PERSPECTIVE

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

Leading an academic health center in today's environment is a task of increasing complexity, and academic health center leaders consistently mention in our conversations the difficulties they encounter in managing this degree of complexity. It is enlightening, therefore, to read the commentaries in this issue on the shifting healthcare environment. Each author discusses a brief overview of their selective challenges. Taken separately, the pieces reflect a cross-section of themes; taken together, they reveal interesting similarities.

Craig Hillemeier, dean, CEO, and SVP for Health Affairs at Penn State University, points out the major priority of growing a robust clinical enterprise. As he notes, building this kind of capacity requires new ways of thinking. He also mentions the need to change approaches to education in the health professions and to develop more patient-centric care.

Brooks Jackson, dean and VP for Health Sciences at the University of Minnesota, stresses the need for integration and collaboration across the various health professions schools, not just in education but also in practice and research. He points out the important influence of state legislators regarding scope of practice, and the need for more integration in the research enterprise and investments in health informatics.

Brian L. Strom, chancellor and EVP for Health Affairs at Rutgers University, focuses on the challenges of integrating two very different practice plans at two medical schools. His goal is to position the clinical enterprise to respond to population-based health and value. He also comments on the ongoing consolidation of health systems, the need for efficiencies, and the ability to have leverage with insurers.

This is but a sampling of the changes the current shifting healthcare environment is inducing. With each passing year, it seems that leaders must invent—and reinvent—strategies to position their institutions to remain paramount and relevant. While there is considerable diversity amongst institutions in the approaches being taken, the trends are clear: academic health centers are doing whatever they can to grow sustainable clinical enterprises and support research.

Regardless of size or geographic location, institutions are creating new structures, partnerships, and funding mechanisms. Complicating the picture occasionally are State Legislatures (e.g., Minnesota as noted above) which change the rules. Another important dynamic in this mix is the growing role of philanthropy with highly focused and often very hands-on donors, as well as the trend of partnering with tech companies (which sometimes co-locate with the new institutes). At this point, there doesn't seem to be one best workable model. The flux and variability, I suspect, will continue for some time.

www.aahcdc.org

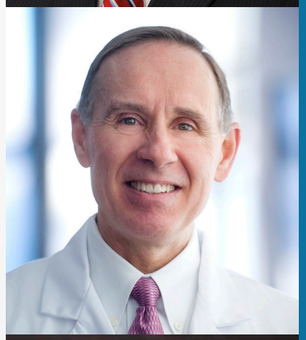
Association of Academic Health Centers®
Leading institutions that serve society
Association of Academic Health Centers
1400 Sixteenth Street, NW, Suite 720
Washington, DC 20036
202.265.9600

ASSOCIATION OF ACADEMIC HEALTH CENTERS

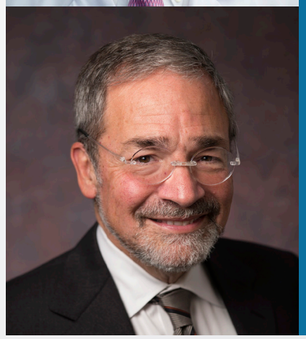
LEADERSHIP PERSPECTIVES

The Shifting Healthcare Environment: Impact on Academic Health Center Models

A. Craig Hillemeier, MD
DEAN, PENN STATE COLLEGE OF MEDICINE
CHIEF EXECUTIVE OFFICER, PENN STATE HEALTH
SENIOR VICE PRESIDENT FOR HEALTH AFFAIRS
Penn State University



Brooks Jackson, MD, MBA
DEAN, MEDICAL SCHOOL
VICE PRESIDENT FOR HEALTH SCIENCES
University of Minnesota



Brian L. Strom, MD, MPH
INAUGURAL CHANCELLOR, RUTGERS BIOMEDICAL AND HEALTH SCIENCES
EXECUTIVE VICE PRESIDENT FOR HEALTH AFFAIRS
Rutgers University

SEPTEMBER 2017
www.aahcdc.org
Association of Academic Health Centers®
Leading institutions that serve society

A. Craig Hillemeier, MD // *Dean, Penn State College of Medicine, CEO, Penn State Health, Senior Vice President for Health Affairs*

Penn State University

Among other changes, the shifting healthcare environment has been an impetus for growth in our clinical enterprise. A decade ago, we were a standalone academic health center in Central Pennsylvania. But driven in part by other medical centers that have started to move into our area, we have expanded our clinical enterprise and community network. And, we have been intentional about building the capacity for people who need the unique care that an academic health center provides to regard us as the best choice, as they can receive high-quality care, close to home.

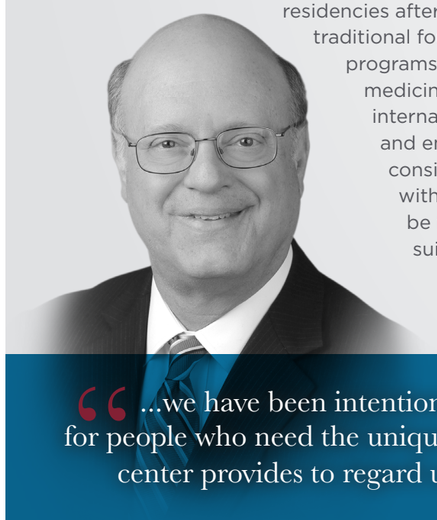
Building that capacity requires new ways of thinking. It also comes with countless inherent challenges. Apart from the need to create governance policies, new management practices, and infrastructure, other considerations include developing alliances, affiliations, and purchase agreements with other physician groups, provider groups, and hospitals. That work takes up an increasing amount of our time and thought processes.

