



Advancing the Academic Health System for the Future

An AAMC Advisory Panel for Health Care Report

What is the new role for faculty?

Janis M. Orlowski, MD MACP


Learn
Serve
Lead

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I have no disclosures to make today


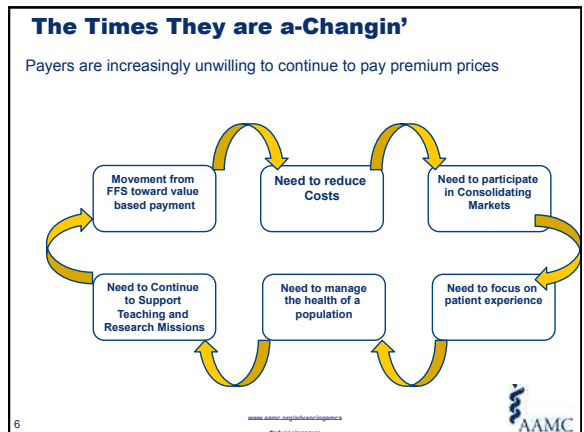
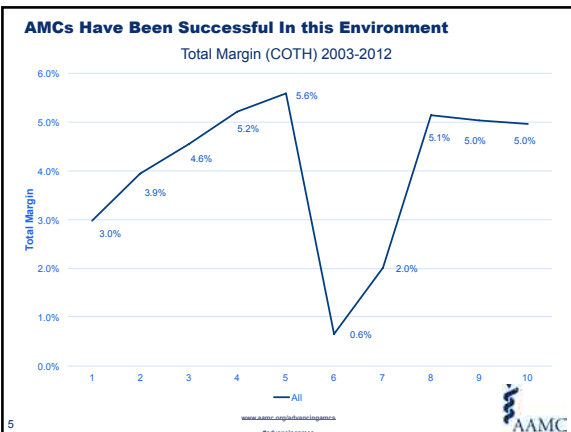
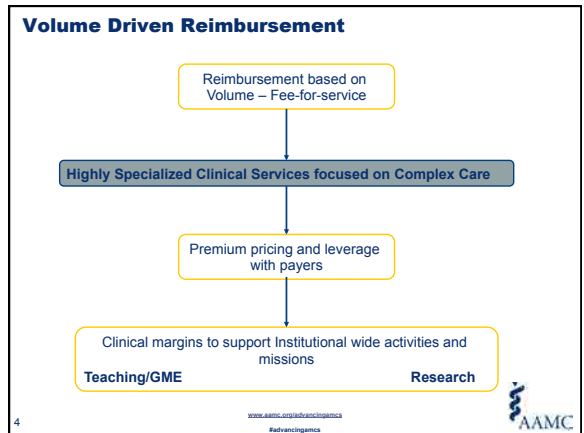
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Advisory Panel for Health Care

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Goal

Create a vision of the future Clinical Enterprise at Academic Medical Centers

Focus/Outcome: Project should focus on developing a blueprint of principles for leadership that will help AMCs move to a sustainable model in the future. Report begins with premise that AMCs are distinguished as institutions that support opportunities for translational research, testing innovative models of care, and education. With those foundational commitments, AMCs must learn to decrease cost, increase integration, and right-size in this new era. The generational shift away from hospital based care must be recognized and addressed. **Focus on who is effectively executing on these initiatives.**

Develop a resource for leaders by leaders



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Approach - Profiles of Leadership



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Themes

1. The AMC of the future will be system based
2. These AMC systems require strong and aligned governance, organization, and management systems
3. University relationships will be challenged to change as AMC systems grow and develop
4. Growth and complexity of an AMC requires enhanced profile for Department Chairs, new roles for physician leaders, and evolution of the practice structures
5. Transparency in quality, performance, and financial information at all levels of the organizations central to achieving high achievement
6. National imperative to bend the cost curve will require a more efficient AMC operating model
7. Time for AMC Leadership to develop skills in Population Health
8. Candid assessment of strengths and weaknesses essential to achieve change

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Theme 1: AMC of the Future will be System Based

