Change Comes to the Organization of Academic Health Centers

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Roger J. Bulger, MD, President and CEO of the Association of Academic Health Centers (AAHC), presented the keynote address at the 1998 American Association of Colleges of Pharmacy (AACP) Academic Management Symposium. Drawing upon a year-long study on the changing organization of academic health centers, he addressed its implications for Colleges of Pharmacy. The concepts that were presented in the AAHC Report have specific relevance for all institutions that educate health professionals.

Bulger noted that most academic health centers have come to recognize that educating competent health professionals in academic isolation from their student colleagues, and in clinical settings organized along outmoded delivery patterns is no longer acceptable. The AAHC report dwells less on the evolution of the health care marketplace and more on the need for centers to concentrate on their core missions: education, patient care, research and service to the community. In his remarks, Bulger emphasized that managed care organizations, on behalf of patients, are demanding a seamless transition of services across the spectrum of preventive, curative and chronic health care. These organizations have the expectation that health profession students will learn to collaborate with their colleagues while providing optimum care with the patients’ best interest as a primary focus.

Large purchasers of health care are concerned that the costs of care provided in academic health centers are too high and that students are not being prepared to collaborate with colleagues in the provision of the seamless care that patients need. The AAHC study addressed this critical issue by identifying those characteristics prevalent in centers that have successfully reorganized. The study revealed that these academic health centers were oriented toward the center’s goals and objectives rather than toward individual disciplines, schools or professions. In these academic health centers, institutional reconfigurations defined, in detail, the ownership, governance, leadership, organization and financing necessary to efficiently manage the center’s core missions. Their change strategies focused on targeted priorities linked directly to resource allocation and reward systems. Benchmarks and performance metrics in core mission areas addressed cost concerns and the demands by external constituencies for accountability. An information infrastructure that generated appropriate efficient information transfer was crucial for management of the planning, resource allocation, tracking, coordinating, outcome’s evaluation
and decentralization activities in the reintegrated academic health center.

The report commissioned by AAHC, noted that most academic health centers are altering the programs and structures of their schools and clinical facilities in order to achieve their societal potential while insuring their financial solvency and guaranteeing their long term survival. There was no single evident format but certain common elements emerged. The change strategies chosen by successful individual centers were a function of their institutional history, culture and mission as well as the local circumstances and characteristics of their parent university. These changes involved deep cultural shifts, however, altering the roles of leaders at all levels, with enormous impact on faculty who hold closely held traditions! The report suggests that a successful change process would bring about the following transformations. Integration and scale forces departmental chairs to share power with new leaders charged to direct the academic health center’s education, patient care, research and community service core missions. Discipline-based faculties become members of interdisciplinary teams addressing the core missions of the center. The resulting reintegration at the academic health center level was designed to create improved levels of patient care, health profession education and research. For these changes to succeed there must be a strong shared vision by both administration and faculty of the academic health center’s goals and priorities.

The AAHC study also observed that higher education, in general, and education in health care disciplines, specifically, was experiencing the same change forces that are buffeting health care delivery. Society’s concerns about cost, quality and access to education are leading to demands for accountability, active student-learning and evaluation of outcomes. The public perceives that the importance of education has been devalued by the dominance of the patient care and research missions in academic health centers. In addition managed care organizations are forcing change in the health care delivery system based on their belief that the health care needs of an aging, and increasingly diverse population can most effectively be met when there is cost effective collaboration across the health professions and related social support systems. However, despite the growing shift to health care delivery by integrated interdisciplinary teams, in academic health centers there is little emphasis on interdisciplinary student education. This is certainly an area of concern for all of us.

Faculties in academic health centers emulate the traditional role models that they followed during their own training. They have been slow to adopt advances in information science which facilitate efficient information transfer in both synchronous and asynchronous distance learning. The clinical education needs of allied health, dentistry, nursing, and pharmacy students are frequently considered when medical school mergers and partnerships are being planned by academic health center leadership. As fiscal resources decline and pressures for accountability rise, it becomes increasingly necessary for the academic health center to change the manner in which education, patient care and research are conducted. This may require pursuing new venue alliances. The academic health center must develop a business plan for each of its core missions of education, research and patient care.

The education business plan must incorporate ongoing and consistent cost analyses of each health profession discipline in order to demonstrate a satisfactory return on the investment. There must be an emphasis on interdisciplinary education which fosters development of team skills, challenge stereotypes and erodes barriers between professions. If quality teaching is to be valued and rewarded, then there must be major changes in faculty incentives and reward structures concurrent with development of education quality benchmarks. Faculty performance reviews must be linked to income generated or productivity by core mission areas. All students at every level in each health profession must be mentored in order for graduates to be well prepared and have realistic expectations about their careers. Appropriate educational integration across disciplines, across specialties and across professions must be encouraged and financially rewarded if the outcome of seamless patient care is to be efficiently delivered by interrelating collaborating professionals. Strong integrated advocacy must ensure that technology transfer also occurs in educational innovations, not just in research innovations.

The academic health center’s research portfolio should be consistent with its culture, resources and mission. Ownership of the research enterprise clearly rests with the university and is best led by an individual who has the trust and respect of the research community. There must be a university-wide interest in the time-honored values of learning, investigation, and social responsibility. Care should be taken to protect and preserve the encouragement of faculty creativity in the discovery of new knowledge. The growing academic participation in industrially-funded research, however, increases conflict and may compromise the traditional academic values of free communication and intellectual capital. Nationally, basic biomedical and clinical research activities are increasingly concentrated in as few as 30-40 institutions. These research intensive centers require large capital investments of financial and human resources. Opportunities, however, exist for other academic health centers to conduct important research on health services, health policy and health profession education that do not require large capital investments. Further, research in educational technique, outcomes and innovation must become a mainstream institution core mission.

