The Transformation of Academic Health Centers

Meeting the Challenges of Healthcare’s Changing Landscape

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UC Davis 2015
What underlies an academic health center?

An academic health center is committed to aligning patient care and academics in order to achieve the “virtuous cycle”
The “Virtuous Cycle”

The clinical and academic missions support each other and make each other better.
AAHC represents:

• The evolving senior leadership teams of academic health centers

• All of the health professions and other academic health center-wide components

• Where the “center of gravity” of health care is moving
AAHC’s focus issues

- Organization and Management
- The Health Workforce (including IPE/IPP)
- Leadership
- Metrics and Benchmarking
- Social Determinants of Health
- Globalization
- THOUGHT LEADERSHIP
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Common goals of academic health centers

• Restructuring health professions education to meet changing and evolving societal needs
• Linking research to improved health outcomes
• Transforming patient care based on population needs and priorities

- This is a worldwide trend -
AAHC International

• Founded in 2008
• 40 members and growing
• Powerful opportunity for information sharing, networking, and building programmatic relationships
Opening 4 regional offices this year

- Doha, Qatar
- Maastricht, The Netherlands
- Manchester, UK
- Singapore
A sample of recent/upcoming meetings

**AAHC**

- Social Determinants of Health, March 9-11, 2014 Wash DC
- Senior Administrative/Fiscal Officers, July 10-12, 2014: Adaptation
- Annual Research Meeting, Dec 3-5, 2014: Genomics and the Frontiers of Health Science

**AAHCI**

- East Asia Regional Meeting, Seoul, November 20-21, 2014: Changing Patterns in Health professions Education
- AAHC International Forum, Washington, April 20-21, 2015: Health Professions Education in a Globalizing World
- Latin America Regional Meeting, Bogota, Columbia, June 11-12, 2015: Academic Health Centers: Aligning Education, Research, and Patient Care
- China Regional Meeting, Beijing, Oct/Nov, 2015
How our members are transforming themselves
Our members’ dominant concerns

• Clinical market consolidation
• Clinical funds flows
• Research funding
• Leadership transitions

- 7 things AAHC is doing to help -
AAHC is supporting members to:

1. Decide on the best “mission-balance” for the institution
   • Emphasizing those areas where the institution can make the most difference and greatest contributions
   • Budgeting accordingly
The result: “a clash of the horizontal and vertical forces”
Vulnerabilities

• High reliance on clinical margins to support the missions because:
  – Education is not profitable
  – Research is not profitable

• Unclear accountability measures so efficiency is hard to measure

• Leadership conflicts (e.g., University, Deans, Hospital, Health System, Departments, Institutes, Centers, etc.)
These vulnerabilities are increasingly unsustainable

The current and coming environment is forcing changes in the ways universities and health systems operate:

– Making internal inefficiencies unaffordable
– Pushing the seamless integration of academics and health care in new ways
Here is our existential problem with culture and programmatic change

“Institutions [and individuals] seek to preserve the problem to which they are the solution.”

- Clay Shirky
Some results from our member profile survey

- 41% are undergoing major expansions of their hospital or physician network
- 37% are embarking upon large scale cost-reduction initiatives
- 36% are opening a new health professions school or new branch campus
- 31% are changing their governance structures or significant reporting relationships
AAHC is supporting members to:

2. Prepare for the era of no more open-ended funding

- Developing methodologies and tools to assess efficiency, especially in those areas chosen for emphasis
  - E.g., Determining what is meant by research, education, and administrative FTEs
- Establishing how much an institution is willing to invest in both current and new areas and gauge how to account for optimization
Example of research: 
A confluence of disruptive factors

• Socio-Political
• Economics
• Rise of “Team Science”
• Management of huge data sets
• Democratization of information
  – Crowd-sourcing
  – What constitutes a clinical trial?
  – Ultimately, who “controls” research?
Research economics

External grants and contracts are the largest funding source for U.S. medical schools

Composition of Medical School Funding Sources

- Grants & Contracts: 33%
- Other General Funding*: 20%
- Tuition: 15%
- Government Appropriations: 11%
- Clinical Transfers: 11%
- Indirect Cost Recovery: 7%
- Endowment: 3%
On average, 35% of total research expenses are funded by U.S. medical schools with **internal funds**

(95% confidence interval of 27%-42%)

Note: Internally funded research expenses are academic expenses attributable to research that are NOT funded externally (e.g., sponsored research, government appropriations).
Multiplier Effect: For every $1.00 increase in research expenses funded by external grants & contracts, U.S. medical schools pay an additional $.52
New cost structure for research needed
Is the single-lab, R01 funded PI a dinosaur?
AAHC is supporting members to:

3. Develop an integrated, interprofessional vision

• Improving internal interconnectivity at all levels to capture the combined power of your components
• Shifting the operations and leadership of the academic health center from a highly siloed enterprise to an aligned organizational structure
• Developing networked and interconnected consortia with other institutions on a national and international basis
Distribution of schools for AAHC members

Inclusion and shared governance, by health professions school

- Medicine
- Graduate Studies
- Nursing
- Public Health
- Pharmacy
- Allied Health
- Dentistry

Source: AAHC 2013 Member Institution Profile Survey preliminary data (N=68), subject to change when analysis is finalized.
Clinical income stream opportunities

% of faculty compensation for clinical activities

- Medicine
- Allied Health
- Dentistry
- Pharmacy
- Nursing
- Public Health
- Graduate Studies

Ratios of faculty compensation for education to faculty compensation for research

Reliance on external grants & contracts

% of Academic funding from grants & contracts and general funding

Developing education innovations

- Electronic/digitized education platforms
- Designing and executing interprofessional teaching in a sustainable fashion
AAHC is supporting members to:

4. Broaden their perspective

- Actively incorporating disciplines previously viewed as external (e.g., engineering and business management) as core healthcare disciplines to facilitate health system change
- Our meetings often feature presenters from other fields
AAHC Response to IOM

• GME reform must be considered in the context of national health workforce policy
  — Not in isolation

• National health workforce policy must be driven by what makes sense for the future of health care
  — Not what is desirable for a particular discipline or industry
“Simply adding more doctors to the current mix is not a thoughtful solution to workforce challenges.”

