PERSPECTIVE

BY **Steven A. Wartman**
MD, PhD, MACP
AAHC President / CEO

One of the most important challenges for academic health center leaders is figuring out how to change organizational culture. Leaders are generally acutely aware of exciting possibilities and external pressures facing their institutions, but they often struggle to bring about the behavioral and organizational changes necessary to take advantage of potential opportunities and to overcome threats. In this regard, this issue of *Leadership Perspectives* highlights three insightful points of view by leaders who are deeply involved in adjustments being made to their institutions' organizational cultures.

Giuseppe N. Colasurdo, MD, president, The University of Texas Health Science Center at Houston, describes his institution's transition in building a significant, community-wide presence. In addition to driving revenue and clinical services, he points out that the more than 100 community sites present opportunities for new learning paradigms for students as well as providing leadership in the development of new models of care.

At Virginia Commonwealth University, vice president for health sciences and CEO of the VCU Health System Marsha D. Rappley, MD, notes that organizations that can align culture, purpose, and strategy will be positioned to drive productivity into the future. She cites the inherent tension between business and academic models, and concludes that finding the right blend of the two approaches is the best way to mission fulfillment.

Helena Teede, MBBS, PhD, FRACP, executive director of Monash Partners in Melbourne, Australia, focuses importantly on the inherent competitive nature of research, commenting that research systems are innately designed to perpetuate competition at the expense of overlooking collaboration, translation, and opportunities for impact. She describes the newly established Advanced Health Research and Translation Centres and Centres of Innovation in Regional Health that are based on the premise that healthcare improvement through research and translation is not a competitive space.

Taken as a whole, these three essays provide an excellent overview of how academic health centers are taking on the future. The themes of competition and collaboration are driving much of what our organizations do, whether in the clinical or research fields. I concur with the authors that adjustments in institutional organizational cultures are essential to future success. The key, as I have noted many times, is having the kind of transformational leadership necessary to bring about the needed strategic and behavioral changes, something that search committees for new leaders need to put on their front burners.

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1400 Sixteenth Street, NW, Suite 720
Washington, DC 20036
202.265.9600

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LEADERSHIP PERSPECTIVES

Adjusting to and Adjustments Within the Academic Health Center Organizational Culture

Giuseppe N. Colasurdo, MD
PRESIDENT
ALKEK-WILLIAMS DISTINGUISHED CHAIR
The University of Texas Health Science Center at Houston (UTHealth)

Marsha D. Rappley, MD
VICE PRESIDENT FOR HEALTH SCIENCES AND CEO OF THE VCU HEALTH SYSTEM
Virginia Commonwealth University

Helena Teede, MBBS, PhD, FRACP
EXECUTIVE DIRECTOR
Monash Partners, Australia

MARCH 2018
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Giuseppe N. Colasurdo, MD // *President, Alkek-Williams Distinguished Chair*

The University of Texas Health Science Center at Houston (UTHealth)

Academic healthcare is inherently competitive—for the best students and faculty, for grant funding, for high-value programs. Markets with a concentration of healthcare institutions within a few square miles are highly competitive; such is the case for the Texas Medical Center where UTHealth is based. In these markets, an academic health center's ability to grow and expand its mission is dependent on external factors—such as the local economy and population growth—and its internal culture, adaptability, and strategy.

Traditional academic health systems rarely focus on expansive clinical practices with a network of primary care and community sites. But over the last 20 years, UTHealth, like our peers nationwide, has seen tremendous shifts in funding—with 70 percent of our revenue now coming from clinical activities. Our future, and the future of all academic health centers, is dependent on building and sustaining a large, successful and innovative clinical practice.

To adapt, UTHealth strategically expanded clinical operations. Our faculty historically practiced primarily in the Texas Medical Center and at limited in-patient and out-patient sites operated by our two hospital affiliates. Working closely with our partners, we sought to build a community-wide presence of multi-specialty clinical sites while continuing to fulfill our commitment to both the uninsured and the underinsured. We now operate one of the largest clinical practices in the region. A decade ago, we had two sites; today, we have more than 100.

This shift in strategy significantly impacted our faculty who now travel to provide care in distant communities and often practice without trainees. But it has also given our institution the opportunity to create new learning paradigms for our students and to lead in the development of new models of care. For example, our stroke care experts now utilize complex care teams, including robots, to provide live diagnosis and treatment to patients across the state. This is the new standard for high-quality care delivery: the best care, anywhere and at any time.

