
Transforming Academic Health Centers for an Uncertain Future

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Academic health centers (AHCs) have long led the advancement of science and medicine by pursuing missions of clinical care, research, and education. AHCs have been places where important fundamental and translational research is performed and medical innovations are created and tested. Given the dramatic changes ahead in health care and deteriorating research funding, can this record of achievement continue, or do AHCs in the United States face a growing risk of extinction?¹

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Despite their substantial societal value, these centers have an uncertain future. The health care landscape is changing rapidly owing to the Affordable Care Act, state budget deficits, and private insurers' responses to pressures to constrain cost growth. Reductions in Medicare and Medicaid reimbursement, strategies for driving health plan enrollees to lower-cost providers (e.g., having narrow networks and tiering network providers), and elimination of government funding (e.g., payments for hospitals treating a disproportionate share of low-income patients) all put pressure on AHCs.

AHCs face additional challenges specific to their research and education missions. Today, the costs of research exceed the "soft money" available to support it: for every dollar of direct federal research support, an additional 30 to 40 cents is needed from institutional resources beyond the federally negotiated indirect-overhead recovery. Total support for research will probably decline as deficit reduction becomes even more of a government priority, National Institutes of Health funding is constrained by budget cuts, industry sponsorship of research wanes, and philanthropic organizations struggle to return to pre-recession contribution levels.² Some portions of the research and teaching missions of AHCs are currently supported by revenues from clinical activities, but shrinking margins on clinical care revenues put this support model at risk.

Looking ahead, there is a risk of what a PricewaterhouseCoopers report termed a "margin meltdown."³ A growing gap between the excess costs of fulfilling AHCs' academic missions and the available funding will jeopardize the

integrity of those missions. In short, profound changes are needed in AHCs' organization and operations.⁴

The transformation will require both rethinking and staying true to AHCs' core missions. Must AHCs be more selective about areas in which they aim to excel? Are they structured appropriately and optimally sized? Are their current measurements of success appropriate? Are planning and decision making for their academic and clinical missions appropriately aligned?

One key consideration will be balancing specialized clinical excellence and population health. Excellence in tertiary and quaternary care has been critical to AHCs' success. However, as large national employers and insurers seek best-in-class care, partly through "centers of excellence" designations, and as even subspecialty health care becomes commoditized, we believe that AHCs must build up highly differentiated programs of distinction — world-class, cutting-edge, highly specialized clinical programs that are leveraged and integrated with translational research and advanced training. Such programs should be capable of producing game-changing advances and delivering superlative care. Of course, achieving this goal will not be easy. To increase the chances of success, AHCs must play to their strengths and adopt clear strategies, prioritization, and implementation.

Simultaneously, AHCs will have to become higher-performing regional health systems, spanning the spectrum from community-based and primary care to highly specialized hospital and post-acute care, all linked by effective information systems. Greater clinical

integration is needed among hospitals, faculty, and employed and unemployed community-based partners; such integration may be achieved through formal arrangements conducive to improving the consistency, efficiency, and quality of care for individual patients, as well as health outcomes for populations. To improve performance, we believe that AHCs should refocus their efforts on their tripartite mission, and we suggest four approaches to doing so. First, AHCs should leverage their university affiliations and redesign care delivery, drawing on insights from health and behavioral economics, psychology, sociology, policy and management, industrial engineering, and computer science.

Second, we believe that AHCs will need to increase the yields of research, accelerating the translation of results into practice and boosting their impact on medicine and health. Doing so will require establishing an effective "discovery-to-care continuum"⁴ to facilitate more seamless translation, by creating structures integrating centers of clinical and translational research with offices of program management, regulatory affairs, education and training, biostatistics and biomedical informatics, and central biobanking, among others. Such structures can catalyze interdisciplinary collaborations and assemble resources into shared core services and facilities that offer natural economies of scale. More should also be done to foster a strong culture of innovation and reward entrepreneurship.

AHCs should also seek to optimize the size of their research enterprise. Specific areas of research excellence could be emphasized, and support for unfunded

research rationalized. AHCs should develop meaningful measures of research success that are related to scientific and societal impact rather than to funding obtained or articles published. Dedicated grant-application resources could also be created, and more structured mentoring provided.

Intrinsic assets of AHCs, such as access to biologic samples and clinical data, should be better leveraged. In the Big Data era, AHCs should strive to become “learning health systems” by making clinical data “research grade” and lowering the costs of data acquisition and knowledge generation. Our institution, like many others, has migrated to a single comprehensive electronic health record platform, which allows us to convert health data from a by-product of care delivery into a central asset for improving research and translation.⁵ The data-and-technology revolution also offers new ways to engage patients, through e-health, mobile devices, and increased personalization driven by advanced analytics.

It's likely, however, that AHCs cannot make this transition to true learning health care alone. We therefore recommend that AHCs seek new research and other collaborations with diverse partners — including nonmedical university disciplines, industry, and businesses — and engage in public-private partnerships and multisite collaboratives.