Factors that are generally overlooked in the GME discussion

• Impact of the professions outside of medicine
• The new physics of patient care
• Effect of machines
• The evolving payment system

AAHC is embarking on a series of “regional roundtables” to determine if there is a consensus on GME reform
AAHC is supporting members to:

5. Adapt their business models to the operational implications of the changing clinical care delivery and payment systems

• Emerging new models of patient care

• Changes in the payment system
Impact of disruption on patient care

- Care is moving from a fixed setting to wherever the patient may be
- *Real-time* continuous monitoring of patients
- *Big clinical data sets*: how to manage and operationalize them
- The Pandora’s Box of technology and new entrepreneurial income streams
- Patient empowerment
- Shifting from provider control to “crowd control”
What’s being created:

The new “physics” of patient care

\[ E = mc^3 \]
E = mc³

The Emerging model of healthcare, where:

- m = the population, both individually and collectively
- c³ =
  - c¹ = care anywhere
  - c² = care in teams
  - c³ = care by large data sets

a. Inspired by Eric Dishman’s Ted Talk at
   [http://www.ted.com/talks/eric_dishman_health_care_should_be_a_team_sport.htm](http://www.ted.com/talks/eric_dishman_health_care_should_be_a_team_sport.htm)
Care in large data sets (c³)
**The Technology Tsunami**

- Collections of huge meta-data sets are becoming standard for patients, eventually leading to continuous monitoring
- A new interpretive and functional infrastructure is required to manage this data
- Locus of decision-making is shifting
But what will the payment models look like?

• Short-term: Some kind of Blended/Hybrid model
  – PMPM with FFS carve outs
  – Shared savings (for ACOs)
  – Partial capitation

• This changes the incentives and care delivery models

• Raises the important issue of *Taking Risk*
Is there a best way to pay healthcare providers?

“There are many mechanisms for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary.”\(^1\)

1. Robinson JC. Theory and Practice in the Design of Physician Payment Incentives. Milbank Q 2001;79 (2)
AAHC is supporting members to:

6. Address health beyond clinical care

• Shifting view of mission from management of individual patients to management of community and population health (locally, regionally, nationally, and globally)

• Risk will be assumed either directly or through networks

• Risk goes beyond the cost and quality of individual procedures
“Risk” demands that we

Increase consideration of the patients’ environment in all mission areas

• Our patients are immersed in an environment dependent on a cascade of social determinants

• Health occurs where our patients

  ** Live ** Learn ** Work ** Play **

• The “5,000 hours” issue
Total health, social service expenditures for OECD countries

Expenditures as % of GDP

Source: OECD Health Data 2009 (Accessed June 2009); OECD Social Expenditure Dataset (Accessed Dec 2009); Health and Social Service Spending; Associations with Health Outcomes Article by Elizabeth Bradley, Ph.D., Benjamin Elkins, MPH, Brian Elbel, Ph.D.
1.1.3. Life expectancy at birth and health spending per capita, 2011 (or nearest year)


StatLink  http://dx.doi.org/10.1787/888932916040
Ratio of social expenditures to health expenditures

“The ratio of social expenditures to health expenditures was significantly associated with better outcomes in infant mortality, life expectancy and increased potential life years lost...”

AAHC is supporting members to:

7. Find the right leaders for these “complex inventions” that require the highest level of leadership to be successful
Why is it hard to find the right leaders?

• Leadership is often opaque

• The problem of the “accidental leader”

• Search committees and decision makers tend to focus on academic skills as opposed to leadership skills
## Academic skills vs Leadership skills

<table>
<thead>
<tr>
<th>Academic</th>
<th>Leadership</th>
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<tbody>
<tr>
<td>• Intellectual capacity</td>
<td>• Emotional intelligence</td>
</tr>
<tr>
<td>• Narrow knowledge base</td>
<td>• Broad range of interests</td>
</tr>
<tr>
<td>• Strong work ethic</td>
<td>• Strong work ethic</td>
</tr>
<tr>
<td>• Highly self-motivated</td>
<td>• Highly institution-motivated</td>
</tr>
<tr>
<td>• Gets individual results</td>
<td>• Gets institutional results</td>
</tr>
<tr>
<td>• Rises up the academic ladder</td>
<td>• Manages 360</td>
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We need to do a better job of developing and supporting leadership

- Demystifying organizational administration
  - Show people what you do and how you do it
  - Be transparent in decision-making and management
  - Succession planning
Successful Leaders

• The truly transformational leaders I’ve met engage others around them

• They have the capacity to take their ego out of the job, and bask in the reflected glow of the professionals with whom they work

• They deeply appreciate, admire, and give credit to other people...
Some AAHC Products and Publications
In closing...

The path forward for academic health centers:

1. Achieve “mission balance”
2. Adjust to changing funding streams
3. Develop an integrated, interprofessional vision
4. Broaden its understanding of what it encompasses
5. Adapt its business models to changing health care delivery and payment systems
6. Address the social determinants of health
7. Find the “right” leaders
An academic health center will be well-positioned for success if it:

- Functions as an organization that aligns academics (teaching and research) with the care of patients
- Focuses on the next generation of education, research, and patient care
- Has the transformational leaders to change culture and behavior
Thank you

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Leading institutions that serve society

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