Graduate School of Public Health
Department of Health Policy & Management
University of Pittsburgh

CLRES 2750 Seminar in Health Systems Leadership

COURSE INFORMATION:

Credits:	1.5 per semester
Term:	Fall or Spring
CourseWeb:	All course materials, presentations, and additional readings will be made available on CourseWeb.

COURSE SUMMARY:

This course will consist of a series of cased-based examinations of specific managerial and leadership problems and decisions that have faced local health systems leaders in Western Pennsylvania. Health care reimbursement, licensing and accreditation, and measuring health care quality has become both more complicated and more important as pressures to reduce expenses and improve quality increase. Simultaneously, there has been a steady increase in the number of clinicians who have assumed managerial positions, such as medical directors of clinical units, directors of quality measurement and improvement programs, utilization review and many others, as well as the appearance of clinicians in the "C-suite" of many hospitals and health care organizations. Utilizing adjunct faculty who are currently (or very recently have been) executive leaders in health systems, this course will examine a series of collaborations, problems, conflicts and solutions that developed between health system administrators and clinical leadership in health care organizations in the Western PA area.

The mechanics of the course will be a series of cases, based on an actual recent issue in health care management in which the senior adjunct faculty member was involved. Students (individually or in groups) will evaluate the case, prepare a response, and make a short presentation of their "solution" to the problem to the health system executive and clinical leader involved in that case. An interactive discussion will follow.

This is a required course for students in the certificate in health systems leadership and management program, and can be used as an elective course by other students with permission of the instructor.

GUEST FACULTY:
Guest faculty comprise a group of senior health system executives who have developed management and leadership cases from their own experiences. They will conduct a session for each case, and will provide feedback, discussion and critiques of student's evaluation of the case. The guest faculty will vary by semester. Each semester will typically involve the evaluation of 5 cases, each 3 weeks in length, each presented and developed by a different executive. The senior health executives listed below have all agreed to develop and present a case: 5 of them have already done so in the context of the special studies version of this course.

Guest Faculty EXAMPLES	Position
Norman F. Mitry, MPM	President, Chief Executive Officer, Heritage Valley Health System
Leslie C. Davis, MPA	President and CEO, Magee-Women's Hospital of UPMC
Mark LaRosa, MHA	Vice President, Planning & Business Development The Western Pennsylvania Hospital
Michael Moreland, M.S.W.	Director, VA Pittsburgh Health Care System
Albert Wright, MHA	Vice President, Operations, UPMC Presbyterian
David Blandino, MD	Director, Chairman of Corporate Governance & Nominating Committee, Member of Executive Committee and Member of Affirmative Action & Diversity Committee, Highmark Inc.
Margaret A. Hayden, BSN	Former President, Excela Latrobe Hospital
Tami Minnier, MSN, FACHE	Chief Quality Officer, UPMC
Everette James, JD, MBA	Professor of Health Policy and Management, Associate Vice Chancellor for Health Policy & Planning (Health Sciences) Director (Health Policy Institute), former Pennsylvania Secretary of Health
Michael Young, MHA, MBA	President and Chief Executive Officer of Pinnacle Health System
Cindy Durundo, MBA, MHA	President UPMC McKeesport, HPM Executive-in-Residence
Will Cook, MHA	President and CEO, UPMC Mercy Hospital

LEARNING OBJECTIVES:
After taking this course, the student will be able to:

