PERSPECTIVE

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The management of academic health centers has become increasingly complicated in recent years. Changes in the healthcare market, financing and cross-subsidization, research funding, philanthropy, education, policy, and scientific and technologic advances are sweeping like a tsunami across our member institutions. And, all this is taking place against a backdrop of the day-to-day challenges of managing institutions of growing complexity.

Most academic health center leaders were trained in the "traditional" way: climbing the academic ranks through the development of a specialized expertise or other singular focus. They directed divisions, departments, institutes, or served in some capacity at a decanal level. But nowhere in their training do they gain the kind of experience that prepares them for today's leadership challenges.

This issue of *Leadership Perspectives* focuses on a critically important aspect of today's academic health center leadership: the need to create alignment amongst an institution's various components. This, in some respects, is the field's greatest challenge—and perhaps the answer to future success.

Randolph Hall, PhD, vice president of research at the University of Southern California, notes that the "unique challenge for academic health centers is the complexity of balancing and aligning the diversity of operations at a university that has health programs." He also presciently comments that what works in one institution is not necessary what works in all institutions.

Dan W. Rahn, MD, chancellor of the University of Arkansas for Medical Sciences, comments that the "value at UAMS lies in the interrelationships between the different components of our mission." He describes an institution-wide effort around a series of guiding principles that promote overall alignment and system-wide planning and allocation of resources.

One commonality that exists between a private institution (USC) and a public institution (UAMS) is their participation in the Association's ***Aligned Institutional Mission (AIM) Program***. The AIM Program, having successfully completed its Developmental Phase, has moved into the Pilot Phase with eight member institutions, with plans for a full roll-out to members in 2018. It is not a one-size-fits-all endeavor or any kind of an accreditation, but rather a highly individualized program that is based on a given's institution's particular goals and stage of development. It consists of an institutional self-study, an in-depth visit by highly experienced former academic health center leaders, and a follow-up period. Participating institutions have commented that the AIM process was critical in facilitating discussions and developing an action plan.

I'm convinced that the key to success for academic health centers in the 21st century rests on their ability to do what no other type of organization can: capture the synergy resulting from the optimal alignment of education, research, and patient care to create a true learning health system. It is imperative for academic health center leaders to create the environment where such a process can take hold.

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LEADERSHIP PERSPECTIVES

Challenges and Achievements in Mission Alignment

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MAY 2017
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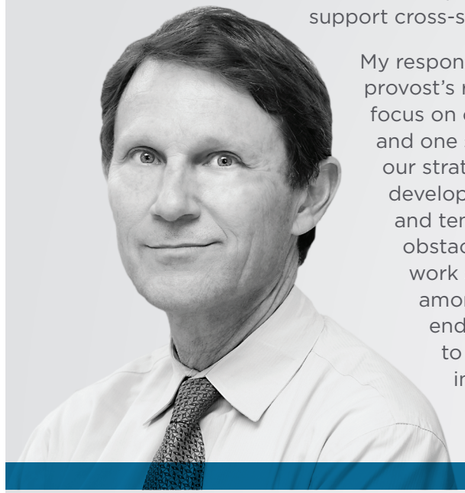
In mission and institutional alignment, a critical caveat to note is that what works in one institution is not necessarily what works in all institutions. At USC, there is strong academic alignment across the university. Because we do not isolate organizationally the medical school or the health science campus from the rest of the university, we have a diverse set of health-focused programs in many schools that support cross-school interaction and innovation.



My responsibility for research and the provost's responsibility for faculty affairs focus on one university, one set of policies, and one set of resources. A key part of our strategy for alignment has been developing guidelines for promotion and tenure that explicitly do not create obstacles for appointments. Faculty work seamlessly with each other among the different schools. To that end, we have processes in place to support joint appointments of individuals across the schools. A faculty member may hold appointments in different schools. That alignment also extends to collaborative decision-making among administrators, which is designed in part to help ensure strong connections.

We have also designed information technology systems for both health science and non-health science programs that support the operations of the university broadly. That means that across the university we have an IT platform that links components such as proposal submissions, awards management, and compliance with regulations.

To achieve financial alignment, as well as organizational alignment, we are developing a single financial system that spans the clinical health enterprise and the entire academic enterprise. Our goal is to become more seamless in managing school and clinical program finances. We want, for example, to have a single way to get reimbursement for general ledger and billing. Because there are somewhat unique requirements for a clinical enterprise versus an academic enterprise, I don't think many institutions have tried this kind of alignment. But for us, we think this is the right way to go, and having such a system within the next three years is a strategic objective of the university.

