

*The University and Its
Academic Health Center:
New Strategic Contexts*

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CONCEPT:

Over the last four decades, national priorities in health professions manpower, biomedical research, and health care for seniors and the poor have created the modern academic health center (ahc). Within the broader university, the ahc's market orientation and different business environment and rhythm generated governance, strategy, management, economic, fundraising, and operating styles that tended to separate the academic health center from the university.

There is no question that, in a comprehensive university with an academic health center, the strategic positioning and financial significance of the academic health center in terms of educational programs, research, clinical activity, and community connections are a very large and visible part of the university's mission assets. However, it is the very presence of the larger university — its branding, operating scale, political clout, and philanthropic reach — which provided the "umbrella" that enabled the ahc to flourish during the past 40 years.

More recently, there has been extensive ahc reorganization through corporate realignment or sale of the clinical aspects of the academic health center (hospitals, practice plans, ancillary services corporations), driven by two principal motivations:

- Competitive pressures on clinical enterprises
- University concerns about hospital financial viability/risk

Considerable attention has been paid to the effect on the ahc of clinical (mainly hospital) reorganization, including a major study by the University HealthSystems Consortium (UHC), entitled, "Supporting the Academic Mission in Difficult Times." This theme was the focus of a joint seminar of the UHC and the Association of Academic Health Centers in October of 2004. The very title of this study is an indication of the role reversal that has occurred, placing the academic mission on the margin of the clinical mission and implying that the string has run out. However, that is where we are. The lens used for

this study was clearly that of the clinical enterprise — an appropriate vantage point for UHC.

This perspective is incomplete on the surface, in that it largely ignores the potential strategic connections of the academic health center to its parent university, and it seems to place the fate of the ahc in the hands of its clinical partner. Nothing could be further from the truth. As health care delivery becomes even more commoditized and homogenized (i.e., diffusion of innovation narrows the gap between the "university" hospital[s] and community competitors), the ahc's educational and research missions will be pushed more acutely to the leading edge. This development will draw academic health center and parent university interests closer together programmatically and economically, but it will also generate a stream of new resource needs that are not likely to be covered by clinical cash flows.

Less attention has been paid to the effect of clinical reorganization on the parent university and its academic health center and the rethinking necessary to assess and alter governance, strategies, academic structures, financial models, support services, and community connections.

The purposes of this paper are: to begin a conversation that uses a university lens on academic health center strategic shifts, and suggest the first iteration of a framework for a continuing conversation.

Some initial thoughts about the impacts of clinical reorganization include the following:

- Contending with the clinical reorganization clearly brought a new sensitivity of risk in the university, especially to its trustees.
- Consequently, trustees may be more demanding about programmatic and financial strategies for all university programs.

- The pressures of clinical reorganization brought trustees into quasi-executive roles; some adjustments may be necessary to rebalance roles.
- University trustees, officers, and faculty and ahc officers and faculty have to be more literate about each other's strategies, economics, and operations.
- University fiduciary and strategic concerns about the clinical enterprise do not go away with reorganization; the new relationship can be much more complex and managing relationships can require as much, if not more, attention.
- Decisions about relationships with the clinical enterprise have moved to an institutional, as opposed to a clinical, departmental/school level.
- The business cycle for the academic health center, likely, is still dominated by clinical frameworks.
- The clinical enterprise will continue to condition university/ahc human resource systems.
- The market, business, and customer service experiences of the ahc will make it highly competitive within the university setting.
- The ahc can help the university understand its emerging enterprise settings.

More impacts will be discussed below.

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DEFINITION OF AN ACADEMIC HEALTH CENTER

Although there are many varieties of role and scope for academic health centers, for the purposes of this paper we will use the definition from the Association of Academic Health Centers as it

applies to academic health centers that reside within larger universities:

An academic health center is the organizational component of a university or a stand-alone institution that comprises at least a medical school, one or more health professions schools (e.g., nursing, dentistry, pharmacy, etc.), one or more university-owned or affiliated teaching hospital(s) and clinic(s) and faculty practice enterprises.

This paper deals only with the academic health center within a university setting. Even with clinical reorganization, the school of medicine remains the most material part of the ahc. However, there may be new strategic and cultural reasons for considering all of the health professions schools in discussions about the new context.

A NEW UNIVERSITY STRATEGIC CONTEXT FOR THE ACADEMIC HEALTH CENTER

The logical extension of the academic health center's enterprise model has come full circle now, as the financial margins of the clinical enterprise have narrowed from the effects of competition, changes in national funding and regulatory policies, and matters of risk and capital formation. The resulting drive to reorganize the ahc's clinical functions has changed the fundamental strategic, economic, and operating models for many academic health centers. Clinical reorganization has accelerated the need for strategic change within the ahc. Clinical reorganization also reaches to the university in direct and indirect ways: finances, governance, community relations, changed constituencies, and scale of operations.