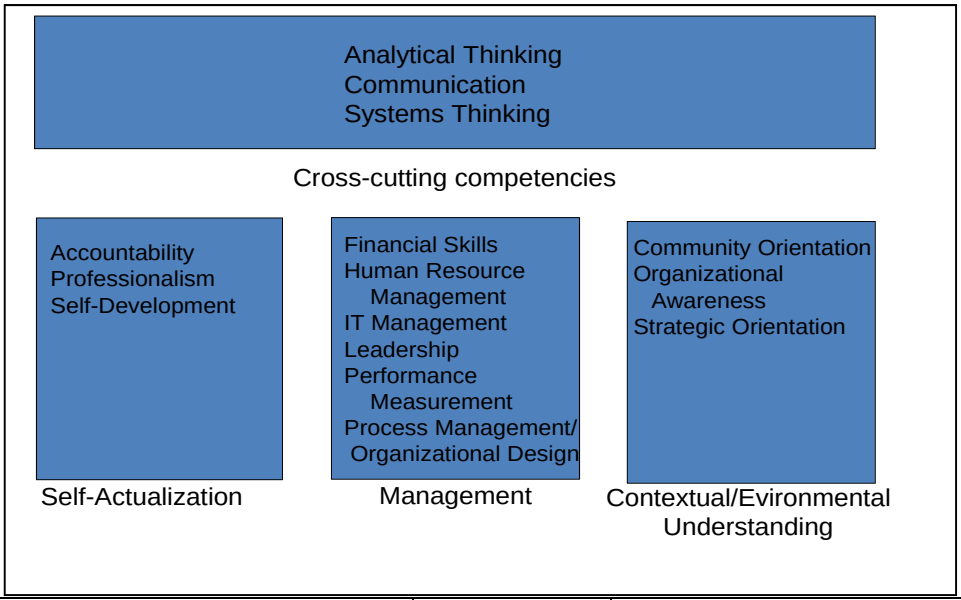
- Identify the specific areas of conflict and agreement in a health care management problem that foster collaboration between management and clinical staff
- Gain skills in analyzing a problem from multiple points of view
- Develop skills in presentation and interaction with senior health system leadership

COURSE COMPETENCIES:

This course will address a series of competencies developed by the University of Pittsburgh MHA program, modified from competencies developed by the National Center for Healthcare Leadership, the AUPHA and others. The basic competency model is:

This course will provide advanced skills and experiences in all of the cross cutting competencies, in all of the Self-Actualization competencies, The Contextual and Environmental Understanding competencies, and will use competencies already developed in Management to bring to bear on the cases. In Detail:

Pitt Healthcare Management Competency Model	Will this Competency be Emphasized in this Course?	Teaching Methods (e.g., Reading, Lectures, Guest Speakers, Class Discussions, Presentations, Field Experiences, Simulation, Consulting Project)	How Will You Assess? (e.g. weekly participation score, debate, policy memo, business plan, term paper, multiple choice exam, short-answer exam)
Cross Cutting			
Analytical Thinking	YES	Reading, In-Class Presentations, Cases	Case Review and Feedback; class discussion
Communication	YES	Reading, In-Class Presentations, Cases	Case Review and Feedback; class discussion
Systems Thinking	YES	Reading, In-Class Presentations, Cases	Case Review and Feedback; class discussion
Self-Actualization			
Accountability	YES	Reading, In-Class Presentations, Cases	Case Review and Feedback; class discussion
Professionalism	YES	Reading, In-Class Presentations, Cases	Case Review and Feedback; class discussion
Self-Development	YES	Reading, In-Class Presentations, Cases	Case Review and Feedback; class discussion
Management			



Financial Skills			

Human Resources Management			
Information Technology (IT) Management			
Leadership	YES	Reading, In-Class Presentations, Cases	Case Review and Feedback; class discussion
Performance Measurement and Process Improvement			
Contextual-Environmental Understanding			
Community Orientation	YES	Reading, In-Class Presentations, Cases	Case Review and Feedback; class discussion
Organizational Awareness	YES	Reading, In-Class Presentations, Cases	Case Review and Feedback; class discussion
Strategic Orientation	YES	Reading, In-Class Presentations, Cases	Case Review and Feedback; class discussion

Learning Methods:

This course will primarily use (80%) what CAHME describe as "higher level" teaching methods, which include in class presentations and case review; with only a small amount of background reading and lectures (20%).

Assessment Methods:

This course will exclusively use caser review and feedback as an assessment of attainment of competencies. Guest leadership will evaluate each team based on how they would evaluate their own employee/colleague when faced with the case to review.

COURSE CONTENT AREAS:

Managing Clinical Quality: assessing clinical outcomes, clinical competence
Medical Staff Organization: Managing and restriction clinical privileges. Should intensive care units be open or closed?

COURSE REQUIREMENTS:

Case Studies: Each student will read, evaluate and prepare a presentation and memo for each case. Each student will be responsible for producing:

- A 15-20 minute presentation to the senior executive regarding their analysis of the case, and their recommendation for the administrative/executive decisions.
- A short (2-page maximum) policy/decision memo, concisely detailing the problem, stakeholders, and proposed action.

Class Participation: Students are expected to be present in class, to make comments on other student's presentations, and to engage in class discussions.