- Consolidation of providers into systems requiring AMC system development. Preparation for future risk assumption requiring breadth and increasing vertical & horizontal integration.
- In developing regional systems, AMCs must manage the brand as they develop strategic partnerships.
- System scale must be sufficient to maintain competitive parity & mission sustainability – multi-billion in size.
- Access to Capital will be a determinant of future system success



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Dimensions of Health System Formation

Profile Area	Dimensions of Academic Health System Formation
Strategy and Governance	<ul style="list-style-type: none"> • Clinical Strategy • Scale • Integrated Governance • Role of the Chairs and Executive Leadership • Education, Research, and Innovation
Fiscal Affairs	<ul style="list-style-type: none"> • Transparency • Compensation & Incentives • Access to Capital
Network Services Strategy	<ul style="list-style-type: none"> • Primary Care Network Development • Community Physician Engagement/Clinically Integrated Network • Mergers/Joint-Ventures/Affiliations
Performance Management	<ul style="list-style-type: none"> • Management of Risk • Data Analytics & Measurement • Cost Management & Quality of Care

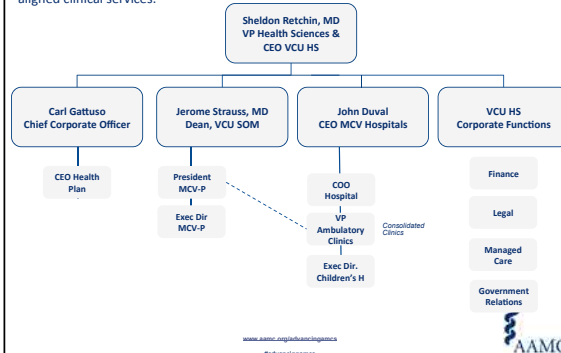
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Example: VCU Health System

VCU Health System operates as a "strong" system with an integrated operating model and aligned clinical services.



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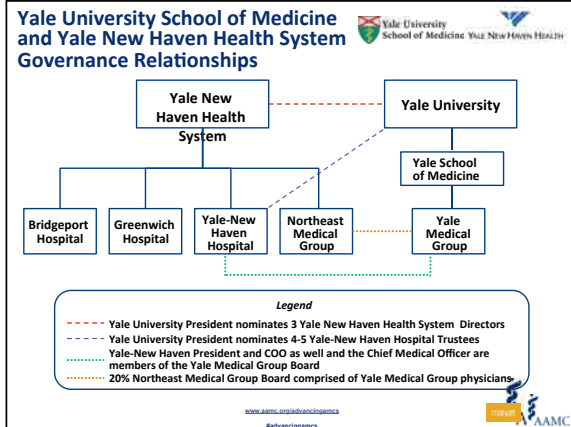


Theme 2: AMC Systems require *strong and aligned* governance, organization, and management systems

- AMC Systems aligning clinical services under leadership that is unified strategically or structurally, enhancing clinical coordination and strategic planning, accelerating decision making, and creating accountability for performance with new emphasis on cross-departmental collaboration
- New structures proving effective because of the trust and commitment to collaboration of their leaders. They are having honest conversations about allocation of resources, simplifying decision making, and evolving the role of leaders commensurate with multi-billion dollar organizations.
- System organization models will differ and there are alternative approaches to organizing clinical entities to achieve economic alignment

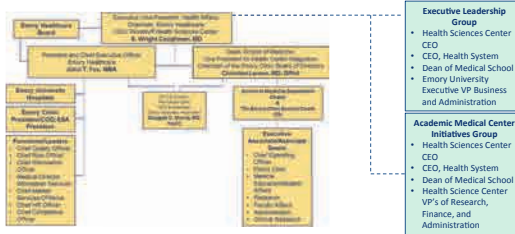
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Emory Healthcare

Characteristic	Features
Integrated Governance	<ul style="list-style-type: none"> • All clinical services are organized under Emory Healthcare under the responsibility of the EVP Health Affairs. Emory Healthcare integrates clinical services under a CEO and academic services under the Dean. • Emory utilizes two major groups of leaders for major strategic decision making. • The first, the Executive Leadership Group, is focused on EHC's organizational view of academic medicine and institutional development. • The second group, "Academic Medical Center Initiatives Group" is focused on implementation of its strategic vision: optimal integration of education, research and healthcare, referred to as "Emory Medicine".



