PERSPECTIVE

BY **Steven A. Wartman**
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If one consults that "definitive source" Wikipedia, politics is defined as the practice and theory of influencing other people, and, secondarily, as exercising positions of governance. This set of definitions certainly rings true for leaders of academic health centers, but how has the art of politics been learned and occasionally mastered? This particularly striking issue of *Leadership Perspectives* vividly demonstrates three approaches to managing the politics of healthcare through the lenses of leaders of very different institutions. It is illustrative of the observation that politics is both local and national at the same time.

Jay Hess, from Indiana University, forthrightly depicts key political challenges: medical expansion, the fallout from the freedom of religion legislation, the expectation of economic development, unrealistic political expectations, and internally-driven issues surrounding partnerships. Some of these challenges were wholly unanticipated; others were outgrowths of long-standing issues. Undoubtedly, all have unintended consequences that need management. He rather understatedly concludes that this is "a very interesting time" in academic medicine. How true!

John Raymond, from the Medical College of Wisconsin, lists six key principles to present to the public: partnerships, community needs, innovation, interprofessionalism, the Triple Aim, and the faculty. He notes that change management represents a real challenge for an institution, and that the "biggest political challenge for leaders in academic health centers resides…with our own faculty." He concludes with the suggestion that our enterprise needs fresh talking points.

Jack Stobo, from the University of California System, finds politics in "every nook and cranny" of what we do. From his perspective, the drive towards more accountability and transparency is evident at every level. He concludes that, in his 50-year career, there has been transformation without change, but that this time may be different because of added internal pressures.

It is timely, therefore, that the AAHC Annual Meeting this September in Atlanta has as its theme *The Politics of Healthcare*. Those of us who have grown up in academia have thought of ourselves as being largely outside the realm of politics. After all, we are teaching students, conducting research, and taking care of patients. But as we have risen up the academic hierarchy, politics has increasingly intruded upon our consciousness; in fact, it was always there—we just didn't appreciate its downstream effects when we were starting out.

Politics is far more than reaching reasonable conclusions and courses of action based on data and logic. It involves a different test of leadership: the ability to influence and change the behavior of others. As we lead our institutions in the 21st century's enormous challenges and opportunities, mastering the art of politics becomes a necessity.

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LEADERSHIP PERSPECTIVES

Managing the Politics of Healthcare

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DEAN, SCHOOL OF MEDICINE
Indiana University

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PRESIDENT AND CEO
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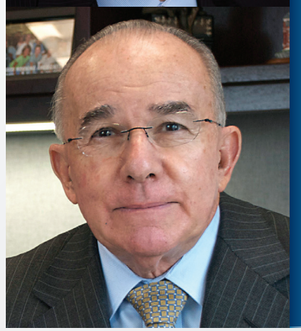

John D. Stobo, MD
EXECUTIVE VICE PRESIDENT, UC HEALTH
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SUMMER 2015
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Jay Hess, MD, PhD // *Vice President for University Clinical Affairs*
Indiana University *Dean, School of Medicine*

A major political trend impacting healthcare in Indiana, as with other states, has been expansion of the Medicaid program. My colleague, Dan Evans, CEO of Indiana University Health, played a major role in coming up with an approach that conservative legislators could live with. The results will have a positive impact not only for patient care, but also financially for the healthcare system.

Recently, we have also been facing challenges presented by the new religious freedom legislation that has been in the news. One unfortunate impact is that some potential job candidates view us as a state institution and have pulled out of the search process. As can often occur with politics and healthcare, it is one of those things that arose quickly and we had to respond to avoid having a more negative impact on our recruitment.

Another factor impacting us from the political landscape is increased expectations for us to drive local and state economic development. In addition to our tripartite mission, we are increasingly looked upon to generate startups and intellectual property. We are also being asked to do more to directly address public health issues statewide. These are important goals, but to some extent they are also a mission creep. And, expectations are not always realistic.

Politics can also be internal. Half my time is spent working to increase integration and alignment with our primary clinical partners. Much of that work focuses on moving from a federation of hospitals to a highly-integrated healthcare delivery system with more central corporate governance. Some steps include having the chairs involved in strategic planning as well as sitting on the capital budgeting committee, and clarifying the relationship between the service line directors and the chairs — all steps towards better alignment.

