

SPRING 2014

The Blue Ridge Academic Health Group

Report 18. **A call to lead:**
*The case for accelerating
academic health center
transformation*

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A call to lead: The case for accelerating academic health center transformation is the 18th in a series of reports produced by the Blue Ridge Academic Health Group. The recommendations and opinions expressed in this report represent those of the Blue Ridge Academic Health Group and are not official positions of Emory University. This report is not intended to be relied on as a substitute for specific legal and business advice. Copyright 2014 by Emory University.

MISSION: The Blue Ridge Academic Health Group seeks to take a societal view of health and health care needs and to identify recommendations for academic health centers (AHCs) to help create greater value for society. The Blue Ridge Group also recommends public policies to enable AHCs to accomplish these ends.

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(August 2013 meeting)

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Executive summary

Unprecedented economic and policy forces are restructuring health care and insurance markets. Academic Health Center (AHC) leaders face critical challenges in developing a comprehensive vision and leading its implementation in their organizations. The challenges reflect the fact that AHCs are complex adaptive systems that cannot be effectively changed through traditional command-and-control management approaches. This report offers an analysis of these challenges and then summarizes recommendations for how leaders can approach and achieve enterprise transformation by building new platforms on which AHCs can serve their vital roles in their local communities and across our nation. Lessons learned from five examples of initiatives currently under way at AHCs reinforce the recommendations proposed to accelerate needed transformation.

Recommendations

Approaches/strategies

- Define the urgent case for change, and communicate the case, clearly delineating why this time is different.
 - Present the qualitative and quantitative data to facilitate evidence-based persuasion.
- Engage key internal and external (especially local community) constituencies in defining a unique vision and value proposition that reflect the organization's mission, role, and current realities (including resources available, partnership opportunities, and competitive environment), while maintaining focus on advocacy for the organization.
- Define and use metrics that demonstrate the value proposition to the communities served and that reflect the organization's mission.
- Apply lessons learned from redesigning clinical processes to transform academic programs.
 - Identify and eliminate administrative and infrastructure redundancy using performance-improvement processes based on desired outcomes.
- Size the missions based on maximizing value

consistent with the following:

- Areas of greatest benefit aligned with the organization's mission and strategy
- Human and capital resource availability and partnerships
- Align compensation and rewards with resource availability and performance toward new institutional goals and individual goals.
- Accelerate team-based care models and use as a platform for patient-centered, team-based learning and discovery model development.
- Leverage shared education infrastructure and curricula across medical, nursing, and other health professions schools as well as host universities.
- Accelerate development of collaborative approaches to research, including building on the model of multi-AHC Clinical and Translational Science Awards.
- Consider nontraditional research partners and funding sources (being cognizant of financial impact), with attention to conflict-of-interest rules, which may need to be modified to lessen constraints.
- Develop a community-engagement strategy to understand local needs and resources and to involve potential partners.
- Foster and cultivate diverse leadership across the AHC to help enable change.
- Advocate for the unique and indispensable mission of AHCs in the integration of education, clinical practice, and research.
 - Work with policymakers to find appropriate and equitable mechanisms to pay for added costs of AHC education and research functions that benefit the health care sector as a whole and that will remain embedded in AHC cost structures.

Structure and operations

- Understand, make transparent, and communicate sources and uses of investment capital.
- Understand, make transparent, and communicate internal funds flow and economics, particularly amounts and approaches to internal investment.
- Shift decision-making to optimize enterprise performance across all missions, and make the

whole better than the sum of the parts. Empower the organization with the following:

- Share decision-making and accountability for overall performance.
- Define boundaries of autonomous decision-making by departments. Limit risk to departments in areas where they don't have authority or accountability.
- Re-envision roles and expectations of department chairs.
- Delineate balance of authority for decisions about strategies, investments, and metrics.
- Integrate enterprise performance and assessment across all mission components.
- Communicate integrated decisions and associated benefits to gain engagement across the AHC.
- Reduce the internal “regulatory” burden of institutional bureaucracy.

Culture and people

- Discover, articulate, and gain agreement on new attributes, values, and leadership skills required for success for chairs, other administrators, faculty, and staff, including the ability to make decisions in face of uncertainty and to embrace change. Build trust. Identify and dispel myths.
 - Conduct an assessment of organizational culture.
 - Develop, promote, and recruit to fit with desired attributes and culture.
 - Create or sponsor leadership skills-development programs.
 - Develop incentives and success metrics consistent with new attributes and culture.
- Empower and reward change agents, risk takers, and others who exhibit the desired attributes and culture.
- Celebrate new values, successes, and benefits of new strategies. Learn from failures.

*Academic health
center leaders face
critical challenges
in developing a
comprehensive vision
and leading its
implementation
in their organizations.*

Introduction

“Because things are the way they are, things will not stay the way they are.”—*Bertolt Brecht*

“Change before you have to.”—*Jack Welch*

The Blue Ridge Academic Health Group has long advocated for nationwide health care reform that could lead to the establishment of a value-driven and evidence-based health care system that “promotes the health of individuals and the population by providing incentives to health care providers, payers, communities, and states to improve population health status and reward cost-effective health management.”¹ The Blue Ridge Group saw the passage of the Patient Protection and Affordable Care Act (ACA) as a determined step in this direction and in April 2012 issued a special report identifying compelling near-term opportunities and critical challenges for academic health centers (AHCs) and their partners as the ACA is implemented. Building on many past reports recommending pathways for leadership and innovation in the critical AHC missions of education, research, community engagement, and clinical care, the Blue Ridge Group recommended that the AHC community act with a strong sense of urgency in leading the transition to value-driven health care. The overarching imperative for AHCs was perhaps best summarized as follows:

... [N]ow through the ACA . . . our nation has adopted a framework designed to achieve near-universal coverage and move toward a value-driven health system. AHCs, as the font of leadership in academic medicine, must resolve to become accountable and to lead in championing the future of a value-driven, accountable health care system. This will be a daunting task. AHCs will have to commit to transitioning from being centers of very special interests and exceptional individuals and individual programs to becoming ever more integrated systems, as well as full community and national partners in creating our value-driven health care system.²

The essence of this recommendation was the need for the AHC community not only to understand and adapt to fast-changing realities but also to take significant responsibility for modeling and

leading the changes necessary to achieve a value-driven health care system.

In August 2013, the Blue Ridge Group met to assess whether and to what extent the health care and insurance marketplaces are indeed moving toward a value-driven health system and whether and to what extent AHCs are rising to the challenges of leading and innovating in this new environment. On the basis of data presented by a range of experts and representatives of major AHC and health-related organizations, the following has become clear:

- Many health care and insurance marketplaces are already changing, catalyzing the reorganization of care delivery and payment mechanisms.
- On top of restraints on the growth of health expenditures caused by the Great Recession³ that began in 2007, traditional sources of federal revenues that support AHC missions are being further reduced by the Budget Control Act of 2011 (BCA). Specifically, Sequestration has resulted in structural, and long-term health expenditure reductions, outside of the periodicity of normal economic downturns. In addition, state funding has fallen, while philanthropic support has been flat.
- Changes in practice patterns and in insurance coverage are also contributing significantly to a slowdown in health care spending;

Of additional concern is stark evidence from the front lines of organizational change management about the following:

- The AHC community overall (with some exceptions) has not taken responsibility for modeling and leading the change or innovation necessary to achieve a value-driven health system. AHCs have shown great resilience over the years in adapting to various environments for care, and they continue to find success by providing health services in traditional ways. But most fall short of providing an integrated, patient-centered experience and in adopting accountability for value in their processes and metrics. As a whole, AHCs are behind their local and regional community-based health care organizations in transitioning to patient-centered and value-driven care models.
- AHCs maintain their critical roles in basic science and clinical research and in health profes-

sions education but have uneven track records in advancing and sustaining innovation in the organization and conduct of these roles. The research enterprise especially has become a major cost center in many places.

- There is much uncertainty about how well AHCs in general are prepared for the leadership and management challenges of catalyzing needed change and innovation throughout their organizations.
- A large body of evidence clearly demonstrates that when enterprises fail to evolve and innovate over time, the vast majority of them fail when finally forced to make large changes to their businesses or organizations.⁴ This is one reason that Jack Welch, the legendary CEO of General Electric, often repeated the admonition, “Change before you have to.”

These findings raise fundamental questions for all of academic medicine: Faced with national policy and related private sector dynamics bringing unprecedented changes to health care and insurance, how well equipped are our AHCs to undertake the system-wide transitions necessary to be successful in this environment? Having spent the past two decades mostly focused on growing capacity and negotiating premium pricing, can AHCs change to being leaders in the new paradigm for accountable care?

The answers to these questions are not easy or obvious. The following pages describe a changing environment that presents unprecedented challenges for AHCs, from the need to integrate health care delivery, to revolutionizing educational programs, reorganizing or rethinking the research enterprise, meeting community needs, and ensuring that changes in the financial obligations and risks associated with AHC success continue to be compatible with the larger university missions of which they are a part. Absent near-term strategic mission- and market-driven initiatives, AHCs could well find themselves unable to fulfill crucial missions in the longer term.

It is true that AHCs have been adaptive over the years. AHCs adapted well and gained much momentum during the past several decades of market conditions that favored growth, local and federal “favored nation” status for university-brand-

ed health providers and systems, and premium pricing. But the confluence of a major recession and austerity measures, along with changes in the insurance market and underlying health care cost growth factors, is creating a new environment for health care characterized by unprecedented and sustained slowing of the rate of health spending. As many health providers and systems are already “wheels-up” in adapting and leading the transition to accountable care, there is reason to worry whether much of academic medicine could run out of runway before getting critical transition processes off the ground.

AHCs have special characteristics that have helped them be centers of innovation and progress in health care but that also make them difficult to manage, let alone change. Herein, we offer an assessment of the challenges AHCs face in the emerging environment and a roadmap to preparing for and undertaking the changes and leadership that the transition to accountable care requires of us.

Unprecedented structural changes in the economy

Impact of the Great Recession

Between December 2007 and June 2009, the United States suffered its longest and worst economic recession since the Great Depression.⁵ The years since have seen a relatively slow and spotty recovery. Altogether, Americans lost more than \$16 trillion in household wealth to the recession. The average U.S. household has recovered only 45% of the wealth it lost during the recession.⁶

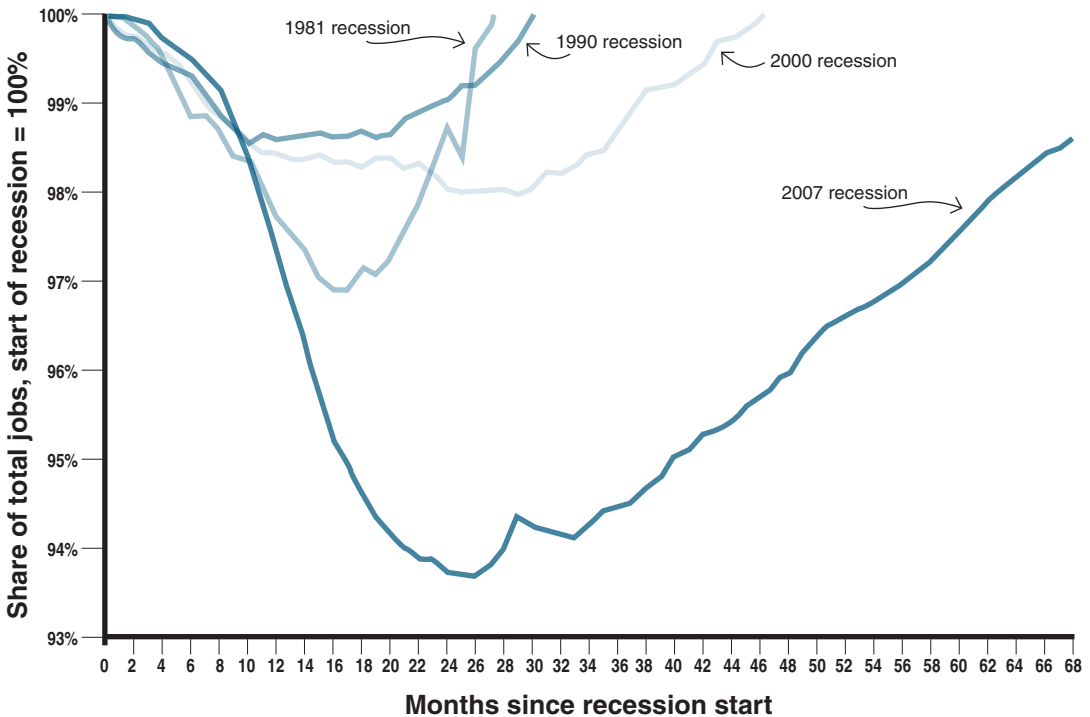
The major significance for health care is that, rather than being a typical bust and boom cycle, this recession was so deep that recovery will take far longer than in other recent recessions (see figure 1⁷). Leading health economists have recently estimated that the recession’s depth and lingering impact already are responsible for about \$185 billion in reduced health expenditures from 2007 to 2013.⁸ Because of political gridlock, it is likely that the recovery will continue to be slow through at least the next two election cycles and perhaps beyond.