At the same moment, the university is experiencing pressures to fulfill its educational mission, look for new revenue sources, and manage costs; these pressures drive the university to be more enterprising. Educationally, the university has taken on a more clinical/experiential stance, through experiential learning, learning technologies, service

learning, technology transfer, and economic development. All of this involves new operating costs and requires new capital — and, in many instances, new partners.

In addition, educational and business models are shifting for professional schools (e.g., business, law, education), science and engineering, and the social and policy sciences, with new educational and research venues, increased experiential education, organized consulting activity, technology transfer, and corporate partnerships. At the macro level, there is a heightened expectation, especially for public universities, for more direct connections to state economic development plans. In some cases (e.g., the state of Virginia) this conversation has included giving universities more managerial latitude in exchange for strategic commitments to economic development.

While there may not be another single factor as significant as the academic health center's clinical reorganization, the university is challenged by a variety of conditions, including those generated by the ahc, that require a strategic response. Some of these conditions include public reaction to increased tuitions, new capital costs, consumer demands, reduced appropriations, economic development roles, and fluctuating endowment values. The possibility exists that the same kind of unique treatment given to the academic health center in recent history is being or will be demanded by schools, colleges, institutes, and other centers throughout the university. This cauldron of change offers opportunities for the university and its ahc to consider strategic connections anew, in the midst of the changing dynamics of the university. Given its experience, the ahc may have something to contribute to a rethought university context.

The ownership status of the continuing clinical enterprise (primarily hospitals) is a large factor in any discussion about the university and its academic health center — be it about the sale to a not-for-profit health care provider, sale to a proprietary health care provider, or a new

corporate status with continued university ownership. Even if the academic health clinical enterprise is not formally reorganized, the impacts of the substantially changed operating environment for academic health centers generally may have similar effects. University governance has been, and will continue to be, tested by the academic health center's clinical mission.

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What is evident is that clinical reorganization and the stimuli that have created that phenomenon have shifted all or part of the locus of decisions about institutional relationships and arrangements with the clinical enterprise from the clinical department chairs to the academic health center and the university. That is, in better financial days, under loose affiliation agreements, hospitals and clinical chairs could make arrangements at the departmental level about new programs, "unfunded research," recruitment packages for new clinicians, and purchasing new, expensive equipment. Capital formation, capital priorities, and capital allocation have now become institutional processes, and in a major sense, they have added new work to university executive and board agendas. Practice plan issues have moved in a similar fashion.

THE HEALTH PROFESSIONS IN THE ACADEMIC HEALTH CENTER/UNIVERSITY

Another point of reference related to ahc clinical reorganization and strategic directions in clinical care and prevention is the potential strategic reordering of the roles of all of the health professions schools. Assuming that the health team (multi-professional integration for care and prevention)

will be at the forefront of strategic thinking for health professions education, then the academic health center is the natural place for leadership in clinical effectiveness and productivity issues, as well as in creating new professional models and educational paradigms. In the post-clinical reorganization environment, there may be a sense that there is no longer the need to treat the health professions as a strategic whole.

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The times call for more academic integration for the health professions, not less. The university has the opportunity to create a new academic health center ethos that also brings the full range of university disciplines to the table. The health team concept has already pushed several health professions fields to doctoral-level preparation, and thereby to increased research roles. Preparation of new faculty educators for all the health professions is an important and continuing need that falls predominantly to AHCs.

The voices of the health professions schools, properly aligned, could influence leading-edge academic and clinical service integration of the ahc; they also could present to the university additional integrative opportunities for responses to societal problems, ranging from new research strategies and venues, deployment of pedagogical resources, philosophy/ethics, and the social and policy sciences, to engineering, mathematics, the computational sciences, and business/ management expertise. However, the connection is to a health professions model, not to one school or another.

ORGANIZATIONAL STRUCTURES

Does clinical reorganization presage the demise of the academic health center structure? It would be easy to answer this question in the affirmative, if clinical reorganization clearly made life simpler. It does not. Furthermore, the strategic paths of health care, health prevention, and biomedical, clinical, translational and health services research call for an organized and coordinated university response. There is still a need to integrate the academic and the clinical. There may be high strategic expectation from our society for the development of the health team. There certainly is a sense about major new and continuing initiatives in public health, biodefense, and bioterrorism.

How should university resources be planned, organized, and managed to meet these needs and fulfill expectations? Can this work be conducted informally by a committee of health professions school deans or a university provost? Does the medical dean need to be the leader of an academic health center, if it exists? These are not routine questions and are not answerable in this space.