Theme 3: *University relationships will be challenged to change as AMC system grows and develops*

Whereas in the 1990's there was a pronounced shift towards separation of higher education from health sciences – largely to protect the parent university from the potential financial risk of large medical centers – there appears to be a reversal of this trend, due to the success that medical centers have enjoyed these past years.

It is reputed that a rating agency evaluating the proposed bond offering of an academic center posed the following query: *Am I rating a University with a Health System, or a Health System with a University?*

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University Relationships Continued

Services support should be transferred on a fair-market-basis, with inter-university flows subject to Board oversight.

Transparency in funds flows between the academic center and the university should be strongly encouraged, and over dependency on clinical income discouraged.

University practices and policies should be modified to recognize the clinical system requirements for growth.

Intellectual property policies should be updated to encourage closer ties with industry.

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Theme 4: Physician leadership and physician practice will change dramatically

- Growth and complexity of AMC system requires evolution in the roles of Department Chairs and new roles for physician leaders
- Emphasis on quality of leadership: selection, succession, training
- Evolutionary change rather than revolutionary. Trends include:
 - Emphasis on teamwork amongst Chairs and with system leadership
 - Delegation of selected functions to group or management
 - Accountability for departmental performance and financial transparency across departments
 - Strengthened role for physician executives, esp. CMO/CMIO/Group Practice management
- FPP leaders are asking the question – "Do we want to be THE physician organization for the health system, developing processes for the addition of clinical faculty and affiliates, or one of many boxes of physicians for the enterprise on an organization chart". The answer may vary from institution to institution.

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Emory Healthcare

Characteristic	Features
Primary Care Network Development	<ul style="list-style-type: none"> Organized Emory Clinically Integrated Network (CIN) which allows them to contract with private community PCPs and specialists (currently 500). While CIN physicians are not employed by Emory, all are on the EHR and Emory HIE. Emory only contracts as a CIN for community, FPP and non-faculty employed physicians. For the payer and patient, the network is the product. This approach allows Emory to offer different "products" to different insurers across 7 hospitals and 2000 docs.
Open Architecture – Engaging with community providers	<ul style="list-style-type: none"> In addition to the CIN, Emory has a group called Emory Specialty Associates (ESA), which are community physicians who are employed by Emory Healthcare, but are not faculty in the School of Medicine. They are organized by division according to specialty and are managed by Emory as a group practice and have own leadership structure. Fortunately, the President of ESA is also the director of the Emory Clinic and thus is able to bridge "town-gown" issues.

Emory Clinically Integrated Network

Non-employed Non-faculty PCP/Specialists ~500 physicians

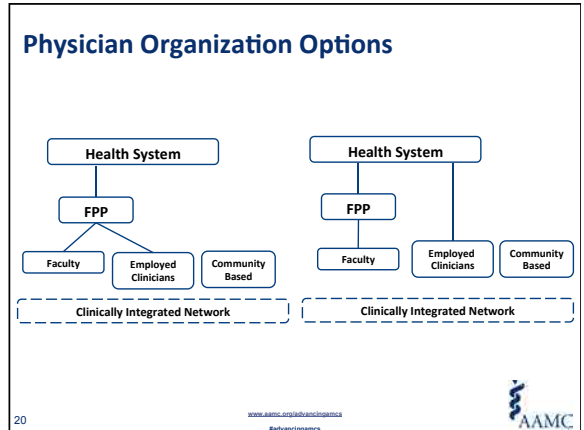
The Emory Clinic (Faculty Practice)

501(c)3 Employed Faculty PCP/Specialists ~1,149 physicians

Emory Specialty Associates

501(c)3 Employed Non-faculty PCP/Specialists ~160 physicians

Common EMR and HIE connectivity.



Physician Leader Profile: UNM Example

University of New Mexico has a "Health System Executive Physician in Chief" that reports directly to the Chancellor, and supervises the Chief Medical Officer and the individual component unit chief medical officers.