For AHCs, another major impact of this deep

Figure 1.

The worst recession⁷

Indexed job loss for prior four recessions



Note: The line for each recession begins at the official start of the recession, so the length of the line to the left of zero indicates the length of each recession.
Source: Economic Policy Institute (EPI) analysis of Bureau of Labor Statistics Current Employment Statistics. Reprinted with permission from EPI's stateofworkingamerica.org.

and lingering recession is that it creates underlying uncertainties that could incline AHCs to avoid financial risk and needed capital investment. It might also have an adverse effect on the financing of recent and in-progress capital improvements, leading some AHCs to become over-leveraged. This economic climate makes planning difficult as leadership struggles with everything from the effects of mounting student debts and deferred and delayed demand for educational and health services to revenue reductions and limits on debt financing.

Impact of the ACA

The vagaries of the underlying economy are just that: economic episodes and cycles that generally occur often despite public policy and for which our political economy has developed a variety of mechanisms to aid in correction and recovery. And while the current recovery is proceeding slowly, the public policy aim is to return the economy to health. AHCs and universities gener-

ally understand how to weather cyclical downturns and have shown historically that they are flexible enough to make necessary adjustments. A recession alone, even one as severe as this one, would not prove to be an insurmountable hurdle for most AHCs.

The ACA, however, adds a new set of challenges for AHCs. Not since the enactment of Medicare and Medicaid has national policy been adopted that will catalyze nationwide and system-wide changes in health care practice and financing. The ACA is designed to drive new accountable care models and mechanisms in the public and private markets for health care and insurance. It is designed also to inform consumers and engage people in their health care and in making better choices in health care-related spending. And in the end, in addition to improving health, the goal is also to reduce the overall rate of growth of national health spending.

One example of a near-term development that

could change things very fast in our environment is the new state-based insurance exchanges.

State insurance exchanges = changes

The ACA is full of provisions and powers specifically designed to address health care cost growth through reform of the health insurance market, while reorganizing the ways in which most health care is both provided and paid for. (See box for a summary of key provisions.)^{2 (p6)} Already under way are a large number of pilot programs, experiments, and demonstration projects testing bundled payments and other new methods of paying for care.⁹ Also being piloted are various forms of accountable care organizations (ACOs), primarily through the Centers for Medicare and Medicaid Services (CMS). What may be less well understood or appreciated is the powerful role that the insurance exchanges are set to play in the transition to accountable care.

As of October 1, 2013, every state was required to have implemented an insurance exchange run either by the state or federal government. The federally administered exchanges got off to a particularly inauspicious start caused by serious deficiencies in the online enrollment system. Nevertheless, as these are sorted out, the new exchanges are expected to catalyze not just significant changes in employer-provided insurance but also unprecedented competition among insurance plans.

State exchanges are granted significant powers to fundamentally reshape health care marketplaces—the way care is funded and delivered—so as to reduce costs and achieve societal goals for health insurance and consumer empowerment.

For instance, to make it easier for consumers to understand and choose plans that are best suited to their circumstances, exchanges are empowered to limit the number of plans insurers can offer, require that they offer particular standardized plans, and that their various plans provide meaningfully dis-

tinct choices.¹⁰ Additionally, and relevant especially to providers, exchanges can be empowered to set standards for the quality of care paid for by plans, to deny participation in the exchange to plans that do not meet quality or price standards, and to selectively limit participation in the exchange to providers that meet these standards.

Exchanges can have the further power to limit the insurance policies that can be sold outside of exchanges or even to require that all health insurance policies for individuals and small businesses must be sold within the exchange itself (as a way, for instance to head off insurers' abilities to bifurcate the marketplace by offering plans inside the exchange designed for sicker patients, etc.).¹⁰ The District of Columbia and Vermont have already chosen to set such limitations. Also available to exchanges will be the capacity to provide and promote information about provider quality, outcomes, and cost to consumers and the public.

Five key provisions of the Affordable Care Act

1. Coverage expansion
2. Insurance market reform
3. Payment and delivery reform
4. Quality and safety improvement
5. Cost control

The era of the exchange ushers in direct provider engagement in becoming publicly responsible for “owning” the care and outcomes for patients: for being accountable.

Insurance exchanges are going to play key roles in restructuring state health insurance markets. In turn, they also will play key roles in moving providers to retool their care delivery processes to meet new standards for quality, outcomes, and price. Each state, of course, will move at its own pace. But for unprepared AHCs, any pace of change could prove too fast. And in some states, exchanges will work to achieve goals by narrowing local provider networks and excluding higher-cost AHCs.

AHCs unable to compete with other providers on value (quality/price) or to be responsive to local and regional health care needs could face significant difficulties maintaining, let alone growing, their roles in their local/regional marketplaces.

The initiation of the state health insurance exchanges is but one (albeit important) aspect of

the ACA that will be redefining health insurance coverage and health care in the coming years. AHCs must be prepared to engage with these many dimensions of the ACA and to come to the table with other stakeholders in their locales and regions with capacity to be a player in an accountable care environment in their markets.

Changes in commercial insurance

The chances are good that the ACA will catalyze very significant changes throughout our nation's health care system. One of the biggest foreseeable changes will be in the commercial insurance marketplace. What it means to be insured will likely change in the following ways:

- Employers shift to “defined-contribution”—The ACA “exchange” model that creates statewide insurance market frameworks in every state already is spurring many private companies to accelerate the creation and adoption of private exchanges for their employees. This can become a form of cost-shifting, as companies shift to providing defined-contribution benefits, which many predict will ultimately result in employees paying more out of pocket for deductibles and co-pays.
- Employers adopt higher-deductible plans as the standard—The “Bronze” and “Silver” insurance plans in the statewide exchanges are priced to be more affordable for moderate-income people; but, at 60% to 70% of actuarial value, they are effectively high-deductible health plans. Employers are likely to adopt these models in their employee health benefits, furthering the trend toward shifting costs and some insurance risk to employees.
- Employers “push” most part-time employees into the public exchanges—Since the ACA requires employers to provide insurance only for employees who work 30 or more hours per week, large employers are likely to adjust their own policies to match the federal standard and thereby effectively move millions of currently employer-insured part-time workers into the new state- and federally sponsored exchanges.

Just this one set of effects of the ACA on commercial insurance could significantly change the profile of the insured population and health

care utilization. In fact, in the foreseeable future, employer-based coverage could become the exception rather than the rule. The effects on health care utilization and spending cannot yet be predicted, but utilization and spending patterns could be significantly altered.

Figure 2¹¹ from the Association of American Medical Colleges (AAMC), shows provisions of the ACA (not including the aforementioned likely changes in the employer insurance market) causing a projected reduction of 14% per year in teaching hospital revenues through 2021.

One item stands out in this graph: the impact of the impending redirection of 50% of Disproportionate Share (DSH) payments to hospitals. The ACA is designed to roll out as a system, and there are many “moving parts” that rely on other parts for the overall mechanism to work. With so many states refusing to adopt the ACA's proffered Medicaid expansion, the scheduled DSH reductions loom as a major financial threat to many DSH hospitals.

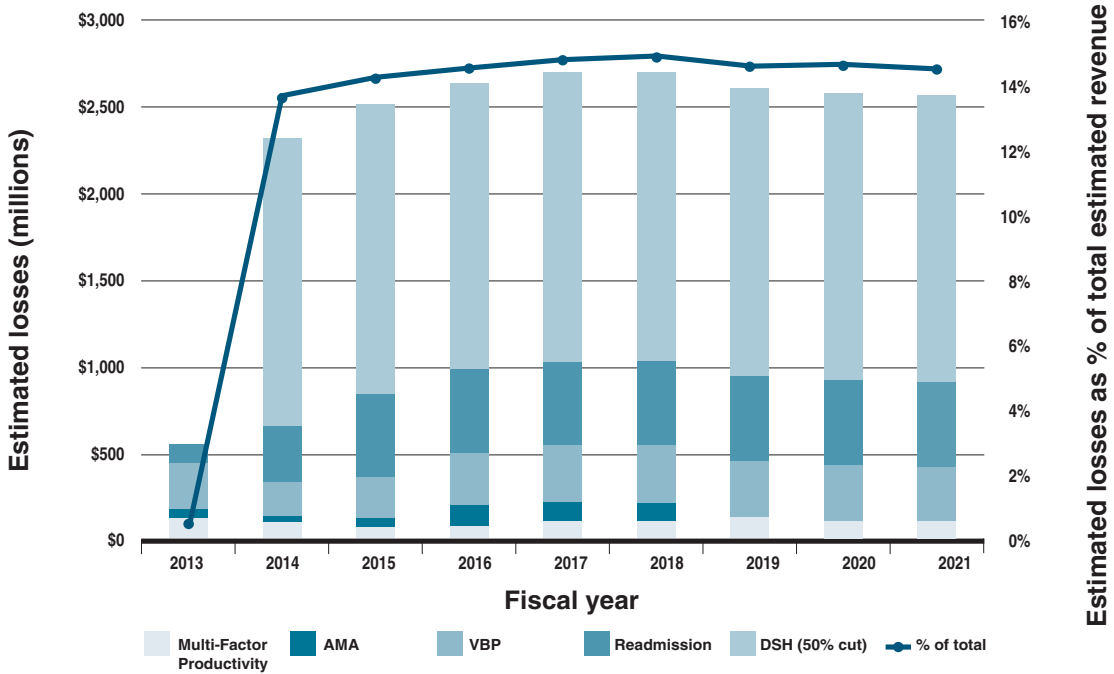
Impact of the Sequester

As if a major recession and national health reform didn't provide enough challenges for AHCs, on March 1, 2013, as required by the Budget Control Act of 2011 (BCA), President Obama signed an order initiating “sequestration.” The Sequester represents the largest reduction in public-sector discretionary spending that most people in health care will have seen or are likely to see in their lifetimes. The Sequester, with its goal of deficit reduction above all, is a broad-brush and indiscriminate approach. The current and anticipated effects of the ACA on top of the Great Recession would be difficult enough to deal with alone. The added impact of the Sequester is what warranted “sounding the alarm.” Taken together, the recession, the ACA, and the Sequester will uniquely challenge the resourcefulness, adaptability, and even viability of AHCs.

The BCA aims to control spending in two ways: First, it establishes caps that will keep federal discretionary spending essentially flat in inflation-adjusted dollars over the next decade. This amounts to about \$1 trillion less in public-sector spending than had been projected prior

Figure 2.

Estimated losses for all major teaching hospitals - Baseline reductions in Medicare revenue from ACA implementation¹¹



Source: AAMC, May not be reproduced without permission

to the law’s passage. Second, it also established the sequestration trigger mandating additional automatic cuts of about 9.4% for defense spending and 8.2% for nondefense spending.¹² As Table 1¹²

illustrates, now that the trigger has been pulled, all federal research programs (and the people and programs they in turn fund) are facing significant and sustained reductions. Table 1 shows the im-

Table 1.

Estimated R&D cuts under balanced sequestration, FY 2013–2017¹² (budget authority in millions of constant 2012 dollars)

	2013	2014	2015	2016	2017	Total Cut	5-Year Percent
Dept of Defense	-6,928	-6,818	-6,696	-6,585	6,495	-33,524	-9.1
HHS	-2,528	-2,429	-2,333	-2,241	-2,155	-11,685	-7.6
NIH	-2,439	-2,343	-2,251	-2,162	-2,079	-11,274	-7.6
Dept of Energy	-972	-944	-916	-889	-865	-4,585	-8.2
Natl Sci Foundation	-456	-438	-421	-404	-388	-2,106	-7.6
NASA	-763	-733	-704	-676	-650	-3,527	-7.6
Dept of Agr	-189	-182	-175	-168	-161	-875	-7.6
Dept of Commerce	-103	-98	-95	-91	-87	-474	-7.6
Dept of the Interior	-65	-62	-60	-57	-55	-299	-7.6
EPA	-46	-44	-43	-41	-39	-213	-7.6
Homeland Security	-50	-48	-46	-44	-43	-232	-7.6
Total R&D Cut	-12,099	-11,796	-11,488	-11,196	-10,939	-57,519	-8.4

Source: AAAS estimates of R&D, based on CBO and OMB analyses of the Budget Control Act (see reference 12). Constant dollar conversions based on OMB’s GDP deflators from the FY 2013 budget. Note: Figures for 2013-2015 do not reflect partial restoration of Sequester funds enacted in December 2013. Reproduced with permission from AAAS.

pact through 2017, but the Sequester will remain in force through 2021.

