Our clinical programs were on the move this year—both literally and figuratively. And that made for some exciting transitions that laid the foundation for patient care innovation and expansion for years to come.

This year’s biggest move involved our cardiologists, most of whom now practice full or part-time at the Cardiovascular Center clinical building that opened in June. This extraordinary facility serves as the new home for most of our institution’s care for adult cardiovascular patients, though we continue to provide outpatient and inpatient care in several other locations.

Besides giving our cardiologists more room and state-of-the-art equipment, the new building allows them to work in close cooperation with U-M’s cardiac and vascular surgeons, radiologists, stroke neurologists, and cardiac anesthesiologists. This allows the specialties to work together as never before, to optimize the care of patients with all forms of cardiovascular disease.

You’ll find more about the move in the Cardiovascular Medicine section of this report on page 16.

On a smaller, but no less important, scale, our allergists moved to their new clinic at Domino’s Farms this year, giving them expanded space for a dedicated Food Allergy clinic (see page 14) and other services. This new location is also much more convenient for patients, many of whom make frequent visits.

Together, these moves have freed up thousands of square feet of much-needed space in the Taubman Center, allowing us to plan for expanded and renovated facilities for our other subspecialty clinics.

At the same time that all this physical movement has been going on, many of us in the department have spent 2007 working on another, more administrative move. This year was a key period in the transition of all outpatient (ambulatory) services from the Hospitals and Health Centers to the Faculty Group Practice, a process that will be completed in mid-2008.

To a casual bystander, this administrative change may not seem significant—but in fact it holds the promise to transform our operation. One important impact is on faculty salaries, which currently lag behind many of our peer institutions and often make it hard to compete for top talent.

Under the new arrangement, we’ll be able to create direct incentives for faculty performance, and maximize revenue streams to help improve salaries and capital equipment acquisitions. The new structure will also give our clinicians more autonomy in creating the environment in which they practice. And, it will help the Health System create destination programs for patients with specific conditions who require a high level of coordinated specialty care.

Other moves this year were of a technological variety. We’ve completed our transition to totally computerized medical records in our clinics. We also began rolling out a software improvement, which I’m especially
Internal Medicine Annual Report 2007

proud to have helped develop, that gives faculty a one-click way to bill for consulting on the care of an inpatient who is hospitalized through another service. This kind of “simple” electronic feature can make a world of difference in how we receive accurate payment and build clinical revenues that we can invest in people, programs, and technology.

We’ve also implemented an electronic solution to the persistent issue of how to manage the care of patients who take immune-suppressing, blood-thinning or cancer-fighting drugs and need frequent blood tests and other checks. The software we began using this year automates the process, makes life easier for clinicians and patients alike, and is being adopted by others in the institution. It’s just the latest example of how we’re on the move—working to put facilities, strategic management technologies, and technology to work for ourselves and our patients. As we continue to grow in our clinical operations and to perform well financially (see charts), these improvements will continue to be vital to our success.