COURSE EXPECTATIONS:

It is expected that the students taking this class are planning to transition or grow into leadership roles in health care organizations, and therefore they take responsibility for their own education. Each student will be expected to complete each case reading, and prepare, within a group, a presentation and decision memo for each of the cases. Attendance at sessions is a component of the entire learning process, and any absence should be approved by the instructor first.

REQUIRED TEXTS:

None. Case-based readings will be distributed in class.

SUPPLEMENTAL TEXTS:

None

ASSIGNMENTS:

Case Studies 100%

GRADING SCALE (expected):

Each case presentation will be evaluated by Dr. Roberts and the guest speaker. Grades on the presentation will use a letter grading system, A, A-, B+, B, B-, C+, C, C-, F. The following grading rubric will be used to evaluate the case presentations:

1) Completeness of analysis of the problem
2) Clarity of presentation (both visually and speaking)
3) Consideration/evaluation of all stakeholder interests
4) Conciseness and completeness of decision memo

ACADEMIC INTEGRITY:

All students are expected to adhere to the school's standards of academic honesty. Any work submitted by a student for evaluation must represent his/her own intellectual contribution and efforts. The GSPH policy on academic integrity, which is based on the University policy, is available online at http://www.publichealth.pitt.edu/interior.php?pageID=126. The policy includes obligations for faculty and students, procedures for adjudicating violations, and other critical information. Please take the time to read this policy.

Students committing acts of academic dishonesty, including plagiarism, unauthorized collaboration on assignments, cheating on exams, misrepresentation of data, and facilitating dishonesty by others, will receive sanctions appropriate to the violation(s) committed. Sanctions include, but are not limited to, reduction of a grade for an assignment or a course, failure of a course, and dismissal from GSPH.

The appropriate faculty member must document all student violations of academic integrity. This documentation will be kept in a confidential student file maintained by the GSPH Office of Student Affairs. If the student and instructor agree upon a sanction for a violation, the record of this agreement will be expunged from the student file upon the student's graduation. If the case is referred to the GSPH Academic Integrity Hearing Board, a record will remain in the student's permanent file.

ACCOMODATION FOR STUDENTS WITH DISABILITIES:

If you have any disability for which you are or may be requiring accommodation, you are encouraged to notify both your instructor and the Office of Disability Resources and Services, 216 William Pitt Union at 412-648-7890 or TTY 412-383-7355 as early as possible in the academic term. This office will verify your disability and help you to arrange for reasonable accommodations for your full participation in this course.

COURSE TIMELINE OF TOPICS & ASSIGNMENTS:

Each case will involve three sequential weeks of class.

Week 1: Case background and introduction, with basic reading material and outline of the problem presented. Case materials and background reading will be provided throu8ghh CourseWeb.

Week 2: Question and answer session. The guest executive will meet with the class to answer specific questions that the teams have developed during their review of the case. The executive can be asked to assume the role of any leadership individual involved in the case that the group wishes to ask a question of.

Week 3: Presentation of recommendations. Each team will present a 15-20 minute PowerPoint presentation describing their analysis of the case, and their recommendation for action by health system leadership. Each group will also turn in a "decision memo" outlining their proposed actions and the rationale behind them: this will not exceed 2 pages.

Session 1	**Operating Room Scheduling Problem**		

Case: Re-Organizing Surgical Services Block Time

The operating rooms at Presbyterian Hospital are currently scheduled according to "blocks" that are assigned to specific services and surgeons. Data from finance and operations indicates that ORs are often vacant but that significant overtime is used at the end of the day. Participants will assume the role of a member on the Surgical Services Oversight Committee (SSOC) which has purview over the scheduling mechanisms. The VP of Operations, Albert Wright, has charged the committee with examining this issue and proposing a solution.