Responsibilities

- Leader and architect of the strategic operating plans for the UNM Health System, leading the implementation of both the UNM strategic plan and operating plan, assuring consistency in approach by all health system component units.
- Responsible for fostering effective collaboration, alignment and integration between components of UNM Health System
- Internal expert in best practices at a local and national level, and external representative in national endeavors in health reform
- Supports Health System CMO and unit CMOs in quality improvement and safety initiatives, medical staff affairs, and lean management systems.

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Theme 5: Transparency in quality, performance, and financial information at all levels of the organizations central to achieving high achievement

- Impossible to succeed in taking on risk / bundles without true understanding of costs across hospital and practices
- Quality reporting and innovation in demonstrating outcomes over longer time periods will be essential to maintain "premium" AMC brand
- AMCs must be more explicit about value (quality/cost) and how they position themselves in the market. The ability to define quality outcomes to purchasers is as critical if not more critical than simply lowering the cost structure for purchasers.

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Partners HealthCare System/ Massachusetts General Hospital

Measure Domains

HIT Adoption

Patient Safety

Clinical Quality

Prevention and Chronic Disease Management

Efficiency

Patient Experience

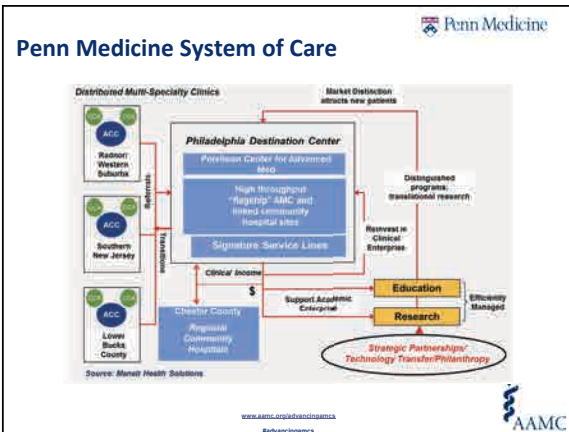
Publicly Reported Dashboards

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Theme 6: National imperative to bend the cost curve will require more efficient AMC operating model

- Persistence in high costs of AMCs primary competitive disadvantage for system success
- Total leadership commitment to lower costs a pre-requisite for taking on population health and risk assumption strategies
- Re-engineering must extend to all missions
- Potential for AMC innovation in total cost management by delivering best results on utilization
- Broad investment in new skills such as LEAN across faculty and staff

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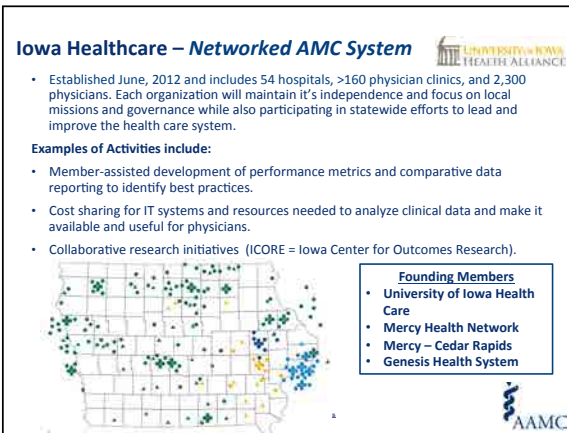
Theme 7: Time for AMC Leadership on Population Health

As the ACO strategy becomes more prevalent, and risk contracting expands, the capabilities for effectively managing an assigned group of beneficiaries also becomes imperative.

Few academic centers have built this capability, or have it at scale. Organizations such as UPMC and Hopkins have built this capability within their subsidiary health plans. Duke Medicine has built this capability to serve assigned Medicaid beneficiaries.