It is essential, under any circumstances, for the academic health center’s research core mission to be integratively coordinated and managed. A research business plan must be established which identifies the individual activities to be managed. These activities might include basic laboratory research, clinical research, large scale clinical research, product development, health services research or clinical evaluative services. Similarly research support activities such as information systems, financial, space and personnel management must be organized to be cost-conscious and mission oriented. Biomedical research is increasingly collaborative in nature bridging departmental as well as school boundaries. New mission oriented interdepartmental and cross-school centers and institutes will likely reflect this reality. Compensation for faculty in research roles must be collaboratively linked to achievement of mutually agreeable research goals. The research business plan must also ensure that the center’s electronic infrastructure is reconfigured to incorporate the necessary compliance and accountability elements but be capable of interfacing with the financial information system.

The patient care core mission needs a patient care business plan. The reality of the marketplace forces academic health centers to compete on the basis of cost in order to sustain a patient base adequate to the needs of the educational programs. Unless sound business principles are applied to the structure and management of these patient care services, the academic health center is unlikely to be a successful competitor in health care delivery. It is essential that the patient care enterprise build on appropriate service line consolidation, effective case management, and sustained attention to customer satisfaction but with sufficient flexibility to meet the changing requirements of large managed care payers. There must be a genuinely seamless interdisciplinary group practice oriented to the success of the entire academic health center. Department or division-based faculty practice plans must be unified to focus on the strategic priorities of the core missions with centralized governance and financial management.

If centralized governance, financial management and seamless interdisciplinary group practices cannot be implemented within the academic health center, it may be necessary to separate the patient care facilities from the parent university and seek new alliances. This can produce a tension between the resulting organizations and the university. This may be due to the alteration of power between the CEO of the academic health center and the president of the parent university. It may also be due to the loss of hospital subsidy for university support systems. Special attention must be directed to the complex issues of organization culture to
assess the degree of congruence or conflict between the academic health center and its potential partners.

There must be a strong organizational balance of the partners to ensure that appropriate attention is directed to education and research. The resulting governance structure bridges the interface between academic and clinical delivery of patient care. Before partnership agreements are signed, realistic and thorough due diligence appraisal of potential consequences should be undertaken to minimize possible adverse effects. Academic health center leadership should not underestimate the leverage clinical research can provide in crafting a clinical partnership, particularly if the center’s focus is on basic science research. Patient outcomes and health status markers for the whole population, including proper surrogate measures for desirable results of care, are at the core of a proper evaluation system to manage the interface between the educational and the patient care systems. Successful partnering requires a relationship between clinicians, faculty and administration that ensures the present and future quality of student learning and the care of patients in a climate for discovery.

The AAHC report notes that the relationship between the academic health center and its community — city, state, region — is crucial as the transformational change, described earlier, is taking place. Perception of how well the academic health center serves the critical health needs of the local community has greater political impact as resources are constrained. The community can influence the center’s ability to create alliances, increase cost effectiveness, reshape the workforce, introduce new products, modify class sizes or the composition of health profession schools. It is in the academic health center’s best interest to promote greater public understanding of the relationship of basic and clinical research to innovations in patient care. This will also facilitate consistent levels of public funding. Special academic health center expertise in public health, community and family medicine, epidemiology, community and public health nursing, pharmacy and dentistry can be focused on community health needs. They can also be used to track population measures of health status, and develop health promotion and disease prevention programs in conjunction with community and public health agencies. With the shift of health care practice to ambulatory settings, academic health centers are increasingly reliant on such affiliations and other relationships with a broad array of community providers, both institutional and individual. For example, the Veterans Affairs clinical facility is an increasingly important partner for health profession schools as cost constraints continue to encroach on the academic mission. To ensure that the VA and other community partnerships are well-served by the academic health center, a central office is often created to coordinate and manage them. A separate international office may be necessary to address institutional relationships and activities.

How does the Association of Academic Health Center’s Report apply to Colleges and Schools of Pharmacy? Pharmacy schools must, like our colleagues in academic health centers, separate and then reintegrate the core missions of education, research, patient care that provide service to our local communities. This can best be accomplished in each academic institution by creating and maintaining an action-oriented business plan for each of these core missions(I). Partnering can occur with the full range of participants who use the health care system—consumers, payers, employers and other providers of care.

During the 1998 AACP Academic Management Symposium, a variety of very successful partnering with practice models were illustrated. The mission of pharmacy practice is to provide pharmaceutical care. This provision of care does not exist in isolation from other health care services. It is produced in collaboration with patients, physicians, nurses, and other health care practitioners (2). To be successful schools must develop faculty practice plans that reward productivity in partnering which fosters the goals of the business plan. If necessary, the faculty practice plan can later be integrated into the academic health center’s faculty practice plans. The opportunities for partnering with practice sites have never been more necessary. Strong and visionary leadership, well informed and flexible governance, and motivated administrators and faculties are all essential if schools are to successfully reintegrate their education, research and patient care core missions in new mutually beneficial community alliances. It is our future and the future of our students and we must be active aggressive participants. The old way is just not relevant in the contemporary environment.

References