as quickly as possible. Given these financial commitments, Fairview should be an active participant in the recruitment process for these clinical program leadership positions.

The review panel has discussed lowering of the 3.5% operating margin threshold for academic program support as a means of addressing the approach to joint funding of new clinical program leadership. The review panel believes that the approach recommended above – that of a jointly planned and budgeted commitment – is preferable to an approach

with a "margin trigger." That belief is based on the review panel's perspective of the importance of clear and known expectations and obligations relative to recruitment commitments. This view does not preclude an agreement between Fairview and the AHC to lower the 3.5% threshold for other reasons (unrelated to recruitment), if Fairview and the AHC believe mutually important objectives would be well served by an amended agreement.

As somewhat of an ancillary observation, the review panel noted that the AHC has, like many other Medical Schools, altered the role of the clinical department head over the past decade, such that the scope and authority of the role has in some ways been decreased. Historical events at the AHC over the past 7-8 years would appear to offer an ample basis for these actions. At the same time, the AHC leadership needs to be cognizant of the need to balance the benefits of the centralization of some functions with the benefits of strongly "empowered" (and highly accountable) department heads as this balance may impact recruitment in the future. The review panel would recommend that the AHC adjust this balance toward a more distributed model at the point where the AHC leadership feels appropriate accountability and control systems have been demonstrated as being in place and effectively applied. Such an adjustment at that point will hopefully aid the AHC in its recruitment efforts.

H. Relationships and Structure

Positive relationships, both organizational and personal, are part of the success formula in any affiliation. Structure is a means of facilitating those relationships.

The Fairview-AHC affiliation was obviously carefully crafted at the governance level. There is meaningful University presence on the Fairview Boards. This presence, however, is nearly the sole point of formal organizational integration. The ability to jointly plan, allocate resources, avoid conflicts, and solve problems that affect both Fairview and the AHC is virtually entirely dependent on personal relationships among leaders and group process, below the Fairview Board.

The review panel heard much about missed or mis-understood expectations during the course of its stakeholder interviews; the review panel also heard much about the multiple groups which have been created as joint planning and problem-solving forums. These forums have met with mixed results, at best. It is clear that the creation of another generation of joint group process is not the solution to more effective interaction between the AHC and Fairview.

The review panel is positively impressed with the goals shared between the CEO's of the AHC and Fairview (Frank Cerra, M.D. and David Page). Those shared goals, do not, however, seem to get consistently translated into positive and effective inter-organizational behavior. While the re-formulation of the vision and re-establishment of

mutual expectations recommended earlier in this report will hopefully set a foundation for improved relationships, more "organic" change may also be needed to change the pattern of dialogue and behavior between the two organizations.

Toward that end, the review panel recommends that Fairview and the AHC create more "cross-fertilization" of leadership between the two organizations. The appointment of a Medical School/faculty officer to the Executive Team of Fairview should be considered with this person and possibly others serving on Fairview executive policy groups. This individual could also serve in the capacity of "Chief Academic Officer" of the Fairview system. Similarly, one or more of Fairview's executives should serve as members of the AHC "cabinet", and actively participate in Medical School leadership forums as well. If this model is followed, it should be one of joint accountability, not merely representation.

Additionally, as often occurs at times of resource constraint, it appears to the review panel that Fairview and the AHC have not committed sufficient resources specifically dedicated to implementation of key joint initiatives associated with the affiliation. Follow through on those initiatives becomes compromised when people have other important responsibilities. When follow through is compromised, credibility and confidence suffers; loss of mutual trust results soon thereafter. Symptoms of this cycle are apparent to the review panel. Intervention at this point is recommended, even if the perception of lack of action is greater than the reality, as is often the case. The AHC and Fairview should identify specific people resources, perhaps to include an individual (or individuals) with full time responsibility to move the relationship forward.