Some of the more daunting impacts include the following:

Clinical spending: Sequestration will take \$109.3 billion per year for the next eight years out of our public-sector national health care spending—resulting in an annual 2% reduction in Medicare hospital and physician payments alone.¹³

Research funding: Sequestration required the National Institutes of Health (NIH) to cut 5% or \$1.55 billion of its fiscal year 2013 budget, which was already \$530 million lower than its budget in FY 2010. The result was that approximately 700 fewer competitive research project grants were awarded in FY 2013.¹⁴ Going forward, the NIH could be subject to funding reductions of anywhere from \$2.3 billion to \$5.6 billion per year over the next five years, depending on whether efforts to exempt certain military spending are successful.¹²

National Science Foundation support: This is subject to a \$2.1 billion reduction in funding over five years.

Military research and development (R&D) spending: Under the best scenario, the Pentagon faces a reduction of up to 20% of its procurement and R&D budget—more than \$33 billion—through 2017. Spending reductions of a similar magnitude can be expected through the remaining years of the Sequester.¹⁵

Altogether, cuts to federal R&D spending will amount to \$57.5 billion through just 2017, while cuts to clinical spending will subtract another \$109 billion per year.

Under sequestration, the AAMC estimates that AHCs stand to lose more than \$3.5 billion in public-sector payments and funding in FY 2014, with increased and then sustained reductions of about \$4 billion in each year through 2021. An alternative scenario, under which the Sequester is repealed, could lead to an even more ominous picture based on the possibility that health spending would face even more draconian cuts not spread equally across all discretionary spending.

Direct research funding cuts of this magnitude will present serious problems for medical schools. There is ample evidence that the slowdown in re-

search support since 2003 has already had a severe impact on the AHC research enterprise and on the work and careers of many types of scientists in all stages of their careers. The elimination of 700 grant awards in FY 2013 alone is reverberating broadly. And the Sequester cuts to clinical revenues add pressure to reduce or eliminate cross-subsidization of research and other academic missions.

Everyone in AHCs can appreciate the impact of cuts of this magnitude. Some AHCs could be facing tens of millions of dollars in shortfalls of funding necessary to cover the overhead and debt service costs on their science infrastructure. The current environment for research is especially troubling to the extent that it undermines much promising work and threatens to derail a whole generation's worth of young people from pursuing discovery and translational research. Failing to protect opportunities for young scientists is tantamount to destroying our own seed corn.

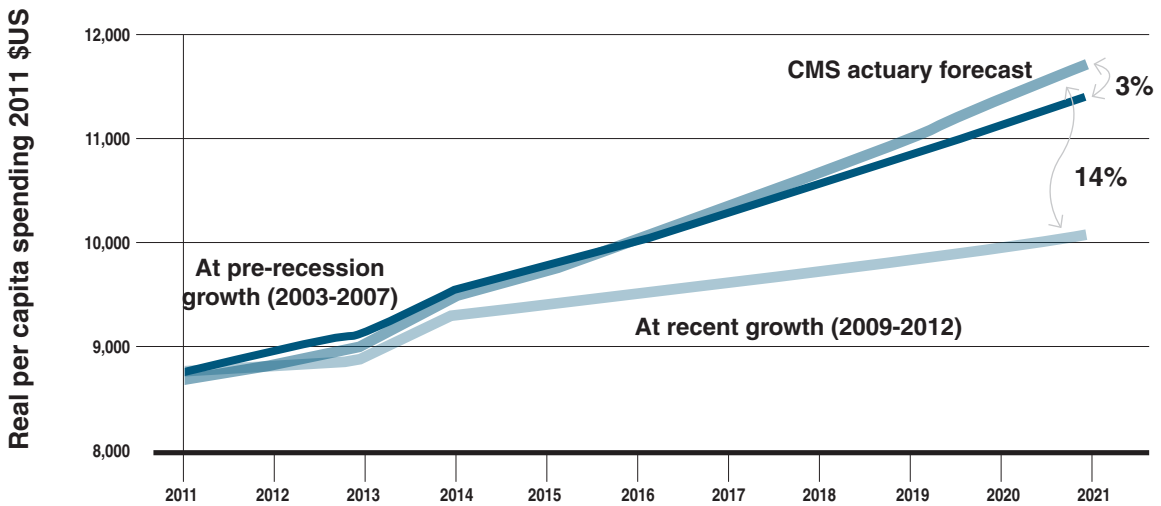
Estimated Sequester-related revenue reductions suggest that the AHC research enterprise is in need of some quick and serious action if it is to be saved from strangulating repercussions. At the very least, AHCs must undertake thorough assessments of their research enterprises to understand how best to invest in and support the research mission so critical to the future of health care.

Unanticipated structural changes in health care spending

Having reviewed the fiscal impacts of the recession, the ACA, and the Sequester, we must draw attention finally to a significant new structural element affecting the health care marketplace identified recently by leading health economists. Economists have found that, in the period from 2003 to 2013, health care spending has slowed much more significantly than predicted by CMS and others. Most forecasting to this point has attributed the vast majority of the slowdown to the recession and, most recently, to the Sequester. These are in fact major contributors to the slowdown. But new studies suggest that emerging payer, provider, and consumer dynamics are driving more than 50% of the slowdown in public-sector health spending and at a rate significantly higher than forecast.

Figure 3.

Projected health spending, United States, 2011-2021⁸



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We conclude that a host of structural changes – including less rapid development of imaging technology and new pharmaceuticals, increased patient cost sharing, and greater provider efficiency – were responsible for the majority of the slowdown in health care spending. The evidence thus suggests at least as strong a case for structural changes as for cyclical factors. . . .⁸

This particular analysis suggests that public-sector health spending could be as much as \$770 billion less than what CMS has been predicting over the next 10 years (even considering the new spending that could result from the millions of new enrollees in the new health care exchanges). See figure 3.⁸ Ongoing spending reductions of this magnitude have large implications for all stakeholders in the marketplace for health care. While forecasts such as these are the subject of much debate among analysts,¹⁶ leadership must factor into institutional planning the possibility of very significant structural revenue reductions going forward.

Altogether, the cumulative prospective impact of the recession, the ACA, the Sequester, and the structural changes in health care spending represent an unprecedented fiscal cliff for AHCs.

When you start with a projected \$770 billion reduction in public-sector spending and add to that potentially similar adjustments within the private sector, especially as state exchanges get their footing and exert their powers, it is easy to envision well more than \$1 trillion in health care spending reductions over the next 10 years, and perhaps much more. These numbers are staggering in their size and proximity. It is no wonder that Moody's projected a negative outlook for not-for-profit hospitals and the higher education sector.^{17,18}

Ready or not. . .

Despite such worrisome data concerning these and related threats to the status quo and much leadership trepidation about the prospective demands of transitioning to an accountable care environment, many AHC leaders have readily admitted that they and their systems are not ready to undertake significant change.¹⁹ Most AHC physicians, hospitals, and services remain focused on maximizing their revenues within the parameters of the existing health care paradigms. This is not surprising, given that demand for advanced specialty care for high acuity patients continues to be strong in many AHCs. With reputations for clinical excellence, AHCs continue to be preferred providers for a range of primary

and secondary health care services as well.

Therefore, even as senior AHC leaders see fire raging all around them, many have not been able to translate this into the sense of a “burning platform” such that leadership at departmental levels and at the front lines of clinical care are moved to plan and undertake large-scale system and operational changes. The inclination is to stay the course and wait for a while to see how this unsettled environment plays out. Why rush into a major transformation effort, which will undoubtedly be disruptive, without any assurance that we will be able to change in ways that can make us more successful than we already are? In fact, why not build that new hospital inpatient tower? Why not open new urgent care centers, hire more specialists, and maybe cannibalize more groups of highly productive surgeons from nearby competitors?

Our response to these good questions is this: This time it really is different. Our nation has adopted accountable care as national policy. Fundamentals of insurance and health care delivery are changing. Far from a transient movement, this is a transitional moment.

The entire community of insurance and health care stakeholders is incentivized to transition to accountable care and to embrace its dynamic to find the best paths forward. The ACA is catalyzing and harnessing an array of creative, competitive, and innovative forces in order to rationalize health services and achieve better health outcomes. Because of their seminal missions and capabilities, AHCs must engage fully in this comprehensive recasting of our nation’s health care system. Failure to engage and to provide leadership could leave AHCs isolated and unable to fulfill their missions.

As one presenter at a 2013 AAMC Leadership Summit remarked, “Change is coming with or without academic medicine.”¹¹ It is the view of the Blue Ridge Group that change must come with AHCs. Failure cannot be an option.

Leading change in AHCs: A world of complexity

The difficulties for AHCs in transitioning to integrated, accountable care have been widely studied. They include the effects of traditional university and academic medical cultures, entrenched bureaucracies and practices, legacy administrative and information technology (IT) systems, and much more.²⁰

The academic medical environment indeed poses particular challenges. But the fact is that change is hard in almost any environment or organization. Above all, change requires leadership. The failure to undertake needed change almost always reflects failures of leadership. The Blue Ridge Group has addressed the issue of leadership in a number of past reports. The issue keeps resurfacing because it continues to be extremely relevant and urgent.

We have examined in a previous report the leadership implications of AHCs as complex adaptive systems.²¹ This organizational dynamic structures all leadership and management issues in AHCs. To recap, complex adaptive systems have the following characteristics:

- They are nonlinear and dynamic and do not inherently reach fixed-equilibrium points. As a result, system behaviors may appear to be random or chaotic.
- They are composed of independent agents whose behavior is based on physical, psychological, or social rules rather than the demands of system dynamics.
- Because agents’ needs or desires, reflected in their rules, are not homogeneous, their goals and behaviors are likely to conflict. In response to these conflicts or competitions, agents tend to adapt to each other’s behaviors.
- Agents are intelligent. As they experiment and gain experience, agents learn and change their behaviors accordingly. Thus, overall system behavior inherently changes over time.
- Adaptation and learning tend to result in self-organization. Behavior patterns emerge rather than being designed into the system. The nature of emergent behaviors may range from valuable

innovations to unfortunate accidents.

- There is no single point of control. System behaviors are often unpredictable and uncontrollable, and no one is “in charge.” Consequently, the behaviors of complex adaptive systems usually can be more easily influenced than controlled.²²

From the point of view of complexity science, our health care system overall has operated as a complex adaptive system (CAS). Such systems can be distinguished from traditional organizations, which are amenable to relatively direct command and control. Power is the main currency in a traditional system, whereas influence is the main currency in a CAS.

One cannot command or force such systems to comply with behavioral and performance dictates using any conventional means. Agents in complex adaptive systems are sufficiently intelligent to game the system, find “workarounds,” and creatively identify ways to serve their own interests.²²

AHCs have intrinsic CAS characteristics that must be well understood in order to be properly managed, leveraged, and changed. AHCs consist of many separate units and individuals who are differently situated depending on a host of professional, personal, functional, institutional, and other factors. To the extent that AHCs have been able to achieve higher integration of units, systems, and practice, this generally has been done not by forcing new behaviors or processes, but by incentivizing behaviors, whether in the form of criteria for promotion and tenure, professional inducements and rewards, new shared-risk or incentive compensation models, or, as in research, through policy-driven initiatives like program project grants and the Clinical and Translational Science Awards (CTSA) program sponsored by the NIH.