Reading:

Two vendor-based or consultant-based shorts on block scheduling:
http://healthcare-executive-insight.advanceweb.com/Columns/Dollars-and-Sense/Operating-Room-Scheduling.aspx
http://www.unibased.com/blockschedulingor.html

McIntosh C, Dexter F, Epstein RH. The Impact of Service-Specific Staffing, Case Scheduling, Turnovers, and First-Case Starts on Anesthesia Group and Operating Room Productivity: A Tutorial Using Data from an Australian Hospital. *Anesth Analg* 2006;103:1499 –516

Calme SH, Shusterich KM, Operating room management: what goes wrong and how to fix it. Operating room management: what goes wrong and how to fix it. *Physician Executive* 18.6, November-December 1992: p43

Optional Reading:

Dexter F, Macario A, Traub RD, Hopwood M, Lubarsky DA. An Operating Room Scheduling Strategy to Maximize the Use of Operating Room Block Time: Computer Simulation of Patient Scheduling and Survey of Patients' Preferences for Surgical Waiting Time. *Anesthesia and Analgesia*. 1999;89:7–20

Denton BT, Rahman AS, Nelson H, Baily AC (2006) Simulation of a multiple operating room surgical suite, Proceedings of the 2006 Winter Simulation Conference. In: Perrone LF, Wieland FP, Liu J,Lawson BG,Nicol DM, Fujimoto RM (eds)

Case Material (available on Courseweb)

Case File: HPM 2700 Re-Organizing Surgical Services Block Time (Wright Case)
Data file: Prior to changes_PUH BLOCK UTILIZATION APRIL 2010 COPY TO SSOC.xls

Schedule: Prior to changes_MUH OR Block Schedule current 11-23-09
Schedule: Prior to changes_PUH OR Block Schedule Current 4-16-10

Session 2	**Operating Room Scheduling Problem**		

Q&A **Groups will expand their understanding g of the problem by developing questions of relevant leadership or staff, and answers will be provided by Mr. Wright as though he were answering for whatever involved individual the group requests information from.**

Session 3	**Operating Room Scheduling Problem**		

Group Presentations
Case 1 presentation due
Case 1 memo due

Session 4	**Excessive Cardiovascular Mortality**		

Case: Excessive Cardiovascular Mortality

Increasingly, health system quality ratings, mortality and outcomes data are becoming matters of public information. Many organizations are producing quality "report cards" that rate hospitals and health systems across a wide array of outcomes. In 2010, several UPMC hospitals did not rank as highly as desired on cardiovascular mortality. You are to be a member of an clinical advisor team to the CEO and Chief quality officer to evaluate this problem and decide a course of action.

Reading:

Society of Thoracic Surgery Composite Quality Score brief, available at:
http://www.sts.org/quality-research-patient-safety/sts-public-reporting-online/explanation-quality-rating-composite-sco

Optional Reading:

2007 Background
David M. Shahian, Frederick L. Grover, Richard P. Anderson, and Fred H. Edwards. Quality Measurement in Adult Cardiac Surgery: Introduction. Ann Thorac Surg 2007;83:S1-S2.

David M. Shahian, Fred H. Edwards, Victor A. Ferraris, Constance K. Haan, Jeffrey B. Rich, Sharon-Lise T. Normand, Elizabeth R. DeLong, Sean M. O'Brien, Cynthia M. Shewan, Rachel S. Dokholyan, and Eric D. Peterson. Quality Measurement in Adult Cardiac Surgery: Part 1—Conceptual Framework and Measure Selection. Ann Thorac Surg 2007;83:S3-S12.

Sean M. O'Brien, David M. Shahian, Elizabeth R. DeLong, Sharon-Lise T. Normand, Fred H. Edwards, Victor A. Ferraris, Constance K. Haan, Jeffrey B. Rich, Cynthia M. Shewan, Rachel S. Dokholyan, Richard P. Anderson, and Eric D. Peterson. Quality Measurement in Adult Cardiac Surgery: Part 2—Statistical Considerations in Composite Measure Scoring and Provider Rating. Ann Thorac Surg 2007;83:S13-S26.

2011 Ongoing Report
David M. Shahian . Public Reporting of Cardiac Surgery Performance: Introduction. Ann Thorac Surg 2011;92:S1.

David M. Shahian, Fred H. Edwards, Jeffrey P. Jacobs, Richard L. Prager, Sharon-Lise T. Normand, Cynthia M. Shewan, Sean M. O'Brien, Eric D. Peterson, and Frederick L. Grover .

Public Reporting of Cardiac Surgery Performance: Part 1—History, Rationale, Consequences. Ann Thorac Surg 2011;92:S2-S11.

David M. Shahian, Fred H. Edwards, Jeffrey P. Jacobs, Richard L. Prager, Sharon-Lise T. Normand, Cynthia M. Shewan, Sean M. O'Brien, Eric D. Peterson, and Frederick L. Grover. Public Reporting of Cardiac Surgery Performance: Part 2—Implementation. Ann Thorac Surg 2011;92:S12-S23.

