

# PERSPECTIVE



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Not infrequently, I am asked about the evolving organizational models of academic health centers. Often at the center of the ensuing discussion is the clinical and academic enterprise relationship.

It is clear that a combination of economic and intellectual forces are motivating many of our members to look at their organizational and governance structures. This was born out by our member profile survey indicating that 31% of the respondents are changing their governance structures or significant reporting relationships. The key theme is unquestionably the need for alignment amongst the various components.

This issue of *Leadership Perspectives* speaks directly to this critically important topic. Leaders from three very different organizations describe their paths to achieving better alignment. John McConnell, from Wake Forest Baptist Medical Center, oversaw the major task of creating a joint operating company for the entire medical center with a single CEO. He describes their approach to funds flows and notes “dramatic improvements in key quality metrics.” Ricardo Azziz of Georgia Regents University has also participated in dramatic structural and governance changes, including the creation of a new health systems structure and a merger with another university. He notes the difficulties in changing culture and advises to watch out for “incipient change fatigue.” Joe Robertson at Oregon Health & Science University provides considerable insight regarding the drivers of change with the biggest challenge involving the “interdependency of success.” He also warns of the potential unintended consequence of these changes — threats to the entrepreneurial model.

It is essential that academic health center leaders learn to manage the degree of change and not be overwhelmed by it. Deciding on the best mission balance for an institution is difficult enough, but when this is combined with a rather fluid economic environment, the challenges are substantial. At the core is the need to develop and then execute an aligned and integrated vision for the enterprise based on the principle of applying knowledge to improve health and well-being.

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## LEADERSHIP PERSPECTIVES

Organizational Governance and Structure



**Ricardo Azziz, MD, MPH, MBA**  
PRESIDENT AND CEO  
*Georgia Regents University,  
Georgia Regents Health System*



**John D. McConnell, MD**  
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**Ricardo Azziz, MD, MPH, MBA** // *President and CEO*  
Georgia Regents University, Georgia Regents Health System

In the past four years, Georgia Regents University (GRU) has been through a significant amount of change towards increased strategic alignment, mutual efficiencies, and a size with which we can respond to future challenges and opportunities.

We first created a new health systems structure that includes a separate medical center and separate faculty practice plan with their own boards, corporate structures, and assets. A joint operating agreement links these entities to the health system. Secondly, we created a system of shared administrative services which allowed us to fully leverage and ensure maximum alignment and synergy across the entire enterprise.

The creation of the health system and alignment of the clinical enterprise with the university was immediately followed by the consolidation of the university, focused on the health sciences and health professions, with a proximate masters-level university, greatly multiplying our impact.

We found, as have others, that cultural change does not directly follow changes in governance or organizational structure. You must include education and transparency that answer the question: “What’s in it for me”? In that regard, we have seen the faculty practice community begin to understand that the hospital is theirs to care for, grow, and enhance. Similarly, the medical center cannot sustain growth of quality programs without engaging the physician community. This greater understanding of mutual needs reflects positively in our Joint Commission reviews, improved margins and operations, and a more engaged staff and faculty. Likewise, we have improved administrative services, adding greater depth and breadth.

Institutional culture does not change overnight.

One factor we are facing is a fair amount of incipient ‘change fatigue’ that can lead to decreased focus on operational excellence. Structural change also creates lack of clarity as to who is in charge, and in the ranking of priorities. Finding the right people who can breach the divides has also proven to be a challenge. Broad enterprises with heterogeneous stakeholders require leaders who understand, respect, and support its many components. That takes a different skill set than managing a more siloed enterprise.

Today, all constituencies want greater value for their dollars while the wave of acquisitions and consolidations in healthcare suggests that size matters. These two trends are driving the need to create governance structures that allow for greater size, alignment, and efficiency while maintaining corporate integrity, fiduciary responsibility, and a focus on mission and values. We believe that the trajectory we are following at GRU will allow us to better respond to these mega-trends, and face the future as a relevant, sustainable, and valued institution.

“...incipient ‘change fatigue’...can lead to decreased focus on operational excellence.”

