

Dean's Newsletter

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Welcome to Amir Dan Rubin, the new President and CEO of Stanford Hospital & Clinics (SHC)

You likely know by now that Mariann Byerwalter, Chair of the Board of Directors of Stanford Hospital and Clinics (SHC), announced on Friday, November 12th, that Amir Dan Rubin will be the new President and CEO of SHC effective January 3, 2011. He will replace Martha Marsh, who retired on August 31st. Ms. Byerwalter co-chaired the Search Committee with John Scully, also an SHC and Stanford University Board member. I served on the Search Committee along with Drs. Steve Galli, Chair of the Department of Pathology, and Bill Maloney, Chair of the Department of Orthopaedics, who both represented the School of Medicine. We are unified in our enthusiastic support for Mr. Rubin, who is currently the Chief Operating Officer at UCLA, a position he has held since 2005. Amir Rubin has had a meteoric rise as a leader in hospital administration, having also held leadership positions at Stony Brook University Hospital in New York and the Memorial Hermann Hospital Healthcare System in Houston Texas.

I was charged by the Search Committee to do the reference checking on Mr. Rubin, and I am happy to say that I heard from medical school, faculty and hospital leaders a consistently incredible chorus of praise for Amir's intelligence, commitment, and ability to work with virtually everyone to solve problems and challenges. I also heard praise about his appreciation and support for the research and teaching missions of academic medical centers and his dedication to making these programs vibrant and stronger. While these comments are enormously assuring, perhaps the strongest evidence of how highly Amir Rubin is viewed by his colleagues at UCLA comes from the announcement sent out to the faculty and staff by David T. Feinberg, MD, MBA, CEO of the UCLA Hospital System and Associate Vice Chancellor, to the UCLA community. Here it is:

"I write to you with very mixed emotions to announce that Amir Rubin will be leaving his role as chief operating officer to become CEO for the Stanford Hospital and Clinics in January. Through Amir's visionary leadership and tireless

efforts over the past five years we have advanced our operations systems to become highly effective, accountable, service responsive and efficient. Because of Amir's leadership UCLA is now the model in health care for the manner in which we adopt "Lean" process improvement ideals and methods in our everyday practices. As the principal architect of "CI-CARE" Amir has been instrumental in reshaping the UCLA Hospital System to become a leader in offering a positive patient experience that measures up our world-renowned clinical quality. Under his leadership our patient satisfaction scores went from the 38th percentile among 600 hospitals surveyed nationally to ranking in the 95th percentile and first among academic medical centers nationally. Along the way Amir has built a tremendous management team and inspired staff commitment that will indeed carry UCLA forward to "Heal humankind, one patient at a time by improving health, alleviating suffering and delivering acts of kindness." [Amir Rubin, 2007].

On a personal note, I will miss Amir for his genuine caring and friendship, his great sense of humor and his unwavering commitment to raise the human spirit through his everyday words and deeds. I know you join me in wishing Amir, Nicole and their children Naomi and Ben the very best as they embark on the next chapter in their extraordinary lives."

Please join me in welcoming Amir Dan Rubin to the Stanford Medicine Community.

The Fourth Stanford Summit on Clinical Quality and Performance

On Thursday November 18th Dr. Bryan Bohman, Chief of Staff at Stanford Hospital & Clinics (SHC), along with Dr. Christy Sandborg, Chief of Staff at Lucile Packard Children's Hospital (LPCH), led the Fourth Stanford University Medical Center Summit for Clinical Excellence. For the first time the Summit was held in the Li Ka Shing Center for Learning and Knowledge; over 200 physicians, nurses, health professionals, administrators and hospital board directors from the School of Medicine, SHC and LPCH gathered there for the day. Importantly and appropriately, we have put a high premium on improving the quality of clinical excellence throughout the Medical Center, and we have measured our progress in doing so. We were all chastened to learn nearly five years ago that the UHC (University Health Consortium) ranking of SHC in clinical quality was in the bottom decile. Major and sustained efforts were made by the School and SHC to improve performance, and we witnessed progress each year - in 2010 SHC ranked in the top quartile. This is a tribute to the work of faculty, physicians, nurses, administrators and staff across the Medical Center. It is also a reflection of the outstanding leadership of Drs. Kevin Tabb, Chief Medical Officer, and Norm Rizk, Senior Associate Dean for Clinical Affairs, in concert with Chief of Staffs Bryan Bohman and Christy Sandborg. Our shared intent is to keep improving, and we should not be satisfied until we have achieved sustained improvement and the highest quality of clinical care possible. We can do no less.

