AAMC CFAS Meeting Summary
March 6-8, 2014
Nashville, Tennessee

This meeting brought together representatives of academic societies and medical schools in an expanded American Association of Medical Colleges (AAMC) organization now called the Council of Faculty and Academic Societies (CFAS). This council is one of three councils (the others represent deans and hospitals) within the AAMC. The IUSM was well-represented with Bob Pascuzzi (representing the American Neurological Association), Cherri Hobgood (representing the Society for Academic Emergency Medicine) and me (the School's appointed senior faculty CFAS representative) in attendance.

The meeting took place March 6-8 in Nashville. There were over 200 attendees and the major focus of the meeting was the changing role of faculty and academic health centers in response to financial pressures and changing institutional priorities. The meeting consisted of two days of lecture, round table discussions, and workshops on a range of topics currently confronting Academic Health Centers (AHC). These included the changing funding and political climates, and the resulting impact on the culture of the AHC and the faculty. The keynote speech, delivered by the former president of the University of California, Mark Yudoff, described changing public commitments to public higher education as the population aged and became more concerned about social security, health care and public safety. He suggested that academic medical centers would face the same pressures, particularly in the area of graduate medical education. He also suggested that all of our institutions would need to be looking at where cuts in personnel and changes in educational structure could be made to preserve the education mission as well as the research mission.

The next day the same theme was applied more directly to healthcare and medical education by and Janis Orlowski, MD, from the AAMC and Jeff Balser MD, Dean at Vanderbilt. Below is a synopsis of their key areas of emphasis:

- Healthcare is changing rapidly. These changes are largely being driven by the move away from a volume-based reimbursement model to one that is more focused on population health and quality. This evolution is driving change and resulting in more AHCs focusing on reduction of costs to effectively compete against "community" health delivery systems. How to do this - by enhancing the patient experience, learning to manage the health of populations, attention to value based payment systems and consolidating markets where necessary.

- By necessity, the AHC of the future will be need to be systems-based. This requires consolidation of providers into systems that are both horizontally and vertically integrated. In the development of regional systems, AHCs must manage their brand as well as develop strategic partnerships. To be

successful, systems must scale to be sufficient to maintain competitive parity and mission sustainability. This scale will be multi-billion dollars in size. A major challenge/determinant of future AHCs success will be access to capital.

- AHCs require strong and aligned governance, organization, and management systems (within the health system and the medical school). AHCs must align clinical services under leadership that is unified strategically and structurally. This leadership will be charged with enhancing clinical coordination and strategic planning, accelerating decision making, and creating accountability for performance with new emphasis on cross-departmental collaboration. New structures will prove effective because of the trust and commitment to collaboration of their leaders. System organization models will differ and there are alternative approaches to organizing clinical entities to achieve economic alignment

- Medical School and University relationships will be challenged to change as AHCs grow and develop. In the 1990's there was a shift towards separation of higher education from health sciences – to protect the parent university from the potential financial risk of large medical centers. There now appears to be a reversal of this trend, in a large part due to the success that AHCs historically have enjoyed. Transparency in the manner in which funds flows between the AHC and the university should be strongly encouraged. Over dependency on clinical income needs to be discouraged. University practices and policies should be modified to recognize the clinical system requirements for growth. Intellectual property policies should be updated to encourage closer ties with industry.

- Physician leadership and physician practices will (and must) change dramatically. The growth and complexity of AHCs require evolution in the roles of Department Chairs and new roles for physician administrative leaders. There is a need for enhanced emphasis on quality of leadership: selection, succession, and training. There must be enhanced emphasis on teamwork among Chairs and with AHC leadership as well as accountability for departmental performance and financial transparency across departments. The role of physician executives, esp. CMO/CMIO/Group Practice management needs to be strengthened. There will be greater definition of faculty practice plans as they determine if they are to be the sole physician organization for the health system or one of many. There will be processes established for the addition of clinical faculty and affiliates physicians. This method will vary among institutions based on market forces.

- The development of transparency in quality, performance, and financial information at all levels of the AHCs will be central to achieving high performance. It is impossible to succeed in taking on risk/bundles without truly understanding of costs across hospital and practices. There is a need

for quality reporting and innovation. The demonstration of outcomes over time will be essential to maintain a strong AHC brand. AHCs must be more explicit about value (quality/cost) and how they position themselves in the market. The ability to define quality outcomes to purchasers is as critical if not more critical than simply lowering the cost structure.

- AHC must have an efficient operating model. Higher costs are the AHCs primary competitive disadvantage for system success. Commitment to lowering costs is a pre-requisite for taking on population health and risk assumption strategies. Re-engineering must extend to all aspects of the tripartite mission. The highest potential for AHC innovation in total cost management will be by delivering the best results on utilization. There needs to be broad investment in new skills such as LEAN across all faculty and staff.

- AHCs must be a leader in managing population health. As the ACO strategy becomes more prevalent, and risk contracting expands, the capacity to effectively manage an assigned group of beneficiaries becomes mandatory. Few academic centers have built this capability, have it at scale, or are expert in this domain. Most organizations will need to assess if they will build this capacity internally or purchase it externally.

- AHC must have a candid assessment of their strengths and weaknesses, which are essential to achieve change (SWOT analysis). The rapidly changing market and policy dynamics are forcing an assessment of the ability and capacity of AHC to succeed as organized systems of care. Current AHC systems' strategy can be costly and difficult to execute well. AHC leaders must achieve new clarity and discuss candidly the system's capabilities. Systems with less strength will require the establishment of strong partners and investment in new capabilities.

- Dr. Balser described the reasoning behind the recent personnel cuts and reorganization at Vanderbilt and how the same reasoning will most likely apply to other AHCs. The key problem (not surprisingly) relates to pressure on clinical revenue, which is now the financial engine subsidizing the other missions of education and research at AHCs. However, with the recognition that health care spending is creating huge public debt, and an unwillingness to continue to add to debt, the clinical revenue stream (CMS and others) is decreasing. This reduction is destabilizing all missions at AHCs and a new balance will need to be found. Making these decisions is not easy. This quote from his presentation is foretelling, "You can't solve problems by nibbling at the edges. Everybody must be in." He admonished all AHCs not to begin this "re-engineering" too late. He also emphasized that robust investment in informatics, decision support and data analytics (Big Data) will be essential for future success.

The remainder of the conference provided group discussions and presentations on a myriad of topics related to academic faculty and institutions. Many of these were "universal" topics in that almost all attendees felt these were relevant to themselves and their respective institutions and societies. Some of the topics included:

- Tools to Promote Faculty Engagement and Satisfaction
- Faculty Advocacy
- AAMC Advocacy (the climate in Washington is bleak for AHCs…)
- Faculty Identity and Value
- GME

The overall take home point – academic health centers and their faculty face a daunting and uncertain future. Faculty, medical schools and health systems will need to work in unison to face the inevitable challenges that face us in the months and years to come.

Respectfully submitted,

James H. Jones MD
Professor of Clinical Emergency Medicine
Indiana University School of Medicine