MARGINALIZING-MINIMALIZING THE CLINICAL SETTING

Clinical reorganization also presents the opportunity for the university and academic health center to minimize and marginalize the criticality of the clinical setting to a second-class status in education, research, and community service. Irrespective of ownership, if the ahc's clinical settings are not infused with an academic ethos, then the value of the experience for students, health care providers, and patients will be diminished. The academic ethos is of vital importance, and it is not inherently in conflict with cost efficiency, productivity, and customer service.

A strategic embrace of the clinical setting requires a new set of institution-to-institution relationships, in which academic and clinical priorities can be treated openly and not in whispers. As noted

above, this is a change from earlier, laissez faire practices and allows a strategic balancing of educational, research, and clinical interests that is not easy to accomplish under old, fragmented systems.

THE NEW INSTITUTIONAL ECONOMY

Just as balancing the “missions” issues within the academic health center and university environment requires major new structures for strategy and management, the overall economics of the academic health center is changing in ways that reposition its needs within the overall university environment. If the clinical enterprise no longer supplies the capital and subsidies that are essential for the academic health center to develop and thrive, then new sources of funding are being required at a time when resources are under considerable stress in all institutional quarters.

Indeed, the financial and economic issues found in the academic health center are shared throughout the university. Strategies for meeting the new capital requirements for programs, facilities, and technology are increasingly critical within all university units and across all missions. The ahc’s needs in terms of the use of debt and leveraging of capital are likely to engender new competition in regard to other university requirements, necessitating a new “compact” for allocating resources and measuring returns. As capital requirements increase, the competition will extend to include access to major donors. Within the ahc enterprise, the issues of capital formation and leveraging also will create the potential for internal university competition and conflicting requirements. In addition, new issues (not small) will present themselves to the university, such as balance sheet management, working capital, and cash management.

New business relationships, joint ventures, and technology transfer programs for the sale of ahc/university intellectual property and research production have generated modest results for many universities and ahcs. Many require upfront

capital investments or the formation of new and less comfortable relationships with commercial business than have been adopted in the past. Concerns about loss of control and potential conflicts of interest are being raised across the university.

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Finally, with the split-off of all or parts of the clinical enterprise, operating scale within the academic health center may require new relationships and “partnerships” with the university, wherever operating scale can be found. These relationships are likely to cross administrative and academic lines and will be built so that intellectual capital can be increased across university and ahc units, while the need for financial capital is leveraged and minimized for the university as a whole.

COMMUNITY CONNECTIONS

In the post 9/11 world, community connections have been brought to the forefront as never before. In the comprehensive university, the health professions present a significant strategic asset in terms of community service, outreach to underserved populations, improvement of quality of life, repositioning of public health and public safety, and economic development. Organizing around this mission area also provides new integrative possibilities, both within the academic health center and across the university. Strategic leadership from the ahc in community outreach may catalyze the university’s expanded role in and connection to its communities.

In a world in which many countries have new higher education aspirations, and capacities, academic health centers in the United States will continue to be unchallenged world leaders. The academic health center represents a significant lead asset in the development of University global strategy.

CHANGES IN THE UNIVERSITY BEYOND THE ACADEMIC HEALTH CENTER

To say that the university as a whole is academically integrated would be an exaggeration. The vectors produced by clinical reorganization and reconsideration of the role of the ahc within the university also will present an opportunity for the university to challenge its academic philosophy. Moving into an integrative effort that is not grounded in academic strategy will only produce effects at the margin. If the university does not fundamentally espouse academic integration as a regular philosophy and practice, then the energy invested in bringing the ahc to a new place will be in vain.

In terms of institutional culture, however, changes in the university's academic and business settings are not limited to those in the academic health center. For example, changed university strategies and models for professional schools, sponsored research, and technology transfer create additional dynamics for the dialogue across the university. Examples of changed academic models include the new academic and clinical connections the university is making to the community through elementary and secondary education and the intensified use of experiential learning. The university generally is learning how to incorporate clinical and experiential facets into the curriculum in ways that were not available in earlier times.

The observable trends of increased capital intensity and the importance of "consumer satisfaction" in higher education create new strategic, managerial, and financial conditions that could affect the university/academic health center relationship. The academic health center's attention to satisfying

clients may provide guidance to the university.

The university, as a necessity, is moving more toward an enterprise model, just as its academic health center, as a necessity, must reorient its programmatic and financial base more toward an academic model. Threading through all of these changes is the ubiquitous role of technology throughout the university as a foundation for education, research, clinical services, and community service missions. This suggests that the high capital cost for technology should be given special attention.