Case Materials:

Case materials are available on CourseWeb

Session 5	**Excessive Cardiovascular Mortality**		

Session 6	**Excessive Cardiovascular Mortality**		

Group Presentations
Case 2 presentation due
Case 2 memo due

Session 7	**Competing for Capital in a Health System: Allocating Catheterization Labs**		

Case: Competing for Capital in a Health System: Allocating Catheterization Labs

Hospitals and health systems have limited capital resources for new construction, expansion, repair, and many other capital needs. This case involves decisions facing a multi-hospital health system in a very competitive market for cardiovascular services. Their flagship hospital has several catheterization labs, but two are in need of substantial repair. They are re-opening a tertiary community hospital that needs cauterization labs to provide full emergency services, and to compete in that geographical market location. There are insufficient capital funds to do both.

Reading:

Reprioritizing Capital Allocation: Deploying Capital in an Era of Tight Credit. The Administrative Board, Leadership through the Downturn Series, Volume 4

Optional Reading:

Case Materials:

Avaliable on BlackBoard

Session 8	**Competing for Capital in a Health System: Allocating Catheterization Labs**		

Session 9	**Competing for Capital in a Health System: Allocating Catheterization Labs**		

Group Presentations
Case 3 presentation due
Case 3 memo due

	No Class – Spring Break		

Session 10	**Restructuring ICU Services**		

Case: Restructuring the Provision of Intensive Care Services in a Large Community Hospital in Transition

This case concerns the problem of different admitting and privilege rules at two hospitals during a merger. A large, tertiary care academic hospital merged with a large, tertiary care community hospital. Intensive care units operated under the "closed" model in the university hospital (only critical care Medicine certified full-time Intensivists could admit to Intensive Care Units) whereas the community hospital had and "open" model, where anyone with admitting privileges to the hospital could also admit and care for patients in the ICU. This case involves the decision regarding the ICU staffing model that will be used after the merger.

Required Reading:

Pronovost PJ. Physician Staffing Patterns and Clinical Outcomes in Critical Ill Patients. *JAMA*. 2002;288:2151-2162

Rockymore MB. Updating the Leapfrog Group Intensive Care Unit Physician Staffing Standard. *JCOM*. 2003; 10 (1): 31-36

Optional Reading:

Levy MM, Rapoport J, Lemeshow S, Chalfin DB, Phillips G, Danis M. Association between Critical Care Physician Management and Patient Mortality in the Intensive Care Unit. *Ann Intern Med*. 2008;148:801-809.

Rubinfeld GD, Angus DC. Are Intensivists Safe? *Ann Intern Med*. 2008;148:877-879.

Case Materials:
Available on BlackBoard

Session 11			

Restructuring ICU services; question and answer Session

Session 12			

Group Presentations
Case 4 presentation due
Case 4 memo due

Session 13	**Triangle Health System**		

Case: Triangle Health System: A Case Study in Connecting the Dots (Strategy….Operations…..And reality!)

This case describes the events surrounding a hospital integration in Greensburg, PA that involved two hospitals that had recently merged, joining with a third to create the a health system, called "Triangle Health" in the case materials. The goals of the integration were developing efficiencies of scale, discontinuation of redundant services, and specialization of certain services (like maternal health services) in single locations, given the institutions were geographically close (< 10 miles).

The integration demonstrated many of the outcomes desired by the board. The financial bottom line of the system improved, costs were reduced through certain service integrations and improved contracting, and the dashboard-type indicators selected by the board were getting better. However, several months after integration, several indications surfaced regarding significant problems: nursing turnover increased dramatically, several prominent medical staff left to join a competitor hospital, and the system e=received many community-based complaints regarding the integration.

You serve as a member of a medical staff committee that the CEO has rapidly put together to assess the reasons for the discontent, and make recommendations regarding how to proceed.

Required Reading:

Heifetz R, Grashow A, Linsky M. Leadership in a (permanent) crisis. *Harvard Business Review*. July-Augiust, 2009

Paul Levy: Taking Charge of Beth Israel Deaconess Medical Center. *Harvard Business School Case*, Jan, 2003.

Case Materials:

Available on Blackboard.

Session 14			

Triangle Health Case: Question and Answer Session

Session 15			

Group Presentations
Case 5 presentation due
Case 5 memo due