One of the particular challenges we face is the sheer size and complexity of our institution and balancing the interests of internal and external stakeholders. We're a $4 billion-plus operation. Our very large revenue stream for clinical care comes not just from the system that we own but also through our affiliations with the LA County Department of Health Services and Children's Hospital of Los Angeles, with whom we must work very closely. We also have an extremely large education program, with some 42,000 students and a very large graduate program. In addition, we have a $700 million research enterprise, which has tremendous diversity across disciplines. Other factors that add to the complexity of our situation include our significant work in community outreach.

Putting that all together, there are many issues to think about that are quite different from each other. It's a challenging job to keep all those balls juggling in the air for a large, diverse institution. This unique challenge for academic health centers is the complexity of balancing and aligning the diversity of operations at a university that has health programs. We are not just a college that primarily focuses on one singular education product line.

Toward the goal of institutional alignment, USC recently participated in the **AAHCI Aligned Institutional Mission (AIM) Program**. While we regularly assess parts of our operations, particularly through accreditation reviews, we had not done a self-assessment spanning the institution. The AIM review was invaluable in that it forced us to look concertedly at the connections across the university and between the pillars of research, education, and the clinical enterprise to develop a vision of collaboration, particularly in inter-professional education.

I firmly believe it's important for an institution to consider these big questions. Undertaking a thorough institution-wide self-assessment and external review can be extremely valuable.

Dan Rahn, MD // *Chancellor*
University of Arkansas for Medical Sciences

The University of Arkansas for Medical Sciences (UAMS) is a public health sciences university. Our health system is a component of the university with the clinical, education, and research missions all under the umbrella of the university. Knowledge creation and its translation to new approaches is the glue that holds the academic center and health science university together.

We believe that alignment of the discovery process with the education and clinical programs is the engine for innovation and for health system change. Our value at UAMS lies in the interrelationships between the different components of our mission to educate and train the next generation of health professionals for the state and the region, as well as provide preventive care through specialized services that are not available elsewhere. Accordingly, we sought to create a business model that would underpin our value and align incentives so that everyone would be focused on these broad objectives.

Historically, the university had been divided into several dozen different budget units. That fostered the creation of silos and made it difficult to invest programmatically in the highest priorities for the institution overall, across all mission areas. To change that, we engaged in a comprehensive process focused on creating alignment across the whole institution.

Our work coalesced around several guiding principles: ensuring that subsidies promote mission-based initiatives and do not inadvertently reward underperformance; creating an organizational structure that supports shared decision-making and shared accountability; establishing incentives that promote entrepreneurialism while aligning individual success with that of the overall system; maximizing the value created by the entire system rather than that created by individual components; prioritizing investments strategically; and promoting transparency by minimizing the complexity of funds flows. We also sought to create a model and information infrastructure that supports a gradual shift to an at-risk reimbursement paradigm in the clinical arena.

To operationalize those principles and strengthen alignment, we decided to fundamentally redesign our funds flow. Across the whole institution, we adopted an activity-based budgeting model. After projecting total institutional revenue, we apportion our revenues to support operations while reserving an amount for strategic investments. We budget spending authority to each unit and monitor performance against the budget across each unit on a monthly basis.

We integrated professional revenue and expense and hospital and clinic revenue and expense into a single revenue cycle management structure and a single bottom line. There no longer is a group practice as a separate entity from health system operations. It's a truly integrated clinical enterprise. To fully align physician incentives with those on the institutional provider side, we redesigned the clinical system into patient-centered service lines. Led by a physician who reports up through a chief clinical officer to the health system CEO, each service line has its own budget—but service lines do not retain margins.

We are halfway through our second year of this new model. The wholesale redesign of institutional funds flow has enabled us to align resources with the highest priorities institutionally, regardless of the source of the revenue. Now, anybody with an important and good idea has access to total institutional resources, not just what they generate within their own operating area. To implement this, we had to overcome the myth that units had more flexibility in the past with "their own money"; there really are more opportunities now than before.

We think this approach gives us a handle on how to focus everyone on excellence and cost management on the clinical side, as well as revenue generation. The system prompts physicians to be just as focused on costs as they are on revenue. All of that, we believe, will help us move toward the Triple Aim of higher quality, better patient experience, and lower cost.

When the **AAHCI Aligned Institutional Mission (AIM) Program** consultants visited us last year, it was their assessment that it will take three to four years for this model to mature, but they felt strongly we're on the right path.