The AHC-Fairview relationship is of such importance to both organizations that the knowledge level, relative to the status of the affiliation and the status of the Medical School, of both the Fairview Board and the University Board of Regents needs to be very high. Periodic joint interaction and information sharing between the two Boards should be considered. Similarly, the President of the University should continue to be well informed and involved in affiliation matters, especially as the affiliation impacts the academic quality and financial status of the AHC and the University. Toward that end, the review panel would recommend that the University President serve as a member of the Fairview Board, at least during the next several, critical years.

IV. SUMMARY

The AHC and Fairview have much to be proud of, including the courage shown by both organizations to be innovative in their joint commitments to patient care, education, and research. No relationship involving universities, faculties, physicians, and hospitals is ever perfect or not in need of improvement, even those that have existed for decades. It is not a surprise to the review panel, and likely is not to the leadership of the AHC and Fairview, that the full potential of the affiliation relationship has not yet been reached. After three-four years, one can only expect to find a work in progress.

The review panel believes that acting on the conclusions and recommendations outlined in this report will substantially increase the probability that continued progress will be made. Of all the panel's findings, three stand out as being absolutely essential:

- A re-formulation and re-affirmation of the vision for the affiliation needs to be agreed upon, communicated, and implemented, with a corollary re-statement of expectations and obligations.

- New approaches directed at improved inter-organizational behavior need to be implemented.

- The core value of the Medical School must be continually reinforced by both the University and Fairview; increased financial support from the State is needed to create a future as bright as the past.

The members of the review panel are hopeful that their work will assist Fairview and the AHC in moving forward in reaching their mutual important goals.

APPENDIX A: INTERVIEW PARTICIPANTS

Gordon Alexander, M.D., Senior Vice President, Administrator, Fairview-University Medical Center

Michael Belzer, M.D., Chief Medical Officer, Hennepin County Medical Center

Mary Brainerd, Executive Vice President, Care Delivery, HealthPartners

James Breitenbucher, M.D., Vice President for Medical Affairs, Fairview-University Medical Center

Rodney Burwell, Chairman, Fairview Health Service Board of Governors

Frank Cerra, M.D., Senior Vice President for Health Sciences, University of Minnesota

Brad Choate, Executive Director, Minnesota Medical Foundation

Denis Clohisy, M.D., Professor, Department of Orthopedics, Medical School Senator, University of Minnesota Medical School

Carolyn Cody, M.D., Community Physician

Michael Doughrety, Former Board Member, University Hospital; Current Board Member, University of Minnesota Physicians

David Dunn, M.D., Chair, Department of Surgery, University of Minnesota Medical School

John Eckfeldt, M.D., Director of Clinical Laboratories

Patricia Ferrieri, M.D., Professor, Department of Pathology, University of Minnesota Medical School

James Fox, Senior Vice President, Chief Financial Officer, Fairview Health Services

Leo Furcht, M.D., Chair, Department of Pathology, University of Minnesota Medical School

Scott Giebink, M.D., Professor, Department of Pediatrics, University of Minnesota Medical School

APPENDIX A: INTERVIEW PARTICIPANTS (CONT.)

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Ashley Haase, Ph.D., Professor, Department of Microbiology, University of Minnesota

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Alfred Michael, M.D, Dean, , University of Minnesota Medical School

James Moller, M.D., Chair, Department of Pediatrics, University of Minnesota Medical School

John Morrison, Board Member, Fairview Health Services, Former Board Member, University Hospital

Barbara Nye, Vice President, Marketing and Public Relations, Fairview Health Services

David Page, President and CEO, Fairview Health Services

Peter Rapp, Senior Vice-President, Fairview Health Services

Jonathan Ravdin, M.D., Chair, Department of Medicine, University of Minnesota Medical School

Royce Sanner, Member, Fairview Health Services Board of Governors

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APPENDIX A: INTERVIEW PARTICIPANTS (CONT.)