Most organizations need to ask whether they have the will to build this capacity internally or whether they should purchase

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Theme 8: Candid assessment of strengths and weaknesses essential to achieve change

- Changing market and policy dynamics are forcing organizations to assess ability and capacity to succeed as organized systems of care
- AMC System strategy difficult and costly to execute
- Board and Leadership must have a new level of candor about capabilities and evaluate the "cards" the AMC holds – or doesn't – in its hand. A weak hand requires rapid action, selection of strong partners, and investment in new capabilities

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Options for AMCs in Health System Formation

Merge / Affiliate with Mega-System	Specialized Complex Care Leader	High Performance Regional System	Public Entity Statewide Hub	Population Health Manager
<ul style="list-style-type: none"> Merge or establish primary preferred affiliation with large health system and become the "academic brand" for the system 	<ul style="list-style-type: none"> Renown regional, national, international for a selected comprehensive specialty service (e.g. Cancer) Contractor to large systems Expert at Complex Care management Very strong Brand promise 	<ul style="list-style-type: none"> Independent AMC with tightly controlled system of care in attractive geography Market share leader in an attractive "sub-regional" geography with "must-have" status Strong brand promise 	<ul style="list-style-type: none"> Sole/primary AMC in state Safety net provider for state; major Medicaid provider Tertiary/quaternary care provider for specialized services Referral based services combined with local primary care 	<ul style="list-style-type: none"> Regionally / nationally distributed health care system Risk bearing "population manager" Health Plan or payer partnership to support Clinically integrated network of faculty and community based physicians

Scale of the AMC as a "System" Balance Sheet strength & capital availability

AMC's must determine type and nature of their future system identity

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Emory Healthcare

Characteristic	Features
Management of Risk	<ul style="list-style-type: none"> Emory views its market in three "tranches" (acute and complex care, chronic disease care, and population management) where payment models for services will vary based on risk assumption by Emory.

Strategy Assessment

"No Future in Fee For Service"


- Providers being pushed to take risk for cost and quality
- Value based payment the future

Competition

- 85% of EHC's services have direct and active competition in the market

Value Proposition

- AMC status less of a differentiator with shift to population health management and new reimbursement models
- All three missions cannot be sustained without a shift in clinical strategy



EHC Clinical Strategy

"The Network is the Product"

1-Tertiary/Quaternary Care

- Packaged set of services with bundled pricing that cover an episode of care – emphasis on Emory clinical strengths
- Bundle includes post discharge outcomes up to a year
- Attractive for purchasers including self-insured employers both in and out of the primary service area.
- Example services: Bone Marrow Transplant; Transplant Surgery

2 – Patient Cohorts with Advanced Illness

- Complex patients with conditions that need intense management, reimbursed in a capitated, risk-adjusted rate
- Risk is syndicated out by patient cohort; actuarially determined risk profiles
- Potential to draw patients into EHC market regionally/nationally for these services
- Example services: Post-transplant care management; congestive heart failure; diabetes

3 – General Services with P4P and Risk-Sharing

- The "Big River" of clinical services in the health system
- Embed process and outcome quality measures into general services and develop risk-sharing contracts with payers (Medicare Advantage, Commercial Insurance, Employers)
- Example Services: \$500M Blue Cross contract with risk corridors up & down on cost baseline projections


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The opportunities


"Being challenged in life is inevitable, being defeated is optional."
 – Roger Crawford

"A healthy attitude is contagious but don't wait to catch it from others. Be a carrier."
 --Tom Stoppard

"If you dislike change, you're going to dislike irrelevance even more"
 -- Gen. Eric Shinseki




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Themes

- The AMC of the future will be system based
 - *Faculty will be part of a system and not a department
- These AMC systems require strong and aligned governance, organization, and management systems
 - *Faculty may be governed through organizations not apparent today. Faculty Senate must be part of the team
- University relationships will be challenged to change as AMC systems grow and develop
 - *For –profit, non-profit, other
- Growth and complexity of an AMC requires enhanced profile for Department Chairs, new roles for physician leaders, and evolution of the practice structures
 - *Opportunity for leadership

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Themes (cont)

- Transparency in quality, performance, and financial information at all levels of the organizations central to achieving high achievement
 - *Individual metrics for achievement
- National imperative to bend the cost curve will require a more efficient AMC operating model
 - *No subsidy from clinical activity
- Time for AMC Leadership to develop skills in Population Health
 - *New skills and need for new curriculum from faculty
- Candid assessment of strengths and weaknesses essential to achieve change
 - *Join the team

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