The growth of our clinical practice underpins the overall growth of our institution. Models and funding sources may change, yet the primary responsibility of academic health centers remains the same. We attract the best and brightest faculty and students, train tomorrow's healthcare workforce, discover new treatments and cures for disease, and provide the best care to the sickest patients in our community and beyond—while maintaining the focus on patient-centered care, comparative effectiveness research, and precision medicine that are the hallmarks of today's academic medicine.

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Marsha D. Rappley, MD // *Vice President for Health Sciences and CEO of the VCU Health System*

Virginia Commonwealth University

The academic health center culture is deeply rooted in a commitment to education, research, and the service and experience we provide for our patients. It is in our best interest to sustain a unified culture that supports the wide range of activities we undertake. This is even more critical in an era when resources are scarce. Organizations that can align culture, purpose, and strategy will be positioned to drive productively into the future. Otherwise, they risk squandering their energy on relatively inconsequential challenges.

Classic cultural tensions and conflicts often arise that test academic health centers. One such tension is between the corporate and academic sides of academic medicine. The corporate side has a tremendous obligation to serve citizens in our communities. The academic side has an equal obligation to our learners—who look to us to provide the best career path in healthcare—and to conduct research that can change lives.

Another inherent tension between the academic and corporate sides of the house is that the former may prefer a more methodical approach to change while the latter might be motivated to move more quickly. Often, neither approach alone is the right solution. You cannot have relentless, impulsive execution. That leads to chaos. Neither can you have excessive processing, because that leads to complete paralysis. The challenge for us is to blend the best of both cultures to enable us to fulfill our mission.

Threats to the cultural equilibrium also arise in the ongoing debate about the content of the curriculum across the health sciences. One issue concerns what constitutes the appropriate balance between teaching learners basic knowledge and imbuing them with the changing practical skills that health professionals need to know, e.g., in quality studies and population health. Too often, our answers to questions regarding curriculum are not rooted in what is best for the patient and learner, but default back to preserving traditional ways of training and familiar systems without really assessing what is the best path forward.

I think the role of organizational leaders is to simultaneously bring the focus back to what unites us while also focusing intentionally on a horizon that looks beyond our day-to-day challenges. Most of us came to this work to contribute to the greater good, so it is critical that we find ways to sustain a culture that enables us to collaborate effectively while we pursue our broad mission of improving people's lives.

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Helena Teede, MBBS, PhD, FRACP // *Executive Director*

Monash Partners, Australia

When our healthcare system works sub-optimally or research fails to translate into practice, systems-level barriers are often to blame. These barriers can be embedded in the academic health center institutional culture, and as leaders we need to identify and address them.

One inherent systems barrier is our highly competitive research culture. We compete around performance metrics, including grant income, publications, or rankings, as indicators of success; and our research systems are innately designed to perpetuate competition, overlooking collaboration, translation, and opportunities for impact.

Whilst a competitive model can promote research excellence, it may not be suited to address our large, pervasive healthcare problems. A different model—a disruptive collaborative model—can integrate research and healthcare and address our large-scale health system problems, recognizing that collaboration, sharing, and translation are vital.

Around the globe, we are seeing intentional disruptions of systems to enhance collaboration. In the UK, a significant component of university funding is linked to research impact. Research metrics in the National Health Service are changing behaviors, priorities, and fueling collaboration. The health system seeks research partnerships. Responsible to new accountability around research integration, universities have incentives to partner for impact. These systems-level changes shift the focus from competition to enabling collaboration, especially around healthcare improvement, research, and translation.

In Australia, newly established Advanced Health Research and Translation Centres (AHRTC's) and Centres of Innovation in Regional Health (CIRH's) are health service led, determine priorities, and co-design collaborative research for impact in prioritized healthcare issues. The Centres have come together in a national Alliance (The Australian Health Research Alliance) *under the premise that healthcare improvement through research and translation is not a competitive space*. Unprecedented collaboration has followed with government funded national initiatives integrated across research, healthcare, and workforce capacity building, reaching across the nation. This represents a dramatic paradigm shift from highly competitive investigator initiated research to strategic prioritized collaborative research that is impact focused. The Alliance covers all Centres nationally, 95 percent of the health and medical researchers and 75 percent of acute health services nationally and can provide a single voice to government.

The Alliance enables us to start addressing big challenges collaboratively and strategically rather than competitively, and it is proving to be a powerful driver of cultural change. It encourages strategic prioritization of research and translation and scale-up of new knowledge. There is much still to do, but progress is being made.

> "A different model—a disruptive collaborative model—can integrate research and healthcare and address our large-scale health system problems..."