**John D. McConnell, MD** // *CEO*  
Wake Forest Baptist Medical Center

For 67 years, we had the classic, autonomous medical school/hospital affiliation model with separate leaders. Our history was typified by alternating decades of great progress and less-than-great progress. At the end of one of those not-so-great decades, the boards of the hospital and medical school began quiet conversations about adopting a more integrated model. In 2008, I was recruited to build and manage such an integrated enterprise. But, at first, I led two separate enterprises with two separate boards.

In 2010, we converted Wake Forest Baptist Medical Center (which was previously only a brand name) into a joint operating company for the entire medical center. Its board is the overall governance board for the integrated medical center. The company is run by me, as CEO, and my management team, reporting to that single board. The faculty practice was moved out of the medical school and merged with North Carolina Baptist Hospital to create Wake Forest Baptist Health, a fully integrated health system whose leaders report to me. The University appoints half the board; the hospital corporation board appoints the other half.

We established an annual budget for the joint operating company with a single bottom line. Net income is split equally between the medical school and the health system and we consolidated debts into one single obligated debt group. The university still owns the assets of the medical school and the hospital still owns its assets, but those assets are wholly managed by the medical center.

We adapted a philosophy – and extremely important principle – of pooling resources, learned during a visit with Michael Karpf, MD, Executive Vice President for Health Affairs at the University of Kentucky. Although we have individual operating units, all revenue and expense is considered “medical center”. We no longer have negotiations over issues of which entity “owns” technical revenue. Our clinical focus today centers around two points: what is best for patient care and what creates the best set of economics for the medical center as a whole.

The most visibly important outcome has been dramatic improvement in key quality metrics and attaining best-in-class ratings in select areas. Through better strategic planning and alignment, we experienced substantial growth in market share. Service by service, we placed physicians who are qualified to do so in charge of integrated clinical units, resulting in dramatic improvement in operations from clarity of leadership to quality accountability.

There are some challenges, such as developing physician leadership capable of taking on operational responsibility. Perhaps the greatest challenge is one that all academic health centers must address: an environment of declining reimbursements per unit of service and reducing our cost structures.

“We adapted a philosophy – and extremely important principle – of pooling resources...”

**Joe E. Robertson Jr., MD, MBA** // *President*  
Oregon Health & Science University

Many of the changes at academic health centers are being driven by the changing models of the delivery system. We see the need for integration of our clinical programs, of the faculty with the clinical enterprise, and of multiple activities across the clinical enterprise. At the same time, within our university we are trying to achieve much greater integration across our missions to leverage our resources. About four years ago, for example, we brought our medical group into the university. It had been a separate corporate entity. Now, as a result of this and other efforts, we are truly a unified academic health center.

Stepping back, I see the biggest cultural and behavioral changes in the interdependency of success. Everything we do is becoming more collaborative. Traditionally in many academic health centers someone could be successful acting alone. That’s no longer really possible for an individual, and rarely even possible for a department. Our research interests are now often collective interests and span many disciplines. It is less and less likely that any unit will succeed acting independently or as a citadel. This interdependency is leading to a complexity of organizational structure much greater than it ever has been. As a result, systems thinking is required.

One of the unintended consequences of this change may be a threat to the entrepreneurial model. As systems become larger, they may thwart some of the individual entrepreneurial spirit that has been a major driver of innovation at our institutions. It used to be that you could hire a faculty member and that faculty member could basically create a successful clinical or research program. That strategy is unlikely to be successful in today’s environment because it takes too many resources.

The greatest challenge going forward is anticipating what the next organizational change will be. I don’t say that tongue-in-cheek. We have changed from an environment where you select a certain organizational structure and then stick with it to an environment where there will be continual change in our structures. You have to be always prepared to create new structures while still supporting the cultural values that have been embraced by previous organizational and professional relationships.

The positive outcomes of our changing organizational model are that, in the face of an ever more competitive environment, we have educated more students, continued to acquire more research dollars, and increased market share. We have quality indicators that have improved as well. Those are good measures of success in any era.

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