We are also trying to address national healthcare workforce challenges. Indiana University is one of the largest medical schools in the United States with nine campuses; these can serve as administrative hubs for a statewide primary care residency expansion. We know that students who train at regional centers tend to stay in the state, so this helps address workforce challenges in terms of physician distribution. I think working at the state level with a primary care system of residencies that includes a variety of healthcare systems will be a trend for other states.

It is fair to say that this is a very interesting time in academic medicine. Applying creative solutions to some of the problems that have dogged us, such as workforce, are what we are going to have to do more of in the future, not just with our traditional partners but also through increased partnering with other healthcare systems.

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John R. Raymond, Sr., MD // *President and CEO*
Medical College of Wisconsin

When I think about politics, I think about three dimensions: how we interact with elected and appointed government officials and legislators; how we interact with consumers, defined broadly; and how we interact with faculty and staff during this era of great challenge.

I have six principles for how academic health centers should present themselves to the public: 1) embrace partnerships—with consumers, legislators, our internal constituents, and other organizations; 2) address the challenges for which our communities seek our help; 3) be leaders in innovation; 4) champion interprofessionalism; 5) practice Triple Aim principles and deliver high-quality, low-cost, highly-accessible healthcare; and 6) engage our faculty and staff.

It is politically important to address community needs. For example, the Medical College of Wisconsin heard hospital partners and competitors, elected officials, and families of potential medical students express a great need to train physicians who would practice in underserved rural communities in Wisconsin. We responded by creating two regional campuses with the goal that students will engage more deeply in their communities. To reduce students' financial concerns, we accelerated the curriculum to three years. Through a low-cost partnership model, we rely on local facilities and local talent for teaching. We have also partnered with four-year colleges and with competing health systems. And, we worked with the state and local health systems to fund the creation of new “destination” residencies based in those regions.

In terms of consumers, we work very hard not only to lower our costs, but also to demonstrate to the public how we are a good value for complex care. We need to make the same case to employers in our region, as well as to insurance companies.

Frankly, I think the biggest political challenge for leaders in academic health centers resides not with legislators or consumers but with our own faculty. There is a tension between fiercely-held academic traditions and our need to be nimble and to centralize tactics and strategies. I am not sure that we in academic medicine have the necessary skills to engage internally in the needed change management.

I think that academic medicine should develop a new case statement about our roles and social importance. Our old elevator speech about generating knowledge, training the next generation of physicians, and having the broadest base of healthcare talent is becoming stale. We need some better talking points about our essentiality.

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John D. Stobo, MD // *Executive Vice President, UC Health*
University of California

Politics is at every level—both locally and nationally. Indeed, politics can be in just about every nook and cranny of what we do. For academic health centers, the political landscape is pressuring us, and rightfully so, to be more accountable and transparent in costs, quality, access, and healthcare workforce needs. At the same time, the number of constituents to which we are being held accountable is increasing.

In California, our constituencies—including our citizens, regents, elected officials, and payors—want to make sure that we operate in an accountable, high-quality, cost-effective, transparent way while addressing both the health needs of the population we serve and the health workforce needs of the state. Our patients, another important constituency, also want increased transparency in the actual cost and price of the healthcare we provide.

Because of this political pressure for transparency and cost effectiveness, the University of California Regents have asked us to ensure that we work like a system to take advantage of the scale that five medical centers can bring to cost reduction and improvement in the quality of care we provide. As a result, our five academic health centers have shifted from acting individually or, at best, in a federated model to a true systemwide approach that takes advantage of our scale to reduce costs; identify, standardize, and optimize best practices; and pursue the highest quality in care delivery and outcomes. This has led to an approach to healthcare delivery in which the total far exceeds the sum of the individual contributions.

In my 50-year career in academic medicine, I have been through several cycles referred to as transformation in healthcare, but it has been transformation without change. Now is the first time that I truly believe things are going to change. The difference is that in the past the pressure to change has been external—from elected officials and others. There has been very little impetus from within the profession to change. Today, however, the pressure is not just coming from without, but also from within. External pressure is there, to be sure, but it is joined by an increasing internal pressure from the profession to change and transform the way we deliver healthcare.

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