Scholars have long pointed to the great capacity of universities and their AHCs to adapt to changed societal and other environmental factors over centuries and attribute this in no small part to the adaptive capabilities inherent in these organizations. It is hard to argue with success. And

despite calls that arise periodically to fundamentally transforming American higher education to become more focused on creating one or another type of educational outcome, most commentators are reluctant to support changes to the fundamentals of the CAS of the academic environment that could possibly compromise its future success.²³

Yet, as a result, engineering change in the university setting comes with its own special brand of difficulties. As Rouse describes it,

We tend to think of universities as being hotbeds of innovation—bellwethers of new trends in art, science, technology, and lifestyle. This is true for the products of universities. However it is far from true for their processes. . . . Universities’ delusion that they have the necessary processes makes it almost impossible for them to tackle big problems. . . .²⁴

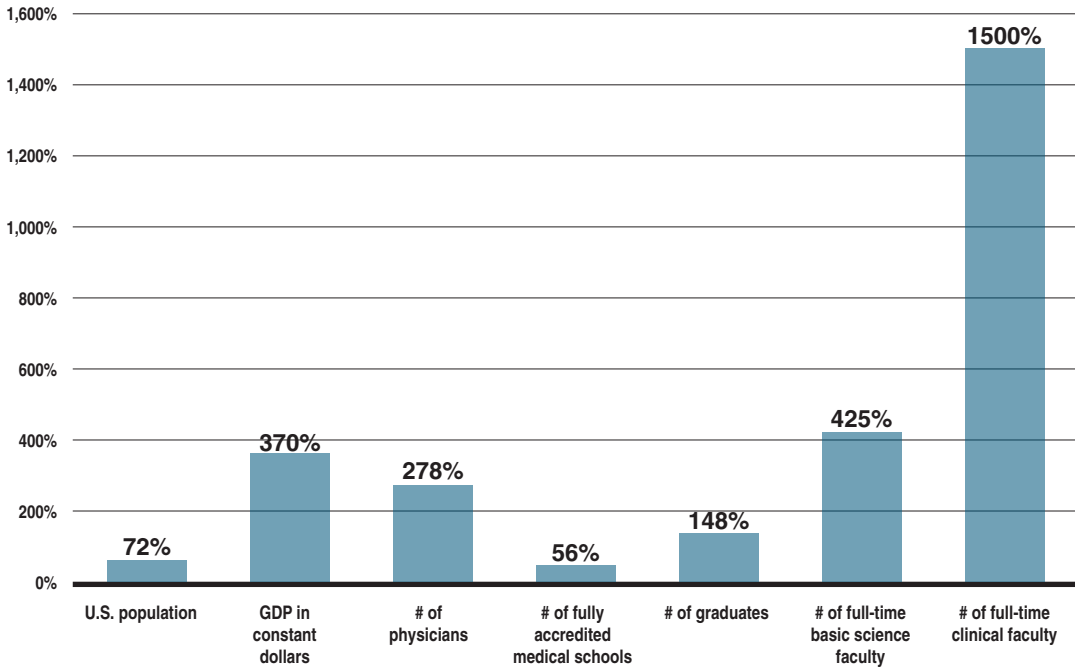
So long as organizations, systems, and individuals are firmly embedded within the academic culture of the AHC, they and their individual actors will be highly competent and inclined to the independent and self-organizing behaviors that are typical within the complex adaptive academic medical environment. This has important implications for AHC leaders who contemplate leading change in the era of accountable care.

Are AHCs “trapped by their competencies?”²⁵

Over the past two decades, AHCs have had to adapt to increasingly competitive markets for health care services while also covering their added costs as the main centers of bioscience and clinical research and of health professions education. AHC leadership eventually did well in adapting to this competitive environment by adopting two common marketplace strategies, especially with respect to highly specialized and unique tertiary and quaternary health services: growing capacity and commanding premium pricing. Evidence indicates that much of the steady increase in health care spending in recent years derives from steadily increasing volumes and costs per case across the health care system. AHCs have been complicit in this.

Figure 4.

Five decades of medical school growth 1960-2011¹¹



Source: AAMC. May not be reproduced without permission

Figures 4¹¹ and 5¹¹ show that AHCs managed to grow clinical capacity quite successfully. Figure 4 shows that, since 1960, medical schools have grown their clinical faculties by an average of 1,500%. Figure 5 shows the results in revenue growth. In 1960, medical school clinical revenues were negligible. By 2013, they were averaging \$426 million per medical school, and clinical revenues grew at a far higher pace than other sources of revenues. Medical schools and their teaching hospitals together accounted for more than \$255 billion in clinical income in 2012.²⁶

By no means have AHCs been unique in pursuing aggressive growth strategies. Providers across the country have long been consolidating and adding capacity to compete in their markets. However, many community-based provider systems could not command premium pricing based on brand and university affiliations. They more vigorously pursued other competitive strategies, including clinical and administrative efficiencies and better customer service. A legacy of AHCs' historic clinical growth and market power has

been that AHCs have not generally been driven by or known for clinical efficiency or patient-centered care.

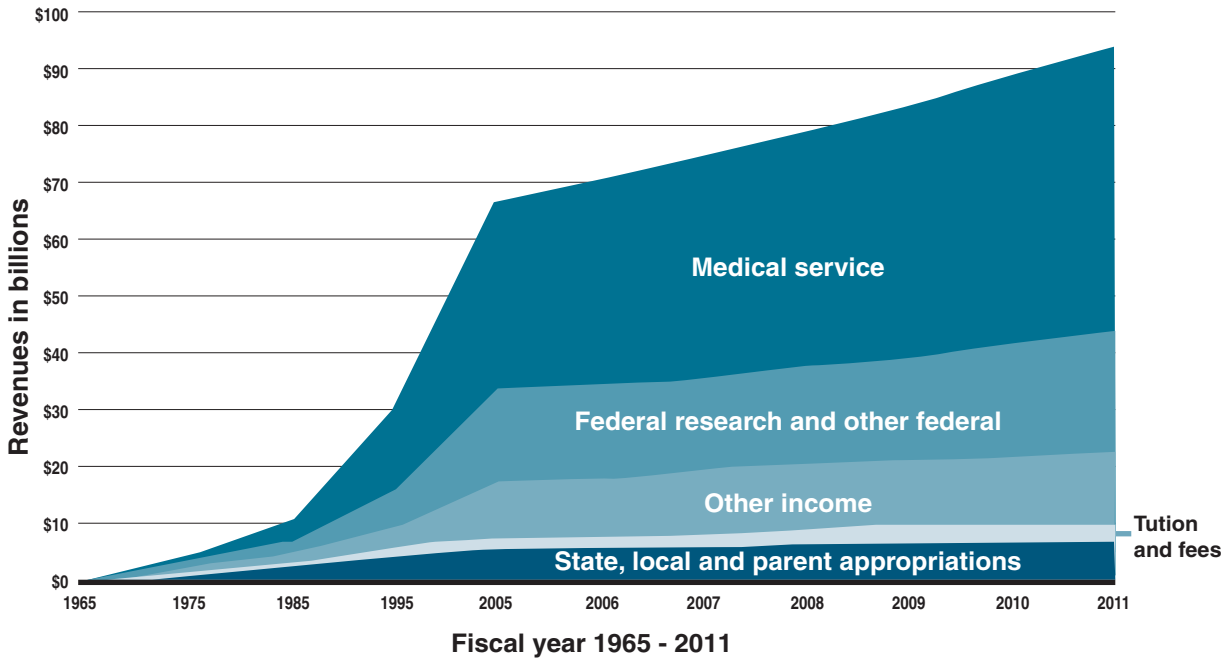
On top of the wide array of policies and incentives that have driven volume and intensity of services, there are the overall projected demographic trends, including the following:

- By 2020, 157 million patients will suffer from chronic disease (81 million with multiple chronic conditions).
- Cancer, mental disorders, and diabetes disease prevalence will increase by 50% by 2023.²⁷
- The number of people with disabilities is projected to grow from about 5.1 million in 1986 to 22.6 million in 2040, or nearly 350%, even as the elderly population overall will grow by only 175%.²⁸

The ACA calls for providers to work within budgets and to assume financial risk for patient populations. This might further incentivize some AHCs to scale up their clinical business. But the added requirements of working within global budgets and accepting financial risk in patient

Figure 5.

Medical schools have witnessed exponential growth fueled by medical service income¹¹



Source: LCOME 1-A Annual Financial Questionnaire (AFQ), 2011 © 2013 AAMC May not be reproduced without permission

management also require the capacity to reorganize and align clinical and administrative systems to manage population health, assume risk, and control spending. So, while demand for health care services will continue to grow, the primary clinical volume and pricing strategies relied on by AHCs are among the causes of rising health system costs being targeted by the ACA.

Not just for AHCs, but also for the health system as a whole, the ACA recognizes that much of the organization and cost of health care is driven by the behavior of physicians and their organizations, acting as agents within the scope of a CAS. It is apparent that the architects of the ACA understood well that the actors and organizations they were trying to influence through public policy had to be incentivized rather than forced into the desired behaviors and administrative structures.

There are many approaches that AHCs and universities have begun to use to grapple with the realities of this evolving accountable care environment. These include efforts to do the following:

- Streamline clinical services, institute quality initiatives, and improve the patient experience
- Rationalize budgeting across traditional departmental and unit “silos.” This includes instituting financial and budgeting transparency as well as clarity on cross-subsidization
- Align management structures across academic and/or clinical units—especially to align faculty practice plans with hospital and medical school management
- Integrate and optimize support functions where benefits of scale can be realized. This includes consolidation in areas such as legal, human resources, and audit services; information technology; debt; and investments.
- Renew via philanthropy capital and subsidization funds for new facilities, hospital/clinic reinvestment and redevelopment, research, endowment, and program and financial aid

All of these are vital to preparing for success in the era of accountable care. But reports from the field are not terribly encouraging. They tend to portray an array of promising initiatives that

remain localized, are designed as “one-off’s,” are only partially achieved, and that fail to grow or to be generalized to the broader institution.²⁹ Very few AHCs are able to report broad-based and high levels of success in transforming themselves to succeed as accountable care providers.

Complexity in defining the future of the AHC clinical enterprise

AHC leadership faces both opportunities and challenges deriving from the explosive growth of the clinical enterprise. There are many different approaches that AHCs have taken to expand their clinical capacities, including adding clinical faculty to the medical school and/or the hospital, adding community physicians in some affiliated capacity, or variations of all of these and more. Whatever the strategy, many AHCs now feature a large cohort of primarily clinical faculty that dwarfs the teaching and basic science faculties.

This vast expansion of clinical workforce at AHCs has changed these organizations, and in many cases has caused medical schools to wrestle with complicated questions about academic and professional roles and expectations, including issues of promotion and tenure. Questions have been raised about whether medical schools are creating two or more classes of faculty and about whether this new clinical workforce consists of individuals, organizations, and systems that are far more like clinical organizations found in regional and community hospitals and systems and some large physician practice settings, than in the traditional academic setting.

There are many different answers to these questions, which we will not review here. For our purposes, the important point is that AHCs have shown that they could adapt to the need for growing clinical capacity and that this new clinical workforce could in various ways be “shoehorned in” to align with, or to work in parallel with, traditional academic and professional colleagues, especially where the additional clinical workforce has been successful in generating departmental and health system referrals and revenues.

One upside of this development is that the accumulation of large clinical faculties and their breadth of clinical experience can enable some

AHCs to pursue a range of strategic options and partnerships going forward that otherwise might not have been possible. These include the capacity to undertake population health and risk management strategies built around this workforce. Of course, there is a great deal more involved in developing the capacity to manage population health and financial risk, but AHCs in many situations certainly can start from the capacity to marshal the necessary workforce and/or to add partners to grow and fill out that capacity.

There is a major leadership opportunity here and perhaps even a path to the resolution of lingering academic versus practice-focused faculty and clinicians: to engage the capabilities and motivations of this primarily clinical workforce and recruit these clinicians to the opportunities of pioneering new team-based, accountable care in the emerging accountable care environment. There are a number of examples of health systems led by clinicians successfully embracing demands of the new accountable care environment. Many of these were already characterized by leadership, organization, and cultures focused on team-based and patient-centered care, usually along with an insurance product. The Cleveland Clinic, the Mayo Clinic, Geisinger Health System, and Kaiser Permanente come immediately to mind. Of course, AHCs start from leadership, organizations, and culture that are mostly products of the traditionally balkanized academic environment. But many AHCs with large clinical workforces should be able to develop a similar organizational and cultural capacity for team-based and accountable care.

There are encouraging examples of AHCs and AHC-affiliated organizations pursuing quite aggressive and comprehensive strategies to transition in such ways to the era of accountable care, several of which we will review here. But while many AHCs are showing themselves to be adaptive and nimble enough to develop significant capacity in population health management and accountable care, one cannot ignore the considerable difficulties that many AHCs have had in initiating and leading change into the era of accountable care. As we will discuss further, AHCs must consider a range of strategic directions forward that are of a scale and nature compatible with a

thorough and honest assessment of the particulars of each AHC's situation and environment.

