Positioning Academic Health Centers for Quality, Safety, and Patient Empowerment

Authors' Commentary

CHAPTER ABSTRACT: The goals of advancing patient safety, improving quality of care, providing transparency, and engaging patients pose certain challenges to academic health centers as implementation of the 2010 Patient Protection and Affordable Care Act continues. The post-ACA environment demands: increased efficiency; detailed focus on all aspects of clinical care and operations; and, rapid translation and dissemination of promising new initiatives in close partnership with multiple stakeholders. This chapter offers several recommendations for academic health centers as the obvious leaders in patient safety and empowerment.

Ratings of patients' experience with hospital care now comprise approximately 25 percent of the Centers for Medicare & Medicaid Services' (CMS) value-based purchasing payment. Improving the patient experience is a goal that academic physicians, trainees, and everyone else who comes into contact with patients could achieve immediately if we applied sufficient effort.

There are four key take-home messages from our chapter. The first is not original to our research, but goes to the reality that faculty in academic health centers tend to be "eminence-based" as opposed to "evidence-based." Clearly, we need to find ways to ensure that faculty rely more regularly on evidence versus personal experience alone. Many senior faculty in academic health centers are highly respected for their research. But too often that means that they provide care based on just their experience. Having done things one way for a long time, they may not necessarily know all of the data on how best to manage patients. We have learned the hard way that this just isn't good enough.

Given the nature of medicine today, team-based research and practice is tremendously important. The second key message is that the data show that faculty are not yet as effective as they need to be in working in teams. That is not surprising. Many of today's senior faculty entered the practice of medicine at a time when autonomy was a defining characteristic. Even now, the National Institutes of Health typically grants money to a principal investigator (although it is moving toward team-based research). Teamwork is not a given, and learning how to practice in teams is going to require active training. Further, metrics need to be developed that demonstrate the value of team-based care.

Third, the idea of the one-day-a-week clinician just does not work anymore. It used to be that we could offer researchers who wanted to see patients the opportunity to do so once a week. Today, however, unless that person has truly phenomenal talents—and there are such exceptions—medicine is so complicated that the traditional one-day-a-week clinician simply cannot meet the standards that outstanding practice centers are held to in terms of availability, efficiency, and effectiveness. That strongly suggests that if one is going to be a full-time researcher, one probably needs to concentrate on that role and probably shouldn't practice.

Fourth, we need to think more carefully and thoroughly about rewarding teaching. We need to find better ways to recognize and reward those who can and do teach effectively. The great teacher almost never becomes a bad teacher. One way to look at tenure is that it is a "bet" on the future contributions of a faculty member. Perhaps for the great teacher, tenure should be awarded on the basis of teaching excellence.

There are two potentially disruptive ideas in our chapter. One is that some academic health centers might consider a path in which the AHC hospital is "quaternary" and cares only for patients with conditions requiring research, referring patients with more common conditions to other network partners. We may have to stop competing for the normal procedures that make money; it is a waste of time for academic faculty. The real value of the academic health center comes from advancing the state of medicine, not competing for appendectomies. Teaching should be done in all parts of the network. If we are to realize the full value of academic medicine, academic health centers need to be paid differently. We outline some options for payment in our chapter.

The second potentially disruptive idea concerns research in the academic health center. We know that research in clinical departments was bolstered in the early days of Medicare when ample money was available. But those funds are no longer available. Consequently, we can no longer rely on the principle of clinical cross-subsidization for either research or teaching. Today, both teaching and research need to be paid for on their own. One suggestion of ours is to house basic research—i.e., not involving the patient directly—in basic science departments that might be part of university-wide research enterprises and part of the university's basic science budget. The university could decide how much it wants to subsidize basic research, and the rest could be supported by grants and indirect costs. The rare faculty members who can take their own bench research to the bedside could receive appointments such as "University Professor."

Recognizing that academic health centers will continue to play a vital role in medical education, research, and clinical care, we offer a range of further ideas in such areas as leadership, mission, continuous learning and improvement, and transparency and patient engagement. One of our observations in writing this chapter was that there are surprisingly few data that demonstrate the superiority of academic health centers in the care of patients. That gap provides an opportunity, however, for academic health centers and health services researchers in academic health settings to, in essence, prove how good they are.

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