Another trend that reflects the shifting environment in healthcare and links to our work in developing a community network is our growing use of telemedicine. Ten years ago, for example, we did not have tele-stroke capacity. But today, 16 hospitals throughout Central Pennsylvania use telemedicine through our neurology department to care for patients who come to emergency departments with a stroke or other brain injury.

We have also seen fundamental changes in our approach to education in the health professions. One example is a greater emphasis on educating more advanced practice clinicians, including physician's assistants, nurse practitioners, and certified registered nurse anesthetists. That reflects the general trend across healthcare toward more use of these professionals, particularly in primary care.

A corollary trend is reflected in our effort to shift our College of Medicine from focusing essentially on physician-centered care to education that is more patient-centric. We also focus more on a team approach to medicine.

Still another trend in education is establishing pilot programs to accelerate medical education. One goal, for example, is for students to start their residencies after three years of training versus the traditional four years. To that end, we have formal programs underway in family and community medicine, and are considering programs in internal medicine, orthopedics, neurosurgery, and emergency medicine. An overall consideration is to help students graduate with less debt. Such programs might not be for everyone, but they seem well-suited for some students.



> "...we have been intentional about building the capacity for people who need the unique care that an academic health center provides to regard us as the best choice..."

Brooks Jackson, MD, MBA // *Dean, Medical School, Vice President for Health Sciences*

University of Minnesota Center

The University of Minnesota is home to a very large academic health center with six schools, including medicine, dentistry, nursing, pharmacy, public health, and veterinary medicine, as well as a college of allied health. The major healthcare trend that we are seeing and responding to is an emphasis on integration and collaboration across the schools in terms of practice, interprofessional education, and research.

Legislators in Minnesota have been expanding the scope of practice for disciplines such as nursing and pharmacy. Encouraging all healthcare professionals to practice at the top of their license builds efficiency and quality care. Having health professionals in addition to physicians in our practice plans also enables us to expand and be more competitive in the healthcare marketplace. We are integrating nursing, pharmacy, and dentistry into our practice plan to provide more effective care and more affordable care. The collaboration and co-location creates efficiencies in the way we deliver care and broadens the portfolio of services we are able to offer our patients.

In terms of education, Minnesota's legislature has recently funded a new health sciences education building that will help us better prepare students in multiple disciplines to work and learn together. In our simulation center, for example, teams that might include physicians, nurses, and pharmacists will better reflect the training that health systems expect of our graduates. We believe the value in that kind of practical interprofessional education is extremely important for optimizing patient outcomes.

We are also focused on interdisciplinary and team science. We have been very active in obtaining NIH funding and state legislative support for research in healthcare disparities, which must involve many health disciplines to be effective. We are lucky to have a very strong School of Public Health that includes many national leaders and experts in population health and prevention, as well as the social determinants of health. Their expertise benefits both patient care and our curricula for students across the health sciences.

As an academic health center, we have made major investments in health informatics that can support research through the ability to analyze patient data from the health system. Research into interventions at a personal level or at a public health level will ultimately inform providers as to what prevention or treatment option will have the best results, thereby advancing healthcare.

> "The major healthcare trend that we are seeing... is an emphasis on integration and collaboration across the schools in terms of practice, interprofessional education, and research."

Brian L. Strom, MD, MPH // *Inaugural Chancellor, Rutgers Biomedical and Health Sciences, Executive Vice President for Health Affairs*

Rutgers University

Rutgers Biomedical and Health Sciences is a $1.7 billion-a-year organization with eight schools. Two components of our strategy to move forward in a changing healthcare environment are to consolidate faculty practice plans and to partner with a large health system, shifting the emphasis from volume to leveraging optimal population-based health and value.

We are somewhat unusual in that we have two medical schools. Each has had different faculty practice plans. One school had a single faculty practice plan, designed several decades ago, that had very little financial incentive built in for faculty. The other school had very aggressive faculty incentives, but was organized into 18 functionally separate departmental practice plans.

To provide better coordination, value, and quality while capitalizing on the complementary nature of the two schools, we created one single, statewide faculty practice plan. As we move toward population health, we need to draw more expertise from other health professions, so we also included nursing, dentistry, and our other schools as central participants in that practice plan. Instead of a fee-for-service world in which only physicians can bill, we created a single, statewide, interprofessional faculty practice plan. In essence, we have knitted together component parts of our large entity, including two relatively small medical schools, into a single plan. This new structure means that reimbursement will support the move from volume to value. We believe this model positions us best for going forward as the practice of medicine focuses on population based health and value.

Another significant change comes as health systems in New Jersey consolidate into essentially four major players. One of those entities was created nearly two years ago, Robert Wood Johnson-Barnabas Health (RWJBH), merging two smaller health systems to create one of the ten largest health systems in the country. We have now partnered with RWJBH on several levels. Educationally, RWJBH will open their hospitals to our schools as training sites. (By design, we do not own a hospital.) The partnership will also facilitate efficiencies and better coordination that will enhance the undergraduate and graduate medical education we provide.

From a clinical point of view, we will combine in a way that will enable us to deliver higher quality care to our patients more efficiently, while providing single signature authority in negotiating with insurers. A dozen hospitals and 2,500 physicians will also provide us a clinical scale and fiscal base that will help support the development of true population health. In turn, there will also be a substantial investment from the health system in our research enterprise.

> "Two components of our strategy to move forward in a changing healthcare environment are to consolidate faculty practice plans and to partner with a large health system..."