Complexity in defining the future of the AHC science enterprise

As AHC leadership contemplates future states, it is also vital to realize that the dynamics of their complex adaptive systems also apply to the other missions and functions of the AHC, in particular, in education and research. Here, our focus is primarily the future of bioscience and translational research. (See our most recent report for an accounting of educational imperatives and opportunities.)³⁰

As with the clinical faculty, basic science faculties operate within the AHC complex adaptive environment in their own ways. Basic science faculties are traditionally organized into particular medical school (and other university and health professional school) departments and also function within the academic milieu in which they trained and consider their disciplinary home. Basic science has traditionally been organized around individual laboratories run by senior scientists who individually develop research agendas, compete for grant funding, and publish their results. Scientists often collaborate across labs, departments, institutions, and continents. All of this occurs within the context of a well-defined apprentice system where younger scientists generally join a lab and are mentored there until such time as they can win their own funding and establish their own lab. Obtaining and maintaining funded support over time is critical to success.

Given the competitive and peer-reviewed nature of most grant funding and the large investments required to build and maintain research space, the basic science enterprise has long been cross-subsidized with clinical revenues. This worked well in the early post-Flexnerian days, when most clinical faculty were clinician scientists and conducted their research in the context of their clinical practice without resort to much if any external support. As the more purely basic science and clinical faculties grew separately and clinical revenues soared, clinical cross-subsidization became implicitly accepted as necessary and vital to the science mission within the constraints

of the science-funding environment.

But as the pressures of the marketplace have increased, medical schools and teaching hospitals have seen margins tighten, and clinical faculties have been under pressure to be more productive. At the same time, expectations have grown for progress in clinical technologies and better outcomes, while pressure has mounted to more quickly move science from the lab to the bedside.

The science enterprise in some AHCs has expanded its funding base through the addition of large project grants and industry-sponsored research but never enough to cover the overhead costs that continued to mount as AHCs added faculty, built modern facilities, and added core technologies. As a result, the research enterprise has heard increasing calls to wean itself off of clinical cross-subsidies, to "right-size" itself, to align itself with the needs of accelerated device and drug development, and to identify new sources of support.³¹ An equivalent call has gone out to the educational enterprise.²⁹ This is another major leadership challenge of the emerging accountable care era.

There is consensus that the AHC science enterprise is absolutely critical to our missions and to forward progress in medicine and health and that working to ensure its future success must be one of leadership's highest priorities. Certainly, public-sector sponsored funding has been in decline for more than a decade and is vulnerable to shocks (like those we are currently experiencing) from socio-economic and political forces. There is also ample evidence that the basic research enterprise in places has lost focus, grown too fast, and often fails to identify and promote some of the most innovative and creative thinking. The AHC science enterprise also has suffered from over-promising and under-delivering on the near-term possibilities for major advances in medicine and health care based on emerging knowledge in genomics and other fields. Given the overall focus on driving integration, alignment, and innovation, there is a groundswell of sentiment that AHCs must not simply re-engineer basic science funding but also expand translational research as a way to put greater focus on the bench-to-bedside drug and device development pipeline.

The research enterprise in AHCs must undergo thorough review. But, as with other aspects of the AHC environment, thorough examination of the science enterprise can occur only in the context of how that enterprise is currently embedded within the complex adaptive dynamic of medical schools and their tripartite mission. There is virtual consensus that all AHC units and functions have to be actively engaged in reducing costs and collaborating in re-engineering operations and behaviors to achieve not just localized but institution-wide goals. But leadership must face some very difficult questions about how and to what extent the scientific enterprise, including its funding and its focus should, or indeed can, be restructured.

At the very least, leaders and other change agents must start from a clear vision of a successful future science enterprise in their institutions and within the context of their communities. From there they can consider the types of changes that can best achieve success. In the context of the emerging accountable care environment, most strategic planning focuses on aligning all units and functions around shared institutional goals. For many AHCs, this will likely mean aligning the science enterprise to become more translation-focused and self-sustaining by forming new philanthropic and industry partnerships, among other measures.

But it is likely that AHCs will assess the capabilities, contributions, focus, and financing of their science enterprises in a variety of other ways as well. Alignment will likely have different meanings in different circumstances. Some AHCs will continue to be the major tertiary and quaternary care center in their locale or region, and on top of that develop capacity for managing population health (i.e., be all things to all people). But for the majority where this may not be feasible or desirable, there are still many possible configurations and alignments of the clinical, science, and education functions and missions. This might include the following:

- Paring down or refocusing the science enterprise or
 - Partnering and sharing resources with philanthropic organizations, industry, or other AHCs
- Alternatively, an AHC might decide to

strengthen the science enterprise by reasserting the clinical mission's role in supporting basic science and by focusing on the training of investigators and clinician scientists. In some cases, this might require innovative partnering with clinical systems of larger size and scope.

With many possibilities for configuring the science enterprise within AHCs, the levels of leadership engagement and the specifics of institutional strategic visioning and planning will determine those futures.

Regardless of the particular strategy or configuration, AHCs must prepare themselves to be able to work effectively with new partners. AHCs have a mixed track record in this. An example is the experience, starting mostly in the 1980s and 1990s, of AHCs deciding to aggressively pursue academic-industry partnerships. This was a leading strategy in the goal of leveraging the extraordinary intellectual and discovery resources within AHCs in order to accelerate drug and device development and to monetize these otherwise latent assets. But AHCs confronted many difficulties, not the least of which was meeting performance expectations in the new environment. To do so meant not simply to network into new markets and partnerships but to adopt new ways of working, along with new metrics. This was difficult for many AHCs that did not adequately prepare themselves for their new roles. Rouse summarizes the problems well:

Universities thought that selling university-industry partnerships would be the hard part of change. They did not expect that making these partnerships work is actually the hard part. Making them work requires rethinking the universities' processes ranging from finance and accounting to incentives and rewards. In other words, they did not expect to have to adapt to their new markets.^{24(p143)}

The fact that it has taken a decade and more of time and effort for many AHCs to adapt their processes and capabilities to new partnerships in markets that function in more traditional (rather than complex adaptive) ways belies a lack of sufficient appreciation for the requirements of operating and succeeding in this environment. The critical lack of

leadership experience and therefore of strategic focus on creating the requisite operational capacities is an important lesson that must inform planning for innovative partnerships going forward.

An important underlying issue for AHCs, with implications for the entire health care system, is how to equitably account for and cover the costs of the education, training, and research that AHCs conduct. This issue has not yet been sufficiently addressed in the planning for the era of accountable care. AHCs, which must cover the added costs of these vital activities through clinical revenues, cannot be expected to compete directly or successfully with other clinical organizations that do not carry such costs. These additional costs can also make strategic partnering more challenging. These vital university and AHC education and research programs undergird our nation's health care workforce development and much of the progress in medicine and health care. Even with extraordinary efforts by AHCs to reduce costs in the education and science enterprises, the economic viability of the AHC community will require policymakers to address the critical issue of how to equitably allocate and pay for the costs of these AHC functions.

Multiple options, one imperative

The economic and policy forces at play nationally are catalyzing a great deal of hospital and health system consolidation. There is growing evidence in many markets that even AHCs with relatively secure or even dominant market positions are being challenged by large, well-capitalized health systems that are also increasingly capable of competing for patients requiring advanced care.³²

As we have previously observed, there are many approaches most AHCs have begun to use to grapple with the realities of our evolving economic and policy environment. But in this new environment, even more is required. Many AHCs will have less market power to command higher prices, and they may have less capacity to grow services. Absent the development of new market approaches, some AHCs could fail to provide sufficient cash from operations to simultaneously meet current operating needs, invest in and renew physical plants, and grow and enhance clinical,

educational, and research programs.

AHCs need to address not just administrative, but programmatic operations and priorities. AHCs must integrate health care delivery both within their own systems and now, too, with those of new partners. They must update educational programs to train physicians and other health care workers for the new era of accountable care, reorganize or rethink the research enterprise, develop the capacity to assume risk in the management of population health and episodes of care, perhaps acquire or create an insurance product, enter into strategic partnerships where necessary or advantageous, align all of these missions and functions, and ensure that changes in the financial obligations and risks (and sometimes missions) associated with AHC success continue to be compatible with the larger university missions of which they are a part. And all of this must be done not in a command structure but within the context of our complex adaptive systems, cultures, and organizations.

We believe that the vast majority of AHCs can find productive and successful paths into the era of accountable care. There are many approaches that AHCs can take in meeting any and all of these challenges and a large number of gifted consultants who can help guide the choice and implementation of options. However, the one over-riding imperative for all AHCs is for leadership to take the initiative and to make the case for change, despite the absence in many cases of an obviously burning platform. And then leadership must engage their institutions in taking on the bottom-up and top-down work that must be done to effect such transformational change.

Leadership needed to effect enterprise transformation

"To achieve success there must be a continual process for anticipating impending situation changes, recognizing their emergence, and responding to them." —William Rouse^{25(p199)}

The difficulties involved in accomplishing the leadership imperative to effect enterprise transformation cannot be overestimated. Large-scale

and system-wide transformation is extremely challenging. Evidence shows that attempts at enterprise transformation very often fail. This can be seen by looking at the track record of even America's most prosperous and successful companies. From 1956 to 1981, an average of 24 firms per year dropped out of the Fortune 500 list. This amounted to 120% turnover in 25 years.³³ And apparently, our information age economy is even more competitive. From 1982 to 2006, an average of 40 firms dropped out of the Fortune 500 list every year, an accelerated 200% turnover in 25 years. Clearly, even our best companies can't keep up with the demands for change and innovation. They falter and/or fail at a very high rate. There is no prima facie reason to believe that AHCs will be exempt from this dynamic.

This rate of failure appears to be in the nature of a highly competitive and successful capitalist economy, where existing companies lose their competitive edge to entrepreneurs who can create new and better products and business processes. Classical economics posits that this competitive dynamic is to be expected and encouraged as the best path to continuing progress and prosperity. But, of course, this is no consolation to the enterprises that can't adapt and change.

This high turnover rate shows that stakes are high and success rates only moderate in maintaining a competitive edge and leadership. Such Fortune 500 turnover, as well as the fate of other large and small enterprises throughout the economy, most often represents the failure to innovate and to anticipate and initiate needed change. As organizations remain embedded in the status quo, it becomes harder and harder to transform essential business systems and strategies in order to maintain competitive advantage. Past a certain point, there is simply too much to do to catch up to the innovators and new market leaders. And as the data show, timely enterprise transformation appears to have become more difficult with the acceleration of the development of new platforms and technologies.³⁴

To beat these odds, leadership in AHCs must be able to develop and "sell" a comprehensive vision of possible futures for their state and local health marketplace (or whatever is the relevant

environment) and then also a vision of the best possible roles that their AHC can play within their markets and communities. Then the leadership must inspire and empower change agents throughout relevant units in their organizations to put meat on the bones of this vision in the form of strategies to achieve the future envisioned.

Importantly, since people and units within these complex adaptive AHC organizations are differently situated and succeed by self-organizing, one of the biggest challenges for leadership is to develop vision and strategies that work for each of the different constituencies. Leadership must make clear to each of them how change will affect them, how they can succeed in the envisioned environment, and how the institution—its culture and rewards systems—will support them and enable them to succeed.

Selling the vision and then committing to working through the success factors for all constituents is critical. In complex adaptive AHCs, individuals and even whole units are invested in countless ways in working with, and sometimes around, current systems. Even the "workarounds" are important parts of the system and culture. Incentives, rewards, policies, and priorities are all mutually reinforcing and "influential" in maintaining "free-agent" investment in the current systems. And most people are not equipped with enough information, perspective, and authority beyond the purview of their immediate responsibilities to understand, anticipate, or begin to address the impact of larger institutional or societal forces.

One of the great responsibilities of leadership is to provide timely information about, and notice of, the need to plan for new pathways for success. Until leadership provides this notice and initiates processes that legitimize planning for change, most people and units can and will only work within existing rules and expectations. Therefore, leadership must not just provide a vision, but must specify the policies, priorities, incentives, rewards, and sanctions by which people and units can or must reorganize their work and behaviors. If leadership persists in keeping people and organizations in the dark and in avoiding issues surrounding the need for change, then leaders will

not prepare their people or their organizations for future success.

Most often, in our complex adaptive systems, a burning platform has provided the impetus to enable leadership to create the legitimacy and the motivation for significant change. In a period such as we are in now, where the burning platform is masked in many AHCs by the local experience of full clinics and reasonable clinical margins, this task is more challenging. The test for leadership in this instance is to develop a vision and motivation for change that is compelling within the context of that AHC's environment and situation.

