Drs. Berman and Beninger, thank you for extending an invitation for me to address this 20\textsuperscript{th} anniversary gathering for the Tufts University MDMBA program.

As healthcare rapidly transforms, requiring more sophisticated structures and processes, the MDMBA graduate will anchor this transformation, for four reasons.

First, a reunification of clinical, medical, and financial segments required for future success in population health necessitates a clinician with deep financial and business acumen in addition to relationship and corporate management skills and competencies. As translator, diplomat, and educator, she will navigate the deep historical siloes separating nursing, physicians, and administrative leadership that resulted in a disjointed and fragmented health care delivery system.

I first learned of team management models shortly after I arrived in Down East Maine following my family medicine residency. In fulfilling a National Health Service Corps scholarship, my duties included an every third weekend, beginning at 5PM on Friday and ending at 8AM Monday, in a small hospital on the Maine-Canadian border. This weekend call included responsibilities to round on the 35 inpatients, inclusive of four ICU beds, be both obstetrician and pediatrician for the OB program, and take call for the emergency room, seeing approximately 40-45 patients a day.

Quickly overwhelmed with the challenges of seeing critically ill ICU and ED patients, as well as manage active labor on the OB floor, the charge supervisor reassured me that they had been doing this for the past twenty years. Coming from an educational background where the physician was clearly the “sole responsible member” of the care team, I failed to conceive how this could be so. Yet when confronted with simultaneous care demands throughout different parts of the hospital, the staff acclimated to a triage and delegating system that smoothly and seamlessly met the patient needs with nurses and technicians and supervisors playing roles that I had always thought were my own. Quality was not compromised, and this “system of care” automatically rerouted me to those areas where my expertise and competencies were required. We now know this as working to the top of one’s license, yet how incredible to see this work.

Following this rural experience, I relocated to a more suburban setting and quickly returned to the “captain of the ship” mentality, reflective of the absence of the need to do anything else.

A successful population health depends upon a new paradigm of medical, nursing, and administrative structures. This sounds rather mundane and structural, yet nowhere in business today is there a more siloed management structure with misaligned incentives and goals than US Healthcare. Rebuilding a
population health network from current healthcare business structures requires an understanding of the historical foundations creating the way we conduct business today.

The profession of nursing has deep holistic and epidemiological roots into the early 19th century. Pioneering leaders such as Nightingale, Dock, Breckenridge, and Wald described nursing as keeping populations well, preventing disease, and separate from medicine itself. In fact four years separates Semmelweis’s treatise on puerperal infections from Nightingale’s treatise on the same. Yet both, suffering from the inferiority of being an Austrian Jew and a nurse, respectively, were negatively received and their recommendations took years to be incorporated into mainstream medical practices.

Medicine withdrew into a deeper silo shortly after the Flexner report in 1912. Medical education prior to this report was variable in quality, democratic in its service to many populations, including both women and minorities. The Report led to the closure of a majority of institutions and the reemergence of the Johns Hopkins model of medical research, focusing less on the patient and more on the organ. William Osler, himself a Hopkins professor, lamented the loss of the holistic approach to the patient, bemoaning that scientists were inadequate clinical leaders, poor role models, with science injuring the physician and patient relationship.

Healthcare administration arose through two major events of the 20th century. Michael Davis, of the University of Chicago, in 1934 published the need for Masters level programs to run this “billion dollar business”. Focused upon a “male only” profession, more than 40 similar programs opened between 1934 and 1969, with graduates slowly replacing the nursing and physician administrative leaders. In the mid-1960s, with the advent of Medicare and Medicaid, reimbursement to hospitals became a cost plus revenue model, requiring the capture and aggregation of all costs consumed to deliver healthcare. The effect was the rise of the MHA and CPA in healthcare to best capture the cost plus four percent revenue.

The MDMBA brings the competencies to bridge these deep historical walls, unifying through the understanding of what each brings to new models of care, and developing those without the educational and clinical background to compete.

Second, a population health culture of success compels our graduates to focus upon the development of others through formal mentoring in order to create the cadre of leaders necessary to implement. We cannot afford nor is there deep interest in, MDMBAs for all physician and nursing leaders. Trust, delegation, flattening the hierarchy of business and professionals will accelerate the opportunity to create new models of care. Focus upon new models without a development out of and a deep appreciation of the historical nature of these professional siloes will be met with passive and active resistance, not aimed at the concepts but inwardly focused upon loss of control, professional identity or both.

Third, healthcare innovation will fuel the consumer revolution and renew its stickiness to a new business model, creating ease of access, new use of human resources (still the most expensive healthcare resource, in spite of billions of dollars in investment, with little or no improvement in productivity nor lowering of cost occurring over the past twenty years), and models of care. Formal education centered upon understanding and testing current and new models of care and leveraging technology are keys.
We are all familiar with the acronym PCMH. Yet in healthcare, far too frequently this means Provider Centered Medical Home, Payer Centered Medical Home, or Physician Centered Medical Home. Organizationally, we create structures to protect or serve the profession and the patient and community are left to navigate alternate care sites. Why else have Minute Clinics been so successful? How can access be convenient when I have to be on hold on a phone, drive 45 minutes in cross town traffic to meet the scheduling needs of my clinic, and adjust to times not convenient to me or technologies that are created upon foundations invented in the 1980s?

What is it about waiting rooms? Healthcare is the only business in which to come to an appointment and must wait upwards of two hours to finally leave the waiting room and spend fifteen minutes with your provider. What about the technology that allows us so many choices and benefits yet is absent in healthcare? Open Table, the restaurant app, allows me instant scheduling at the time I want, immediately sends me confirmation and directions to my selected restaurant, offers options for similar restaurants nearby if reservations do not exist, and sends me a ratings survey the day after. And what about identity? People spend countless hours filling out paperwork on multiple occasions, give medical histories in duplicative fashion. Meanwhile, we have master patient index operational costs in the US to match disparate medical identities accurately with total costs exceeding $10 Billion annually! Apple IPhone6 does this once with a simple fingerprint recognition app, allowing unique identification at no cost with high reliability and financial access for payment. Virtual nursing and telemedicine development exist to recreate staffing and resource use, lower human costs of care, and revolutionize care delivery yet remain relatively dormant due to high capital cost of entry (healthcare moniker adds roughly 250% to cost of any technology), desire to get fee for service for all interactions, and the siloed financial models between payers, providers, and physicians.

Fourth and last, turning inward, self-reflection and a spiritual commitment towards change secures this foundation of new leadership. Time spent in managing self and others allows our graduates to bring an apostolic passion for spreading the word about change management and new delivery models. The concepts and philosophies remain generally mainstream. The change management skills required to navigate these deep cultures and their equally deep entrenchments, the lack of innovation, the cadre of new leaders seeking competencies and skills to be successful are simply overwhelming. Apostolic passion and the competencies and skills of both clinician and business person will lead US healthcare out of the wilderness and into the holistic person and community centered system we know it can be.