While clinical excellence and quality performance are essential they are not sufficient. We must also make much more progress in the clinical services that define the patient experience. Our performance in this area is inadequate, but efforts to improve clinical quality are underway and are already showing modest gains. Much work remains, and the goal of close alignment of the quality and excellence of patient care with the quality and care of the patient experience must be pursued in synchronous and concerted efforts. Furthermore, these improvements must be carried forth with an effort to dramatically improve the value proposition of our clinical services. We are too costly and going forward it will be imperative to focus intensively on quality, service and cost. Indeed, it is also clear that rapidly developing changes in payment reform are unfolding that will be tagged to quality outcomes and not simply to the amount of clinical work performed.

These changes will also be coupled with the need of medical centers to form integrated hospital, ambulatory and community based services capable of managing populations and to engage in managed risk through Accountable Care Evolutions (the final configuration of which is still to be determined). Major changes and innovations in clinical care delivery in hospital and outpatient as well as home care settings will be required to meet this need – something that most academic medical centers are only beginning to learn to do. We are also on a steep learning curve, and it is clear that we have to accelerate our efforts given the changes likely to take place over the next 2-3 years. Thankfully, we have begun this process and also have developed initiatives to address these challenges, such as the Clinical Excellence Research Center being led by Dr. Arnie Milstein, Professor of Medicine.

In addition to excellence in the quality and cost of clinical care and patient service, it is also imperative that Stanford Medicine have outstanding physician providers and that we lead in innovations and discoveries that create knowledge and ultimately provide new improvements in the diagnosis, treatment and prevention of human disease. The question of how to foster innovation while reducing the variability of patient care was the focus of the Fourth Summit. While it might be argued that any attempts to standardize patient care – through protocols, management guidelines or algorithms – runs the risk of stifling patient care or is at odds with the move to “personalize medicine,” I think a compelling case can be made that innovation and protocol management are not at odds and that one helps to affirm and substantiate the other.

We had the opportunity to approach the balance between innovation and standardization from a number of different perspectives. Dr. Arnie Milstein led a panel in which Dr. Tom Krummel, Emile Holman Professor and Chair of the Department of Surgery, and I participated. We also heard a presentation from this year’s guest speaker, Dr. Alfred Casale, Associate Chief Medical Officer at the Geisinger Health System – one of the national leaders in provider and payment reform. In addition, Drs. Pat Gibbons, Clinical Assistant Professor of Medicine and Associate Medical Director of Quality Improvement, and John Wachtel, Adjunct Clinical Professor in the Department of Obstetrics and Gynecology, provided case study experiences.

From my perspective, we have an opportunity to create a continuing learning environment at Stanford that combines and integrates innovation and discovery with protocol management that helps standardize therapies to achieve high quality and lower cost. My reference point is pediatric oncology, a discipline I have been part of for a number of decades. Unlike virtually any other part of clinical medicine, the care of children with cancer almost always occurs under the banner of a clinical protocol that is designed to compare current state-of-the-art care with an opportunity to improve care, often as part of a randomized clinical trial. New innovations are key to future improvements in healthcare, but each new innovation requires validation. Carrying out “innovative care” without an attempt to assess outcomes and ascertain whether they offer an improvement to “standard therapy” can perpetuate less optimal or more expensive options or miss the opportunity to validate useful innovations that should become part of standard therapy.

In many ways the sequential improvements in the care of children with cancer are the result of a constant interaction between innovation and standardization – with evidence-based innovations becoming integrated into the sequential “standardizations of care.” This is true for adults with cancer, although far fewer enter clinical trials. The cycle of innovation and standardization has also been extrapolated to many other diseases – including AIDS, cardiovascular disease and others. Conversely, presumed “innovations” have also been shown to have negative outcomes when subject to clinical trials that standardize management and underscore the importance of validating whether an innovation is truly beneficial. Also of interest is the observation that simply taking part in a clinical protocol that “standardizes care” improves outcomes – even when patients are in the less effective treatment arm of a therapeutic regimen.

It must be clear that I am strongly supportive of innovation and discovery, and I firmly believe in the importance of physicians and scientists creating new options for diagnosis, management and prevention of disease that break past molds of assumption or standard practice. And of course I recognize that the cycle and process of innovation in drug and even immune based therapies are different from surgical and technological innovations. But I also believe that, regardless of the innovation, validation is important, followed by its incorporation (or not) into “standard therapy.” It seems plausible that at any point in time a standard regimen can be employed for a specific disease or illness (perhaps between 50-80% of the time) as long as there is regular assessment of the standard regimen and the incorporation of new innovations as they emerge or evolve. By treating the majority of patients on standard protocols we have the opportunity to better manage outcomes, improve quality and service and control costs (by determining which tests or studies should be performed and when they should be done).