Leading health professional organizations, including the AAMC and Association of Academic Health Centers (AAHC) have been working to build better awareness of the impending transformational changes in health care and insurance and to help AHC leadership enhance their change management capabilities. The AAHC has held conferences and published white papers on various aspects of preparing for health system transformation.³⁵ The AAMC has been developing and sharing expertise in leading change. It held

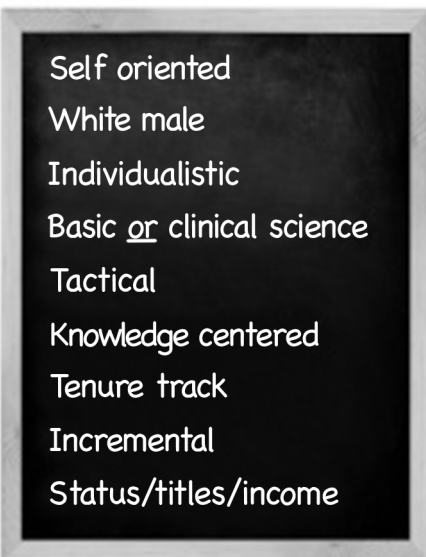
a Leadership Forum Summit in February 2013, where AHC leadership met to discuss how AHCs could and should approach the era of accountable care. And it devoted much of its 2013 annual meeting to this and related topics.³⁶ An overarching theme and motivation in these efforts is to identify leadership qualities and to spur leadership action that can preserve and enhance the special missions of AHCs in clinical care, research, education, and community engagement. The new leadership qualities are identified in table 2.³⁷ Preservation and enhancement of these missions is paramount, since these distinguish AHCs from other providers and are indispensable roles in the nation's health care infrastructure.

But it has become clear that not all AHCs will be able to go forward with real strength and impact in all of their traditional mission areas. Some AHCs are positioned in their environments to feature the full-range of clinical capacities and prosper as major clinical systems in the new accountable care environment. Yet even these will be differently situated, depending on the particulars of their local or regional markets. Some will

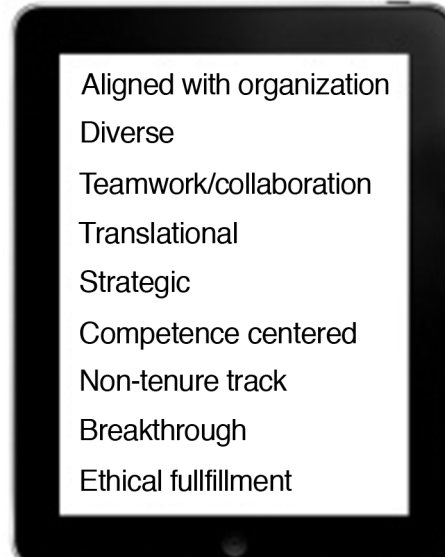
Table 2.

Transforming academic medicine requires different leadership competencies³⁷

Traditional



Future-oriented



own all of their assets, including personnel and facilities. Some will own only assets that constitute particular strengths and partner for the rest. Some may partner for virtually all facilities or for a large number of clinical and referral physicians.

Other AHCs may be better positioned to focus on their educational and research missions, while reducing their owned clinical services and partnering with community hospitals and ambulatory practices to fulfill their clinic-dependent missions. Then again, some AHCs will be better positioned to focus completely on preclinical and clinical education and training, most likely with community-based partners. It is interesting to note that the most recently created medical schools are not directly connected to university hospitals and are favoring this latter model.

The overall societal goal is universal, value-driven, accountable care. In this context, it is necessary for each AHC to consider the possibilities of alternative priorities for their missions as well as many new types of relationships and partnerships within the multiple capacities required to achieve accountable care.

Focus on value

The challenge of value is the foundation challenge of strategic management. Understanding the ways in which your enterprise provides value to its stakeholders and then continually enhancing—and occasionally reinventing—how value is provided should be a driving strategic priority.³⁸

Leadership looking ahead to develop a compelling vision of the future of an AHC must start by asking and answering three basic questions:

1. What are the emergent market dynamics and opportunities?
2. What is our vision? And what is/are our value proposition(s) (the organizational output(s) that add value to customers and stakeholders and align with community and national health priorities)?
3. How can we transform and align our organization (including people, processes, culture) and our value proposition(s) with emergent market dynamics and opportunities?

Once leadership understands the emergent

market and policy dynamics and opportunities, then the second question is how to establish a vision that is in line with these realities and with the realities of the AHC itself. The third question is entirely separate in the sense that it involves developing the capacity to win over all of the relevant AHC constituents to the efforts needed to effect the needed transformations.

Perhaps the single most difficult hurdle for leaders in addressing the second question and developing a vision for change is to develop and work from an accurate assessment of their organizations and their capacities to drive strategic change management. Systems engineer and consultant William Rouse reports that one of his most important roles with clients is “myth-busting.” This involves helping clients correct outsized or inaccurate estimations of their own capabilities and track records, as well as their capacities to change and innovate. It is very hard to know where you are going if you don’t start from a realistic assessment of where you are. Striving to attain an accurate and honest assessment of organizational capabilities and, where necessary, myth-busting, is critical to the capacity to effect successful change. Knowing where your value lies is the only way to understand and potentially revise or reinvent the organization’s value proposition(s) to align with emergent opportunities.

The challenge of understanding an organization’s value proposition rests in large part in the fact that value means different things to different stakeholders. In a typical private enterprise, for example, value for customers involves the benefits of products or services relative to their cost. For employees of the company, value relates to things like the work environment and compensation. For stockholders, value rests in stock prices and market valuations.^{38(p60)}

Value in health care can be defined as

... the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes. Improving value requires either improving one or more outcomes without raising costs or lowering costs without compromising outcomes, or both.³⁹

Using this definition, it is not hard to see that the definition of value within the AHC as traditionally understood is different from the value proposition being driven by the ACA and by other forces current in health care and insurance marketplaces. This difference is captured in the *Harvard Business Review* by Porter and Lee:

We must shift the focus from the volume and profitability of services provided—physician visits, hospitalizations, procedures, and tests—to the patient outcomes achieved. And we must replace today's fragmented system, in which every local provider offers a full range of services, with a system in which services for particular medical conditions are concentrated in health-delivery organizations and in the right locations to deliver high-value care.³⁹

The challenge for leadership of AHCs is to clarify that the new value proposition will structure everything that matters in the organization going forward.

Once leadership has made the case for change, then the truly herculean task is addressing the third quest: growing and re-enforcing the new value proposition throughout the organization and culture such that it catalyzes the organization to adopt the new definitions of value and to become proactive, in all of its complex adaptive ways, in inventing new ways to create that value.

How leadership can succeed in catalyzing value-based enterprise transformation

Enterprise transformation is driven by experienced and/or anticipated value deficiencies that result in significantly redesigned and/or new work processes as determined by management's decision making abilities, limitations, and inclinations, all in the context of the social networks of management in particular, and the enterprise in general.³⁴

The failure to effect needed change in our AHCs is most often rooted in very basic leadership issues or miscalculations rather than in outsized complexity or overwhelming demands intrinsic to success in a new environment. The following guidelines represent key insights from AHC

leaders that can increase the chances of success in initiating and driving needed enterprise transformation.

Get out of the weeds

One of the basic issues in effecting and managing change necessary to achieve success in the accountable care environment has to do with limitations of leader and manager experience in strategic as opposed to operational thinking, planning, and execution. In most enterprises, including AHCs, the imperatives of increasing competition in health care over the past two decades or more has tended to select for leaders and managers who are skilled at reducing costs, creating efficiencies, and responding to an array of interrelated operational issues.^{38(pp9-10)} These leaders and managers spend most of their time responding to immediate or short-term process, human resources, and budgeting issues. At the same time, leaders and managers also have had to learn to manage people and systems across disciplines outside their traditional expertise. This has contributed further to keeping management focused on mastering the details of effective operational solutions, rather than overall strategic planning.

Understanding the overall situation of an AHC and envisioning a successful future state in a new era of accountable care requires leadership that has the time for strategic thinking and is capable of engaging a wide array of stakeholders in strategic planning. Even in situations where there are any number of managers and team leaders with good strategic capabilities and ideas, these are often preempted by immediate operational issues and goals. AHC leadership must be capable of abstracting out of the weeds to the broader fields of vision necessary to lead transformational change.

Adopt a strategic cast of mind

In order to be able to approach the strategic dimensions and requirements of the transition to accountable care, leadership must essentially adopt a new "strategic" cast of mind. Leadership must be capable of saying, "We may not simply have to reorganize what we are doing, we may have to rethink it."

Communicate, communicate, communicate

Once leaders and senior managers have honestly come to grips with the possibility that serious rethinking is required, then it becomes leadership's responsibility to communicate to the entire organization the nature of the challenge ahead and then to articulate the imperative to undertake the rethinking process. Leaders can often fail to articulate and communicate the "story" of the organizational vision being pursued, why change is necessary, how the organization will achieve this future, what everyone's roles will be, and what help will be provided to succeed in this role. Not to "sound the alarm" means not to prepare our people and our organizations for future success. It is the role and responsibility of leadership to communicate the need for new thinking and then to help chart the paths to success as well as motivate and move people along those paths. Otherwise, even knowing that change is necessary, people will continue to work according to existing rules and within existing frameworks unless—and until—leadership effectively gives them the permission, the imperative, and the process by which to begin the change-making process.

"... to drive the efforts of the organization long term, the message must be more than inspirational. The value of the message must be real and be something the organization can rally around."⁴(p387)

Employ appropriate leadership models

Another pitfall for leaders is to misconceive the role of leadership as a form of "Moses coming down from the mountain" with an enlightened and fully formed set of prescriptions that are writ in stone. Instead, leaders in our complex adaptive systems require change agents "whose roles are to facilitate communication, cooperation, and collaboration."²⁵(p209) Planning for change of the magnitude called for in the transition to accountable care requires more facilitative leadership and a broad-based and multi-layered planning and implementation process that can evolve on the basis of the wide array of inputs needed from within all mission areas and units of the AHC.

Identify and eliminate mythologies that crowd out realistic assessments

Another major issue that leads quickly to failure is the inability of leadership to accurately assess their own and their organization's strengths and weaknesses. As noted previously, myth-busting is critical. It is very hard to know where you might go if you don't start from a realistic assessment of where you are.

Leading causes of failure to effect needed transformation include the following:

- A reasonable plan is never created: Leadership adopts a wait-and-see attitude.
- A reasonable plan is developed that is not viable: Leaders choose to "get back to basics" rather than to move ahead with innovative solutions. Complex adaptive behavior on the part of multiple constituencies in the AHC can cause leaders and managers to default to paths of least (or less) resistance and so the organization undertakes too much localized process re-engineering and not enough enterprise transformation.
- A reasonable and viable plan is achieved but is not executed: Incentives and rewards are not changed adequately to align with the plan.
- Critical relationships and trust are missing: Leaders have failed to engender the fundamental trust that is essential to engaging people in their best efforts as honest agents of change and working toward success. Ingredients necessary to building trust include mutual respect, transparency, and integrity in all interpersonal and organizational matters.⁴(pp388-392)

"Changing an organization is about changing hearts and minds. It is about changing the way individuals feel, think, and act. It is not a logical, analytical endeavor."⁴⁰

Conclusion

"An organization is nothing more than the collective capacity of its people to create."—*Lou Gerstner, former IBM CEO*

The environment for AHCs is challenging, and the stakes are high. Leadership in AHCs must develop a compelling vision of possible futures

for their AHCs in their local and regional health marketplaces. Proactive and forward-looking leadership can bring meaningful engagement and necessary, innovative change. There are as many possible futures and scenarios as there are leaders of AHCs. To preserve and strengthen the critical roles and missions of AHCs in our health care future, AHC leaders must step forward and lead their people, their institutions, and their communities in the transformative work of creating the future of accountable, affordable, value-driven health care.

