

VIEWPOINT

Academic Health Centers and the Evolution of the Health Care System

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Today there are approximately 135 academic health centers (AHCs) in the United States. These institutions exist to ensure sustainable health care through their multifold, integrated missions of patient care, education, and research. Yet AHCs have in some ways contributed to the intractable problems that threaten both their viability and the sustainability of health care. To flourish—indeed to survive—AHCs must reconfigure and transform rapidly and broadly in size, speed, value, and innovation, driven by self-reflection and leadership.

A Critical Issue

Academic health centers are a crucial component of the health care system. But like other participants in US health care delivery, AHCs have existed as a “cottage industry” in a fragmented market, blind to the costs of duplicative infrastructure and paid a premium for claims of quality without tools to measure or ensure it.¹ As value-conscious purchasing by employers, government, and health plans forces AHCs to compete among themselves and with community health organizations, many AHCs will face critical threats.

Academic health centers that invested early in integrating care, primary care, information technology and analytics, and competing on value are poised for continued growth. Those that fail to respond effectively to this changing health care landscape may find their clinical

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revenues providing less funding to support education and research and also may find that antiquated clinical settings will jeopardize their leadership in clinical training. Above all, AHCs will miss a unique opportunity to assume the lead in creating the new models for care, education, research, and innovation.

Contributing Factors

Academic health centers have been slow to integrate across the clinical enterprise. Traditionally, clinical excellence in AHCs has been distributed irregularly, with care still predominantly organized by academic departments designed to meet the needs of research and training. “Siloed” clinical care has diminished accessibility and coordination of care for patients and allowed unnecessary duplication of services and comparatively poorer health outcomes, while slowing the

adoption of new models of care and education across the AHC enterprise.

In addition, prices of services provided at AHCs have often been higher than prices for comparable services provided elsewhere. To an extent, this higher cost reflects the actual value of care provided for highly complex conditions. However, some of this cost is also related to limited integration of care as well as to unnecessary care.²

The lack of integration has made it difficult for AHCs to assume risk and manage population health, both primary skills for the future. Few AHCs today have responsibility for the comprehensive health of a large population—a critical substrate for practice, education, and innovation.

Potential Solutions

To met these challenges, leaders of AHCs will have to change their fundamental models of clinical care, developing new patient-focused models of care, engaging in population health management, ensuring that “big data” are extended to the redesign of clinical care, and establishing value-conscious offerings.

Patient Focus

Making patients the center of attention is paramount among these shifts. Many medical groups and health delivery systems in the United States are already engaged in patient-centered redesign of care.³ For AHCs, however, integrated approaches that “follow the patient,” deploying multidisciplinary teams and integrated practice units across departments, are particularly challenging.

To support integrated care and enterprisewide strategic and operating decisions focused on patients, most clinical enterprises will need to be reorganized to move away from department-based clinical structures and to support multidepartment integrated practice units. Because hospital and outpatient care must be integrated, the leadership of faculty practice plans should, in many cases, be transferred from the deans of medical schools to the chief executive officers of these new academic health systems.

Population Health

Academic health centers must learn to care for the health of populations, beyond that of individual patients. Population health refers to using a global budget to manage the health of a specific population. The Patient Protection and Affordable Care Act, increasing enrollment in Medicare Advantage, and new forms of risk sharing in commercial payer contracts all drive this new emphasis

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on population health management. The new model will find that patient education and coaching are as important as the pharmacopeia and that telehealth modalities are as key to access as opening ambulatory clinics.⁴ The question is whether AHCs will prove capable of not only adopting this new care model but of leading as well—in research, training, and innovation.

What does this mean in practice? It means that AHCs will need to operate a full-service, integrated health system designed to meet the broad spectrum of needs presented by a diverse population of people. Because few AHCs have all the requisite components, most will have to reconfigure through new alliances and partnerships to fill the gaps. Partnerships will also allow AHCs to reach the size necessary to invest funds in critical infrastructure, substantially improve operational efficiency, and develop new capabilities in population health management. Leaders of AHCs must make the decisions about how to reconfigure, in partnership with other AHCs or with other health systems, with a realistic understanding of what the market will support.

This emphasis on population health management is expected to incentivize AHCs to promote health and prevent disease instead of just managing and treating disease.

Big Data

Academic health centers must leverage the vast reservoir of health-related data being amassed.⁵ Health systems throughout the country are bringing electronic health records and powerful analytics online, creating opportunities to partner and lead research using these new “big data” resources. Few of these health systems are AHCs. Centers should seize this moment to partner with these other systems and with groups of other AHCs to spearhead progress with as-yet unimagined speed and depth in research and discovery toward the most effective means of providing care.

This partnering also will allow AHCs to track the proliferation and diffusion of important innovations in care and to tackle the persistent lag between discovery and broad adoption of valuable advances. The still-new translational efforts of AHCs have ended with demonstrations of clinical effectiveness. Now AHCs must forge ahead with a new implementation stage in translational medicine that requires them to strengthen and evolve their relationships with physicians in the community. These partnerships will give AHCs leverage to spread the best science and new models of care beyond their own patients to broader communities.

Value Conscious

Only by shifting to a value-conscious state of mind will AHCs be able to reorganize and improve the care they deliver.⁶ The sustainability of AHCs is inextricably intertwined with their ability to improve the value of care provided—as demonstrated by the quality of outcomes and patient experience—to a level commensurate with the resources expended. With increasing transparency in the reporting of quality and cost, the performance of AHCs will be evident to all. Academic health centers should be not only competitive but also leaders in the relative improvement and the absolute value of the care they provide.

Elimination of waste is the best opportunity available to AHCs to improve value.² Consistently using best evidence-based practices, relentlessly addressing variations in care, assiduously avoiding unnecessary tests, and continually reducing errors will directly improve value. Academic health centers have yet to demonstrate comprehensive adoption of these steps, and this should be a priority.

Shifting downstream—going beyond the immediate patient encounter to capture outcomes in quality of life and the resumption of everyday activities—is another source of value. This will carry AHCs far beyond traditional health system boundaries into people's homes, schools, and workplaces. Calling on schools of public health and departments of preventive medicine, AHCs can lead discovery in the prevention of disease and disability, recognizing that prevention is perhaps the ultimate value-added measure. Because AHCs are defined by their commitment to the creation of knowledge, their exploration and reporting of the successes and failures on this journey to redefine health care delivery will be an added value to everyone involved in improving care systems.

Conclusion

The profound changes now unfolding in US health care bring very specific challenges for AHCs. Their fate—and ultimate contribution—will be determined by how they respond. Will AHCs become victims or make the necessary shifts to reinvent themselves meaningfully? Centers pursuing the disruptive transformations outlined here will survive and thrive in the value-conscious, patient-centered world of healthcare ahead. And these institutions will continue providing value to society, patients, and communities.

ARTICLE INFORMATION

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