The use of an electronic medical record should make such protocols easier and more reliable to conduct and can also incorporate education modules as well as management tools. Further, such protocol based therapy permits more team based management (by doctors, nurses and other professionals) and can enhance training and education by staying closer to evidence-based interventions in contrast to “my experience” ones. If I could do so, I would have the majority of patients admitted to

clinical care programs enrolled in a protocol that added new knowledge as well as provided standard therapy. I also hasten to add that protocol based management is not a counter to “personalized medicine,” since the determination of which protocol or treatment patients receive can be determined by the eligibility requirements they meet as a consequence of defining personalized metrics.

In my opinion standardizations of management are inevitable and can be done in concert with innovative care and discovery. The absence of standardization will lead to a greater number of poorer outcomes and errors and will deteriorate both quality and clinical performance metrics. Protocols or new standards can address disease management as well as specific problems and can also be open to new observations as they emerge. The process of innovation and standardization should help define the future of Stanford Medicine.

Stanford Medical School Faculty Senate Takes a Stand on Same Sex Marriage

Across the USA there has been a contentious debate about whether same-sex marriage is a civil right. The debate has engendered strong emotional reactions from all sides of the religious, ethical and political spectrum. The opinions expressed pose moral outrage on both sides of the equation but have failed to assess the impact of the decision on the health outcome of the adults and children who are affected by varying positions and opinions. I am very pleased that the Stanford School of Medicine Faculty Senate considered the issue of health disparity and same-sex management and unanimously approved the following resolution on Wednesday November 17th.

The Faculty Senate at Stanford School of Medicine supports granting the rights of civil marriage to same-sex couples as part of our commitment to reduce the documented health care disparities affecting those couples, their families, and their children.

I fully endorse this resolution and thank the Faculty Senate for taking this position. I also want to thank Dr. Gabe Garcia, Professor of Medicine and Associate Dean for Medical School Admissions, for bringing this important issue to the attention of the Senate.

An Update on Space

At the November 19th Executive Committee two important presentations on medical school space and facilities were considered. First, Dr. Sherril Green, Professor and Chair of the Department of Comparative Medicine, provided an update on the current status of animal space both on and off campus and the important strategic planning process now underway to determine and optimize future animal research space for the School of Medicine as well as Stanford University. Then Niraj Dangoria, Assistant Dean

for Facilities Planning and Management, presented a comprehensive update on both on-campus and off-site developments.

We have been in a constant planning mode for space utilization during my time as Dean. My last major update on facilities planning was in the December 4, 2006. Over the past year we have realized the fulfillment of some of this planning with the opening of two highly visible projects (the Li Ka Shing Center for Learning and Knowledge and the Lorry Lokey Stem Cell Research Building- Stanford Institutes of Medicine I) as well as the less visible but very important project that created a new loading dock and underground tunnels connecting our medical school campus. These new facilities have transformed the face and appearance of the School of Medicine and, perhaps for the first time in many decades, have created architectural harmony, consonance and coordination. Despite these dramatic changes, this is best viewed as Phase I of a process extending out over the next decade or more that will ultimately add two additional Stanford Institute of Medicine Buildings and replace the GALE (Grant, Always, Lane and Edwards) buildings by three new Foundations in Medicine Buildings. And of course also coming are the New Stanford Hospital and the major addition at the Lucile Packard Children's Hospital, both of which will further transform the Medical Center.

Between 2001-2010, School of Medicine space has increased from 1,102,456 net available square feet (nasf) to 1,558,543 nasf, of which 238,655 nasf is on campus and 214,642 nasf is off campus. The growth in space includes laboratory, office, vivarium and support space. At the same time, our basic and clinical science faculty numbers have increased such that the overall amount of space per faculty member remains unchanged. Although I doubt it feels this way, nearly all basic and clinical science departments have had a net increase in space between 2004 and the present time.