Pathways to AHC transformation: Examples from the field

“To flourish—indeed to survive—AHCs must reconfigure and transform rapidly and broadly in size, speed, value, and innovation.”⁴¹

To get a better understanding of what the process of transitioning to accountable care can involve and what success might look like, we examined the experiences of several AHCs that illustrate pathways to meaningful engagement in achieving accountable care. The pathways we review in the accompanying special section include the following:

- Restructuring decision-making around clinical strategy, operations and funds flow
- De-balkanization of research funding and enterprise
- Developing an integrated approach to faculty hiring
- Building capacity through nontraditional partnerships
- Modeling the future of integrated, accountable health care
- Engaging from “top to bottom” in defining and leading the transition to accountable care in a regional environment

Restructuring decision-making: University of Michigan Medical School

“Stop trying to think your way to a new way of working. Work your way to a new way of thinking!” —*University of Michigan Medical School planning moniker*

The University of Michigan Medical School (UMMS) has been at the cutting edge of reform of health care systems. As leaders at the medical school began to prepare for the era of accountable care, they understood that the concept of accountable care should be rooted in the following:

- Addressing the fragmented nature of health care delivery
- Financial incentives for broad cost containment and quality performance across multiple sites of care
- A provider-led organization with meaningful beneficiary input
- Accountability for quality and cost of a population
- Encouraging physicians to think of themselves as a group with
 - Common patient population
 - Care delivery goals/plans
 - Metrics

In the context of looking to develop new models of accountability, UMMS created a new set of imperatives:

- Be a leader in the transformation of the quality and value of medical care.
- Innovate in care delivery and payment models in addition to technological advancements.
- Create a clinically integrated organization.
- Partner with other physicians and hospitals to improve health.
- Succeed in achieving the triple aim: better health for populations, better health care for patients, and lower costs.

UMMS looked at the group employed model characteristics of organizations like the Mayo Clinic, Cleveland Clinic, Geisinger Health Care, and Kaiser Permanente Medical Groups. What they found were organizations characterized by large multispecialty medical groups, capable of delivering high quality and lower costs. These organizations were permeated by a culture of

patient-centeredness and accountability. And they attributed their success to critical factors such as physician leadership, governance and management, transparency, individual and shared accountability, and appropriate health information technology.^{42,43}

The school also looked carefully at the definition of “value” in health care: Value equals appropriateness times outcomes over costs. The school decided that guidelines must be developed with criteria for appropriateness and indication for procedures. Units and individual providers should get no credit for good outcomes and/or low cost for procedures that are not indicated.

The capacity to operationalize the new roles and values appropriate to accountable care led to key structural and management changes within UMMS. These included the following:

- Transitioning the faculty practice plans to a medical group model
- Focusing medical groups on care delivery, quality, safety, collaboration, transparency, and care coordination
- Giving medical groups meaningful responsibility over the clinical enterprise
- Participating in the new payment models
- Taking on the responsibilities of pioneering accountable care organizations
- Organizing to accept bundled payments
- Engaging external physician organizations and hospitals in care improvement

The structural changes at UMMS built into ambulatory care services include the following:

- Moving key management responsibilities to the faculty group practice (FGP)
- Appointing a medical director responsible for each ambulatory care unit
- Making a thorough commitment to transparency so as to build trust
- Eliminating budgeting and moving to simple profit and loss statements with forecasting.

The FGP was given responsibility to pay departments based on specialty-specific benchmark relative value units (RVUs). The FGP is responsible for performance against risk. This results in faculty salaries being the only clinical expenses in departments. The medical school has found that department chairs will work together

well if they have shared responsibility.

The FGP has been able to undertake significant new integration initiatives. It became a pioneer ACO with responsibility for 25,000 beneficiaries. It then partnered with other organizations to create the Physician’s Organization of Michigan ACO with 82,000 beneficiaries. The FGP also supported the need to build a Great Lakes Health Information Exchange (in partnership with the IT division of the Michigan Hospital) and began establishing patient-centered medical homes based on an innovative pharmacist practice model that links directly with community pharmacists for critical point of contact engagement with patients on medication compliance and related issues. The FGP has also established new multidisciplinary clinics and shared practice guidelines.

Moving management control of ambulatory services from the University of Michigan Hospital to the FGP resulted in the FGP implementing a management structure and incentives that have improved physician satisfaction, patient satisfaction, patient access, and margin.

In primary care, the medical school has undertaken signature initiatives to embed pharmacists in the patient-centered medical home, to move to new payment models based on RVUs, and to implement a capitation plus fee-for-service model risk adjustment of patient panels to focus resources. The school recognized the need to identify and train new “comprehensivists” to focus specifically on coordinating and improving services for patients with complex conditions.

UMMS has also been developing targeted specialty initiatives in departments with patients with multiple chronic conditions, high cost, and significant coordination of care issues. This includes hematology/oncology, cardiology, orthopedic surgery, and nephrology. There is also a major initiative to develop acute diagnostic and treatment centers connected to major clinical areas as an alternative to emergency department use for patients with acute exacerbation of their chronic disease. This is a concept first successfully implemented within the UMMS cancer center to reduce hospital admissions in managing neutropenic fever, dehydration, and pain.

Another vitally important medical school

initiative has been to learn from other industries about the importance of processes and the manufacturing equivalent of medical “handoffs” to quality and outcomes. The school has been working to build not only the right structures and processes but also to develop the frame of mind among the entire workforce to think of their roles and the role of their AHC not as a traditional referral center, but as the integrator of a clinical network. In these and many other ways, UMMS is well on its way to success in the era of accountable care.

De-balkanization of research investment and enterprise

In order to better establish and achieve institution-wide scientific research goals, UMMS has undertaken a significant restructuring of management of its science enterprise to enable coordinated planning and efficient, effective deployment and utilization of resources. A research board of directors (RBD) was established with the mission to work collaboratively to establish a vibrant intellectual milieu that is conducive to scholarly research activities and to implement a shared institutional vision for the research enterprise of UMMS.

The RBD is composed of the dean of UMMS (who chairs the RBD), along with the department chairs; senior leadership concerned with basic, clinical, and translational research; the chief financial officer; and others. The objectives of the RBD are as follows:

- Represent the interests of UMMS research.
- Create a mechanism for UMMS administration and departments to work together to implement strategic research goals.
- Make recommendations regarding strategic research initiatives and expenditures necessary to provide research services and infrastructure that support the research mission of UMMS.
- Act as an advisory body to the UMMS Office of Research while recognizing that final decision-making authority rests with the UMMS dean’s office.

The RBD is expected to help the UMMS reach the full scale of its collective potential by creating a shared vision for the research enterprise, facilitating strategic research initiative development and driving common priorities to tangible outcomes, identifying strategic research recruitment and retention opportunities, guiding institutionally minded decision making on issues of significant and broad impact, coordinating to minimize duplication and leverage specialized resources across the UMMS and the university, achieving sustainability through shared resourcing, promoting and strengthening the financial viability of the research enterprise, ensuring continuous improvement of research operations, and aiding in strategic master planning of research space for the UMMS as a whole.

For more information see: <http://medicine.umich.edu/medschool/research/strategic-research-initiative>. See also table 3.

Table 3.

The evolution of the Michigan vision of the successful AHC of the future

Current	Future
Hospital centric	Medical group driven
Referral center	Partner in care
Quality assumed	Proven quality
High cost	Proven value (quality/cost)
Integrated system	Integrator of a clinical network
Fragmented education	Accountable education

Integrated approach to hiring: University of Pennsylvania School of Medicine

Leadership at University of Pennsylvania School of Medicine determined that future success was going to require achieving the capacity for institution-wide planning and coordination. In the traditional structure of medical schools, departments are relatively independent, and department chairs define and drive goals from the point of view of their departments. School leadership believed that the capacity for institution-wide planning would best occur by harnessing the chairs' collective knowledge and experience and having them work together to focus on defining and achieving overall school and system goals.

UPenn leadership undertook this change, and the chairs were convinced of the benefits of working collectively and sharing responsibility for institution-wide success. This was accomplished in part through an incentive program that had the dean and chairs participate in a common incentive structure. Half of compensation became dependent on institutional performance and half on chairs' own department performance.

This bringing together of the chairs around institutional goals also catalyzed a new process to centralize faculty hiring so that hiring decisions would be made in the context of overall institutional goals.

Nontraditional partnerships: University of Colorado Health System

In 1990, in the wake of a newly competitive environment for hospitals, the University of Colorado spun off its university hospital. The move proved very successful, and the medical school saw robust growth, supported by its centralized practice plan. The university also very successfully moved the pediatrics department to the local/regional children's hospital. Yet even with their ongoing success, medical school leadership saw the environment around them changing quickly.

Colorado is a state of 5.5 million people that has become a very competitive health care market. HCA has seven hospitals with more than \$2 billion in revenues. Centura has 14 hospitals with strong capital reserves. Sisters of Charity has four hospitals. All of these health systems are very

active in building and buying physician groups and expanding their market share. The University of Colorado felt an imperative to partner and grow or else be marginalized in their marketplace. They decided to look at innovative partnership(s) they might forge to strengthen their clinical business and their related missions in education and research.

In 2012, medical school and university leadership decided to pursue a relationship with the Poudre Valley Health System (PVHS), a three-hospital system with a successful focus on quality. Truven Health Analytics has named Poudre Valley Hospital one of its 100 Top Hospitals every year since 2001. In 2012, PVHS received the Malcolm Baldrige National Quality Award and was named one of Thomson Reuters' top 15 health systems in the nation.

A partnership was formed, and the University of Colorado Health System (UCHS) was created. UCHS was established as a joint operating company with a shared bottom line and an 11-member board made up of four medical school representatives, five Poudre representatives, and two university representatives. Each hospital maintains local management and its own board. Each also maintains continuity in its local brand identity in its market. The partnership invested substantially in integration of central services like health information technology, finance, human resources, marketing, and legal.

Not long after, Memorial Hospital in Colorado Springs became a partnership opportunity, and the deal was sealed around the idea of creating a branch medical school campus in Colorado Springs.

The benefits of a closer relationship between these two organizations are numerous:

- Combined academic-based and community-focused medicine, bringing innovative and leading-edge care to patients throughout the Rocky Mountain region
- Ability to call on the collaborative care of the deepest bench of medical specialists in the region, especially in quickly advancing areas such as oncology, cardiovascular surgery, the neurosciences, and the biosciences
- Top-quality training sites for the next genera-

tion of health care professionals eager to meet the needs of diverse populations from the Front Range region to rural areas across the Eastern Plains

- More opportunities for people in underserved and non-urban areas to get family and complex care

Together, these organizations that make up the UCHS have been recognized in the following ways:

- Three consecutive Magnet designations by the American Nursing Credentialing Center, an accomplishment only 31 hospitals worldwide have achieved
- Repeatedly ranked among the best hospitals in the country by *US News & World Report*, other ratings services, and health care organizations that closely examine medical specialties
- Multiple Nightingale Award winners for excellence in nursing care
- Medical outcomes better than state averages in many areas
- Deep involvement in implementing Institute for Healthcare Improvement, patient safety, and clinical quality initiatives⁴⁴

Overall, the UCHS is pioneering an innovative partnership in which the AHC is not the majority partner. Though carrying some risks, the model is a proving ground for the proposition that AHC and community partners can maintain distinct identities but also move forward with shared values to improve patient-centered and accountable care that is integrated with support for academic missions.

Results

- **Innovative partnerships:** All of this was engineered within a short time, about one year. Institutional leaders admit that putting together such a joint venture in a year challenged the bandwidth of the institution. There were many issues to confront, not the least of which was that everyone involved needed to cede some control to others or to the venture overall. Additionally, there were different board and management cultures to merge.
- **Staff engagement and morale:** A key challenge was simply to keep morale high among staff

and physicians throughout the system as they worked through the uncertainties of change of this magnitude, along with the goal of taking \$150 million out of the budget. Integration of information technology alone is reported to have been a huge challenge. Given the new alliances with community-based physicians and hospitals, there has been much focus on the best ways to support the academic enterprise. The “dean’s tax” continues to be a focus of adjustment.

- **Strategic agility:** Though still a work in progress and evolving to meet stakeholder and patient needs, the University of Colorado example demonstrates that AHCs can act quickly and decisively when needed, even without a burning platform. Senior-level participants report that good relationships among the leaders of the various institutions have been the key to enabling this new partnering. As a result, in addition to working to build solid systems and relationships throughout the venture, there is also a strong focus on succession planning.
- **Responsiveness to community and demographics:** The vision for five years out is that new regional branches (the clinical branch campus and Fort Collins) will have taken hold and be much stronger; new clinical capacity will have been developed in local market-related areas, like military health care; clinical research will be stronger; and the joint venture will be strengthened so as to allow each independent entity to be part of a strong and vibrant single system.

Overall such new, nontraditional partnerships are currently reaping benefits:

- Opens doors to bigger markets
- Creates larger geographic footprints
- Develops innovative strategies to thrive in a changing marketplace
- Drives efficiencies
- Strengthens quality
- Adds market power and leverage

For more information see: <http://universityof-coloradohealth.org>.