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Jeffrey Spartz, CEO, Hennepin County Medical Center

Gordon Sprenger, President and CEO, Allina Health System

Kathy Taranto, R.N., Vice President, Patient and Family Services, Fairview-University Medical Center

Roby Thompson, M.D. Vice-President for Clinical Affairs, University of Minnesota Medical School, Board Chair, University of Minnesota Physicians

Paul Torgerson, Chief Administrative Officer, Fairview Health Services

Margaret Van Bree, Ph.D., Chief Operating Officer, Fairview-University Medical Center

Connie Weinman, Chair, Fairview-University Medical Center Board of Governors

Mark Yudof, President, University of Minnesota

Fairview Health Services
University of Minnesota
Academic Health Center

Affiliation Evaluation

Presented to

Fairview Health Services Board of Directors

University of Minnesota Board of Regents

March 15, 2001

External Review Panel

- William Loveday, President and CEO
  Clarian Health Partners
  Indianapolis, IN

- William Peck, M.D., Executive Vice Chancellor and Dean
  Washington University School of Medicine
  St. Louis, MO

- Winston Wallin, Former Chairman of the Board
  Medtronic Corporation
  Minneapolis, MN

Process

- Scope Defined
- Data Collection
- Document Review
- Stakeholder Interviews
- Draft Report
- Transmit to Leadership

Scope & Objectives

- To assess whether the objectives of each organization are being met as it relates to the affiliation
- To comment on the progress of the merger
- To highlight the challenges
- To evaluate the agreements between the organizations
- To recommend methods for accelerating progress towards the goals of the affiliation

Key Findings and Conclusions

- Core goals have been achieved
- Positive results recognized
- Complexities and challenges understood
- Need additional attention to the relationship and its objectives
- Move forward together

Key Findings & Conclusions

- Enhancement of the Medical School is critical to the future success of the affiliation between the AHC and Fairview, and to the University and state of Minnesota

Key Findings & Conclusions

- Fairview cannot be sole source of support for the Medical School
- University and State must exercise leadership
- Enhanced State funding essential; legislative request critical

Key Findings & Conclusions

- Mutual Commitments Fulfilled, but….
- Lack of Clarity, particularly pertaining to:
  - Expectations and Obligations
  - Vision for Relationship
  - Operating Model/Role of F-UMC Campus
  - Joint Priorities and Plans: Fairview and UMP
  - Community Physician Value from Affiliation

Key Findings & Conclusions

- Importance of Medical School Recruitment of Clinical Department Leadership
- Fairview Role: Targeted/budgeted financial support, with accountability

Key Findings & Conclusions

- Governance level integration effective
- Additional "cross-participation" of leadership between two organizations beyond the top leadership is needed

Key Recommendations: AHC Funding

- Significant new funding will be required to restore the Medical School to a position of national prominence. Increased state funding is required above and beyond the current legislative request.
- University leadership needs to champion need for new investment in Academic Health Center
- Fairview can play supportive role

Key Recommendations: Need For Clarity

- Leadership of both organizations need to *reformulate* and *communicate* the vision for the relationship
- Role of F-UMC: "University Hospital"
- Outcome oriented strategic planning and prioritization between Fairview and UMP
- Value of the affiliation to community physicians who practice at Fairview facilities
- Communicate and market role of F-UMC: internally and externally

Key Recommendations: Academic Support

- Reconcile And Communicate Academic Support Funding
- Collaboration between Fairview and the Medical School is required in recruitment of targeted clinical leadership positions
    - Priorities for Fairview funding
    - Budgeted allocation of resources
    - Joint recruitment
    - Monitor results
- Consider Changing 3.5% Threshold If Mutually Agreeable For Purposes Other Than Recruitment Support

Key Recommendations: Relationships/Structure

- Fairview and the Academic Health Center/University need to find ways to promote more effective, consistent inter-organizational behavior:
  - Cross participation between management cabinets (beyond the CEO level)
  - Resources committed to implementation of affiliation initiatives
  - University of Minnesota President serve on the Fairview Board of Directors

Summary

- Much reason to be proud of accomplishments
- Re-formulate vision, expectations, and obligations
- Reinforce core value of medical school - support state legislative request
- Create approach to improving inter-organizational behavior
- Stay together