Despite these changes, concerns about the adequacy of space is one of the major and continuing issues for faculty and department chairs – as is the length of time it takes to address space needs. We are also concerned about this but offer this perspective. In addition to the major construction and renovation onsite and offsite projects that cost \$20 or more million (the LKSC, Lokey-SIMI, Connecting Elements and Arastradero facilities), there have been 10 other projects ranging in cost from \$2-10 million that have been completed in this same time period along with 19 projects costing under \$2 million. Each is important to the individual user and all consume time and resources. Plus, there are nearly 50 ongoing facilities projects and renovations – some of which we have anticipated and initiated and others that are the result of decisions made by others in the area (e.g., the need to relocate a large number of faculty and staff when LPCH took over the 701/703 buildings to prepare for hospital construction and required that we move out). The bottom line is that faculty and individual departments only see a portion of the large number of complex projects underway.

Going forward, the overarching principles we established at the onset of our master facility planning still obtain. We want to do everything possible to keep research programs on campus – something we hope will be optimized by the future build-out of the Stanford Institutes of Medicine II-III as well as the Foundations in Medicine I-III.

Along with new construction will also come the demolition of aging facilities (e.g., GALE along with other facilities to provide GUP [general use permit] space or to permit the footprint for major construction projects). There will also be the need for renovation and repurposing of other buildings (e.g., Fairchild Science). A major immediate and continuing priority is to develop more vivarium space, some of which will be on-campus and some off-campus. The future requirements for animal space will also be driven by the strategic planning activity referred to above that is now ongoing. We will also need to develop space for cores (some of which will need to be off-site) as well as surge space. A major unmet need that will prove increasingly critical is space for clinical faculty – especially as hospital construction gets underway. And, needless to say, the hospital construction projects will have an impact on all facilities simply because of their size, scope and timelines.

We are also seeking to more rationally organize our now quite significant off-site space and leases to accommodate consolidation (e.g., administration space) but also to permit the development of facilities for innovation (e.g., genomics and early diagnosis) and surge space. As some of you will know, over the past 18 months we explored the prospect for doing this on the Roche campus site but have now abandoned those plans since the costs proved prohibitive. We are now exploring an opportunity to develop a consolidated off-site campus on Porter Avenue – which appears to offer both immediate and long-term opportunities. I will have more to say about this in the future.

We are also working to finalize our facilities on Welch Road, most immediately with the planning for the Jill and John Freidenrich Center for Translational Research, which will be located at 800 Welch Road. Construction of this Center will begin in 2012. We are also exploring opportunities for a contiguous building on Welch Road that will further optimize our clinical and translational research programs.

So while a lot of very visible changes have occurred over the past 3 years that have begun the transformation of the School of Medicine, numerous other projects have been completed, are ongoing or will soon be initiated to further our efforts. Over the next several years we can look forward to additional major projects on campus as well as the development of some unique opportunities off-campus. While each of these projects is important, the most critical issue is to continue to support our most important resource – the faculty, students and staff who comprise the School of Medicine. It is their work that makes these capital investments important – and that helps to support the future of Stanford Medicine.

Town Hall Meeting with Students

On Monday evening November 15th, Drs. Charles Prober, Clarence Braddock and I had the opportunity to participate in one of our regular Town Hall Meetings with students. We welcome these opportunities to interact with our students and to learn about the issues they are facing or are concerned about. These sessions provide an opportunity to engage in dialogue and, as best as we can, to address current issues. We spent the most time discussing the status of the CBEI (Criterion-Based Evaluation Initiative), which

commenced this past June (<http://med.stanford.edu/md/curriculum/CBEI/index.html>). While there was understandable anxiety and even some consternation before CBEI was launched, I am pleased to note that it is moving forward successfully. It is already apparent that many more faculty are participating in the evaluation process than was the case prior to CBEI– which has been largely normalized across clinical departments. There are many outstanding issues and a clear need (and expectation) to evaluate the impact of CBEI thoughtfully and appropriately – but this is now in progress. I will plan a more complete report after more experience is gained. I am thankful and appreciative of the constructive input of our students to this and other major initiatives underway.

Annual Meetings for All Faculty – Regardless of Rank or Seniority

In an earlier Newsletter I posed the question of whether chairs (or their delegates) should hold annual meetings with senior faculty in the same way as they now are expected to do with junior faculty. In that article I reported on a discussion of this question led by Dr. Gary Schoolnik, Associate Dean for Senior Faculty Transitions, at an Executive Committee meeting in July. Dr. Schoolnik recently returned to the Committee for further discussion and to propose a set of concrete recommendations he and his colleagues in the Office of Academic Affairs have developed. These recommendations include the following:

- There should be regular individual (annual) meetings of senior faculty with their chairs/chair delegates. Parenthetically, it turns out that 50% of senior faculty already have such meetings.
- The Office of Academic Affairs will provide a standardized form/template for these meetings; departments may also use their own forms.
- Among the topics for this meeting would be:
 - A discussion of the faculty member’s plans over the next 1 year, 5 years and 10 years in the areas of teaching, research and clinical care.
 - Expectations of the chair/chief for the faculty member - and the reverse.
 - The identification of action items
- There should be a written record of the conversation.