Table 4.

Transition from traditional to new model for Emory Transplant Center

2012	2017
Unit- or physician-centered care delivery organized around traditional academic specialties/departments	Patient-centered care delivery organized around dominant problems that affect populations served (aligned medical school and clinical administrative units and programs)
Care delivered by independent Emory physicians directing other health professionals	Care delivered by highly effective, optimally composed, interprofessional care teams
Variable care plans based on expertise, experience, and preference of individual providers	Consistent, evidenced-based care delivered to Emory standards (standardized processes and care plans customized to meet individual patient needs)
Basic electronic medical record implementation, billing documentation, and regulatory requirements dominate information technology priorities	Technology-enabled clinical workflow and decision support; consistent, cost-effective care; data capture; and two way patient-provider team communication
Clinical analytics limited primarily to hospital outcomes	Descriptive, predictive, prescriptive, and comparative analytics guide care delivery across the continuum; continuous improvement and innovation
Medical school department and clinical administrative leaders focus on partially overlapping goals toward partially shared visions	Physician and administrative leaders share clear, aligned, tripartite goals

Future of accountable care: Emory Transplant Center

Transplant medicine is arguably a model of what accountable care can and will look like in the years ahead. Transplant medicine has the following characteristics:

- Data rules supreme; mandatory data submission; detailed center-specific public reporting of short- and long-term outcomes

- Intense quality oversight: CMS, United Network for Organ Sharing, Scientific Registry of Transplant Recipients, payer centers of excellence
- Bundled payments have been used for a decade
- Attributable lives
- Chronic disease management

The Emory Transplant Center (ETC) serves as an especially good model for AHCs because it has also managed to build an innovative approach to

integrative practice and administration within the AHC that builds bridges across traditional AHC silos. The ETC model provides for the following:

- Team-based care models organized around patients and not around individual disciplines or departments
- Compensation, incentives, and professional development pathways, for both individuals and teams, that are aligned with ETC, departmental, and overall institutional goals
- IT and informatics customized for the programs, including optimization of workflows and the electronic health record.
- ETC organized as a platform for patient-centered, team-based learning and a discovery-driven development

The transition from the more traditional model of transplant centers to the new ETC model is captured in table 4.

Key principles for the new model include the following:

- The center director has the authority and responsibility for the activities of faculty and staff who are active members of the ETC and has dedicated resources to administer ETC programs and achieve its vision.
- Research grants are tracked by schools/units/departments and for ETC.
- ETC has dedicated space (research and clinical).
- Faculty and staff who spend significant time (more than 50%) in solid organ transplantation or who are essential to the mission of the ETC have appointments both in the ETC and in their departments. These faculty and staff are managed by ETC leadership.
- Performance reviews and development plans for faculty with ETC appointments are done by ETC leadership, with recommendations made to the schools/units/departments of appointment as appropriate.
- The ETC fulfills traditional educational responsibilities of the schools and departments and takes the lead in pursuit of educational programs that build interprofessional teams.
- The center director reports to the CEO of Emory Healthcare, the dean of the medical school, and the director of Emory Clinic.
- The center director's review is completed by

the CEO of Emory Healthcare, the dean of the medical school, and the director of Emory Clinic, with input from others within the organization as appropriate.

- A transplantation section (i.e., a transplant practice) in Emory Clinic was established to include the medical and surgical transplant faculty essential to the core mission of the program.
- All clinical activities and revenues of these faculty are assigned to this new Emory Clinic section, e.g., transplant-related activities as well as dialysis coverage, endoscopies, etc., to avoid splitting clinical income for these faculty among multiple Emory Clinic sections.
- The ETC brings together the key stakeholders with a role in its success. Participants include the chairs of the medicine and surgery departments, the CEO of Emory University Hospital, the COO of Emory Clinic, a representative from medical school research administration, and a health sciences executive staff representative.
- Information transparency ensures that leadership can assess performance and make informed decisions about ETC's program and impact across AHC entities.⁴⁵

These initiatives to support ETC faculty and to share administrative and professional development with related departments provide solutions to issues that otherwise vex AHC center development and the continuity of center activities. The ETC model has been able to achieve within the AHC environment an unprecedented level of integrated operations and patient-centered accountable care, while also excelling at core academic functions in basic and translational science, training, and faculty development. This model has great potential relevance to AHC clinical integration initiatives of all kinds.

The director who led the creation and integration of the ETC has recently been named by Emory as the new dean of medicine. In this way, Emory is empowering leadership with the experience and vision to lead it into the era of accountable care.

For more information see: <http://www.emory-healthcare.org/transplant-center/>.

Figure 6.

Partners HealthCare overview

Brigham and Women's Hospital
Founded 1832



Massachusetts General Hospital
Founded 1811



Key statistics FYE September 30, 2013

■ Total operating revenue	\$10.3 billion	■ Licensed beds	4,100
■ Patient service revenue	66%	■ Physicians	6,660
■ Research revenue	16%	■ Employees	60,600
■ Premium revenue	13%	■ Clinical trials	1,650
■ Other	6%	■ Clinical and research fellows and residents	4,300
■ Inpatient discharges	165,800		
■ Lives under management	760,000		

Thorough engagement in accountable care: Partners HealthCare

According to its website, Partners HealthCare (see figure 6) is a

not-for-profit health care system that is committed to patient care, research, teaching, and service to the community locally and globally. Collaboration among our institutions and health care professionals is central to our efforts to advance our mission.

Founded in 1994 by Brigham and Women's Hospital and Massachusetts General Hospital, Partners HealthCare includes community and specialty hospitals, a managed care organization, a physician network, community health centers, home care and other health-related entities. Partners is a teaching affiliate of Harvard Medical School.⁴⁶

After many years of largely unsuccessful insurance coverage and cost-control initiatives, the state of Massachusetts committed in 2006 to transition to near-universal insurance coverage and an insurance exchange model (the Massachusetts Health Connector) to provide an accessible insurance marketplace for consumers. The Massachusetts experiment succeeded in achieving insurance coverage for more than 98% of its population within the first year. The state prioritized achieving near universal care ahead of tackling the difficult issue of costs. The ACA is closely modeled on the Massachusetts experience, and so experience there is distinctly relevant to what providers, payers, and other stakeholders might expect to encounter throughout the United States as the ACA is rolled out.

Undoubtedly, a key to the success of the Mas-

Figure 7.

Since 2006 Massachusetts, and now, national health care markets are changing rapidly



- 2006 Massachusetts Universal Coverage Bill
- 2008 Massachusetts Cost Containment Bill
- 2010 Massachusetts Small Business Premium Relief
- 2010 Federal Affordable Care Act
- 2012 Massachusetts Cost Growth Benchmark/Payment Reform

sachusetts initiative is that, for years, providers, insurers, the patient advocacy community, state officials, and other stakeholders had been engaged in dialogue (at times contentious) about the best pathways forward to universal coverage, accountable care, and cost control. As figure 7 shows, the rollout and fine-tuning of the Massachusetts model has been a multi-year process involving a series of legislative initiatives. All stakeholders now have many years of experience working together to navigate the many complex challenges of expanding access.

Having achieved near-universal coverage through implementation of the bill passed in 2006, the latest major milestone has been the adoption of a new state regulatory framework for managing costs. The 2012 health care cost-control bill set annual state spending targets, encouraged the formation of accountable care organizations, and furthered transparency in insurer and provider payments. It also established an independent state agency to monitor health care system performance and to continue to develop policies

to reduce cost growth and improve health care quality, outcomes, and service.⁴⁷

Partners Healthcare System is the largest AHC-affiliated provider system in Massachusetts and has been deeply engaged in helping define the marketplace for health care in Massachusetts. In light of its experience, Partners defined two broad parameters for participation in the accountable care marketplace:

1. Align a strategic path with the overall goals of statewide and federal public policy
2. Be capable of competing in the local or regional marketplace on terms that enables Partners to control its destiny

Partners defined a strategic path that involves being a comprehensive accountable care provider. Partners became a Pioneer ACO in November 2011, taking on risk in a contract with the CMS that incentivizes Partners to manage costs so they increase at a rate lower than the national average.

From Partners' point of view, state and federal regulation is now emphasizing three major sets of tools:

1. Payment reform linked to the creation of ACOs based in global payments and risk assumption

2. Transparency of pricing (which can turn patients into informed consumers) and, increasingly, in outcomes data

3. Various forms of rate setting

Partners determined that to control its destiny it must be guided by three simple but powerful principles:

1. Own financial responsibility for patients

2. Price must be linked to quality in the marketplace

3. Must deliver the right care at the right place with the right providers

Each of these principles represents an array of commitments and approaches that the organization has determined are essential to success in this accountable care marketplace. Most important, each of these principles expresses significant values and responsibilities that Partners is committing itself to in order to succeed. The values include the following:

- Taking responsibility for patients and populations, not simply for encounters
- A commitment to transparency highest value (quality/price)
- A commitment to the teaching, research, and collaborative care and systems that provide care where and when it best serves patients.

To meet these commitments, Partners is engaged in reforms and innovation across the full spectrum of its organization and operations, including the following:

- Revisiting contracts to meet state cost-growth targets
- Implementing major IT upgrades and conversion to centralized IT system
- Changing Partners' internal structure to become a leading provider of population-based care
- Assuming a greater role in managing overall and episodic care—especially in coordinating for high-risk patients
- Creating a new internal performance framework with changed incentives
- Developing enhanced access to low-cost specialty services

- Converting to patient-centered medical homes
- Changing external structure to develop community-centered health villages that can promote disease prevention and wellness while being portals to the full range of integrated care services

- Engaging new partners along the full range of academic and health care missions.

And this is just a sampling of areas of major commitment that are ongoing and are considered important priorities.

Interestingly, though, a recent study of the Massachusetts experiment summed up one of the big uncertainties for the newest Massachusetts cost-control initiatives, which is the uncharted future of AHCs:

... the potential impact on the state's teaching and research institutions, which are more expensive than their community counterparts, is unclear. These institutions attract substantial federal and private medical research funding, provide high-quality care, and contribute to local economies through direct employment and related activity in the life sciences. Compelling them to direct their innovation and creativity toward the production of more efficient delivery models, and the elimination of waste should yield positive benefits. However, starving them into decline would be a severe loss for the state.⁴⁸

The Partners example illustrates that there is a broad range of initiatives and re-engineering required for active and successful engagement in an accountable care marketplace. It is a model of engagement that seeks to answer the uncertainties in the environment by defining their value propositions and committing the entire institution to them in order to gain and maintain control over the institution's destiny, including putting special efforts into redesigning academic and research programs to align with overall state and societal accountable care goals.

Nevertheless, even in Massachusetts, where Partners and other AHCs have been engaged for years in working to develop the state regulatory structure and in remaking their own systems for the responsibilities of accountable care, the future of these institutions and their core teaching and

research missions remain an object of significant concern.

But the situation of Partners and some of the other AHCs in Massachusetts is not alarming. They are fully engaged in their environment and in shaping it so that they can have some sem-

blance of control over their own destiny. They are fully engaged in identifying and leveraging their strengths and opportunities, while shedding or re-engineering their weaknesses and liabilities. How many of our AHCs can say the same thing?

For more information see www.partners.org.

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About the Blue Ridge Academic Health Group

The Blue Ridge Academic Health Group (Blue Ridge Group) studies and reports on issues of fundamental importance to improving the health of the nation and our health care system and enhancing the ability of the academic health center (AHC) to sustain progress in health and health care through research—both basic and applied—and health professional education. In 17 previous reports, the Blue Ridge Group has sought to provide guidance to AHCs on a range of critical issues. Previous reports identified ways to foster a value-driven, learning health care system for our nation; enhance leadership and knowledge-management capabilities; aid in the transformation from a paper-based to a computer-based world; and address cultural and organizational barriers to professional, staff, and institutional success while improving the education of physicians and other health professionals.

Reports also focused on updating the context of medical professionalism to address issues of conflict of interest, particularly in the relation-

ship between academic health professionals and institutions and their private sector partners and sponsors; quality and safety; and improved care processes and innovation through the use of informatics. One key report explored the social determinants of health and how AHCs could reshape themselves to address this critical dimension of improving health. The group also issued a policy proposal that envisioned a new national infrastructure to assure ongoing health care reform, calling for a United States Health Board; identified opportunities and the most critical challenges for AHCs and their partners as the Accountable Care Act (ACA) was implemented and examined ways in which AHCs could leverage their unique characteristics and capabilities through the ACA to improve health care, research, and training systems.

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