THE UNIVERSITY-ACADEMIC HEALTH CENTER STRATEGIC DIALOGUE

For the purposes of this discussion, the outline presented below is put forward as a potential template for fostering university/ahc strategic dialogue. Undoubtedly, there are other categories and/or clusters of categories that could be listed, but this outline should be sufficiently comprehensive to begin a productive dialogue. The applicability of particular questions and possibilities will vary from university to university and ahc to ahc, arguing for a locally tailored subset of these topics.

Questions to Stimulate Dialogue:

- Should we rethink university-wide academic strategy and business arrangements that are being opened up by clinical reorganization and/or by new university needs?
- Do the strategic directions in health care and prevention drive a new concept and continuing role for an academic health center structure? How can other parts of the university participate in health matters?
- What is the post-clinical reorganization economic base of the university? How does the ahc economy fit with the university economy, and vice-versa?
- How can the university exploit the full scale and breadth of its human, technical, financial, and physical resources as it pursues its missions?
- Are new relationships within the university available and beneficial to the academic health center as it reworks its underpinnings?

A BASIC FRAMEWORK FOR REEXAMINING UNIVERSITY-ACADEMIC HEALTH CENTER RELATIONSHIPS

The following are general categories to be considered in building a basic framework for reexamining university-ahc relationships. A more detailed consideration of each of these categories follows.

- 1. Mission/Vision/Strategic Planning**
- 2. Academic Philosophy/Organization**
- 3. Governance, Corporate and Organizational Structures; Strategic Partnerships**
- 4. Economic Models/Capital and Financial Structures and Policies**
- 5. Common research, learning resources, information technology, administrative, facilities and business support services**
- 6. Compliance/risk management**
- 7. Research administration, Intellectual Property and Technology Transfer**
- 8. Community Outreach**
- 9. Philanthropy/Development/Foundations**
- 10. Government Relations/Economic Development**

- Are ahc practices, such as enterprise management, mission planning/ management, and all-funds budgeting relevant to the broader university?
- How is university/ahc governance affected by clinical reorganization?

1. Mission/Vision/Strategic Planning

Integrated, shared, or separate vision for the university, including the ahc

Is the whole greater than the sum of the parts?

- University-wide mission management orientation
- Commitment to continuous planning
- Integrated university strategic plan/unconnected ahc strategic plan

Planning, decision and budgeting cycles

Enterprise philosophy

Priority-setting across the whole university

2. Academic Philosophy/Organization

Regional and specialized accreditation issues

Intra-university collaboration (e.g., life sciences, statistics, informatics)

Joint degrees

Guaranteed professional degree admission for undergraduates

Role of clinical/experiential education throughout the university

Academic reporting structures

Tenure and promotion impacts of changes in clinical approaches

Changes in professional school faculty models

Varieties of faculty compensation models

Health professions schools

3. Governance, Corporate, and Organizational Structures; Strategic Partnerships

Operational definition of university fiduciary responsibilities, post-reorganization

Formal board governance relationships within the university
Faculty governance
University strategy re. separately incorporated activities
University strategy re. internal partnerships
Strategic partnerships (including clinical enterprise), conflicts of interest
Internal management, consultative and advisory structures
Separate corporate structures/foundations

4. Economic Models/Financial Structures and Policies

All-funds university economy
Balance sheet/debt/unresolved impacts of clinical reorganization
University balance sheet objectives
Treatment of cash balances/deficits
University financial relationship to ahc clinical enterprises
The ahc financial relationship to the university post-clinical reorganization
Staff compensation/incentive/labor relations systems
Budget and financial reporting policy/structures
Financial reserve structures
Funds flow
Business/responsibility models schools, colleges, specialized research, support and clinical units

5. Common Services (illustrative)

Technology
Information Systems
Highly skilled/trained human resources
Outsourcing
Facilities
Business services
Financial services
Human resources

6. Compliance/Risk Management

Approaches to general liability/firewalls
Professional liability

Integrated university regulatory compliance policy/structure
Definitions/limits of shared liability with partners/affiliates

7. Research and Technology Transfer

Common university research mission/strategy
Clinical enterprise role in research and research support
Cross-unit, multi- /inter-disciplinary research packaging
Separate research foundations/corporations
Core research facilities/talent strategy
Common research regulatory compliance
Indirect cost recovery policies
Common technology transfer policies/support systems

8. Community Outreach

Coordinated university strategies, intentionality of connection
Commitments to diversity
Impacts of clinical reorganization
Academic health center as provider of choice for university employees

9. Philanthropy/Development/Foundations

Allocation of access to philanthropy
Strategies/organization for alumni relations
Connections to clinical enterprise
Organization
University strategy re. separate fundraising foundations

10. Government Relations/Economic Development

Federal, state, and local government relationship strategies
Economic development organization approaches (ties to technology transfer in research section, above)

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