The chairs agreed on the importance of the kind of continuing dialogue that annual meetings allow for, and they acknowledged that it is important throughout a faculty career. At the senior level, the topic of retirement can be challenging both for faculty and for their chairs, and Dr. Schoolnik noted the resources available in the Office of Academic Affairs to assist in discussing this subject. For many faculty their career is not a “job” but rather a cause, or a mission, and the separation that occurs at retirement can be daunting. The chairs felt that we should think of ways to be more welcoming of the ongoing involvement of emeriti faculty. One chair pointed out that economic preparation for retirement should begin early in the career, and he introduces it to his junior faculty when they first join the department.

The Executive Committee endorsed the idea of annual meetings with all faculty along the lines proposed and discussed here, with the caveat that in small, cohesive

departments, the meetings might be less frequent, while still done on a regular basis. The Office of Academic Affairs will follow up and implement this process. I am very supportive of this outcome and look forward to its incorporation into the life of all our departments.

Dean's 2010 Staff Awards:

Employee of the Year SPIRIT Award, and the INSPIRING CHANGE LEADERSHIP AWARD

On April 21, 2011, the School of Medicine will again award the Dean's Annual Employee of the Year SPIRIT Award to two exceptional staff members, who will have been selected based on outstanding dedication, initiative, motivation, positive attitude and customer service. In addition to the annual SPIRIT Award, this year the School is inaugurating another staff award, the INSPIRING CHANGE LEADERSHIP Award. This Award will recognize an individual staff member who initiates or leads change and innovation: implements new processes, systems, organizational structures, or operating paradigms which will result in transformative improvements in service, efficiency, value, effectiveness, outcome, or satisfaction. Criteria for this award will be broad in scope so as to encompass significant change or innovation affecting an entire work group, department, or multiple departments. This award will be given to an individual (or up to two individuals) at any level or unit in the School of Medicine who have led an innovation project and who have service at the School of Medicine of at least 2 years. A school-wide email announcement is going out today to all faculty, staff, students, and post docs. Please go to the following url: <http://med.stanford.edu/employeerecognition/awards/> which will connect you to the website for further information as well as the eligibility criteria for both awards. After you have reviewed the criteria, please submit your nomination for either award using the online Nomination Form – be sure to select the correct “button” SPIRIT Award or INSPIRING CHANGE LEADERSHIP Award and describe why your nominee meets the specific criteria for that award.

Please note: DEADLINE FOR SUBMITTING NOMINATIONS IS Thursday, December 9, 2010.

Happy Thanksgiving

It seems hard to imagine that we are zooming into the holiday season, with Thanksgiving later this week. I want to take this opportunity to wish each of you along with your family and friends a very Happy Thanksgiving and Holiday Season. Have fun, be well and wear helmets and lights if you are riding bikes.

Awards and Honors

- I am very pleased to let you know that Scope (the blog from members of our Office of Communications and Public Affairs) has *won* a 2010 Excellence in New Communication Award for blogging from the *Society for New Communications Research*. The Society's awards program honors individuals, corporations,

nonprofit organizations, educational institutions, and media outlets that pioneer the use of social media and other communications technologies. This is wonderful honor and tribute to our terrific communications staff.

- **Dr. Frank Longo**, George E. and Lucy Becker Professor and Chair, Department of Neurology and Neurological Sciences, has been named one of GQ magazines “Rock Stars of Science” (see: <http://med.stanford.edu/ism/2010/november/longo.html>) and is featured in the December issue of GQ. None of us will be able to think about Dr. Longo the same way now that he is a rock star. Truly, congratulations to Dr. Longo (or is it just “Frank” from now on?).
- **Dr. Paul Berg**, one of our most revered and respected faculty was honored for Lifetime Achievement at the 2010 Pantheon Ceremony. Congratulations to Dr. Berg.
- **Dr. Lawrence "Rusty" Hofmann**, Associate Professor and Chief of Interventional Radiology, is the inaugural recipient of the Ohio State School of Medicine Early Career Achievement Award for his significant contributions to the field of medicine before the age of 40. Congratulations, Dr. Hofmann.