Third, we're convinced that medical education and training must be reinvented to adapt to the changing health care paradigm. We think that AHCs should reexamine traditional beliefs and approaches to medical education, questioning its cost and duration. Should education shift toward using dedicated in-

structors, increased online instruction, simulation, even gaming? Can AHCs shorten training time by streamlining the educational continuum — for example, providing a focused 3-year medical school curriculum in primary care, plus a 2-to-3-year residency?

AHCs would also be well advised to expand beyond their focus on physician education and think more expansively about programs for other health professionals and about emerging areas such as population health management, clinical informatics, and leadership and management. Robust interprofessional education will be important, since health system performance will increasingly depend on high-functioning, team-based approaches to care. Health care reform's success will depend on modernization of health education so that students and trainees learn transparency and accountability while developing competencies in social determinants of health, health economics, and informatics.

Fourth, we believe that AHCs require enterprise-wide planning and management to prepare for their uncertain future. The PricewaterhouseCoopers report highlights AHCs' decentralized structures as a barrier to their ability to respond to these challenges.³ AHCs are complex organizations — amalgamations of health care units with traditional departments, disciplines, and thematically organized research institutes. Such decentralization has permitted innovation, but a culture of faculty individuality and autonomy can conflict with the imperatives of team-based care and regulatory compliance. In true enterprise-wide planning and management, leaders, faculty, and administrators from throughout the

enterprise would engage in coordinated planning to affirm, align, and prioritize specific aspects of their institution's missions; develop clarity about decision rights and accountability; and agree on and implement changes that enable long-term sustainability and success. They must ensure that critical decisions and tradeoffs — such as priority setting regarding faculty hires or allocation of clinical and research support in a resource-constrained setting — are made collaboratively and serve the entire institution's long-term interests.

AHCs urgently need to reexamine their approaches, challenge sacred cows, and prepare for transformation. Above all, as they pursue these new directions, AHCs must remain accountable to society both locally and globally.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Vanderbilt University Medical Center to cut more jobs, offer buyouts

Medical center will trim \$250M from budget by 2015

*By Getahn Ward
/ The Tennessean*

Vanderbilt University Medical Center is looking to trim \$100 million from its budget for the current fiscal year and will pursue several options, including offering early retirement for certain employees.

That option would be available to staffers who might wish to retire earlier than planned, Dr. Jeff Balsler, vice chancellor of health affairs and dean of Vanderbilt's School of Medicine, said in a memo that offered new details on cost-cutting measures at Nashville's largest private employer. He said details on the early retirement would be released soon.

In recent weeks, the academic medical center has been reducing its workforce by at least 300 employees as executives try to plug a \$70 million shortfall in revenue for this year compared with the previous fiscal year. The \$100 million in targeted cuts or savings for this year equates to just more than 3 percent of budgeted expenses, Balsler said, adding that VUMC's overall annual budget is roughly \$3.3 billion.

His memo signaled more workforce reductions over the next two years as part of "strategic downsizing" and a workflow re-engineering effort called Evolve to Excel, or E2E. Overall, VUMC is targeting \$250 million in budget savings over two years, or roughly 8 percent of its current expenses.

The cuts are coming as Balsler and other officials said VUMC is experiencing declining reimbursements for its three largest sources of federal revenue — reimbursements for services to patients insured by Medicare and Medicaid, along with declining federal support for research through the National Institutes of Health.

People familiar with VUMC's plans expect its workforce to be reduced by more than 1,000 employees over the next two years.

"It is clear that we must embark on a comprehensive effort that is immediate, achievable, proactive and ensures success over a multiyear period, while the health care and biomedical science economies we live in reshuffle into a 'new normal,'" Balsler said in his memo to the staff. "Our plan will preserve the vast majority of our mission-critical programs, while keeping compensation at market-competitive levels."

Nationwide, similar cost-cutting steps are being taken by other hospitals and academic medical centers.

"It reflects the fact that Vanderbilt is an extremely well-run organization and they realize that they're going to have to cut expenses to remain viable," said Joshua Nemzoff, a hospital industry consultant.

Balsler referred to savings from supplies, facilities, contract improvements and other nonlabor cost areas as the highest and first priority under the Evolve to Excel effort that's focused on saving costs through improving function and expected to boost revenues in targeted areas.

Management consulting firm McKinsey & Co. is helping with identifying and implementing cost-savings opportunities that include simplifying various systems and services many VUMC employees use on a daily basis, Balser added.

In addition to offering early retirement, VUMC plans to take advantage of regular retirements and other staff departures including through re-engineering workflow to reduce the need to replace those positions. Some positions also will be permanently eliminated, mostly in support and overhead functions versus direct patient care jobs. A hiring freeze that has been in effect over the past two quarters will continue, Balser said.

Additionally, VUMC plans to move to a new paid time off plan that combines vacation, personal, holiday and sick leave and introduces a new paid parental leave benefit.

Spokesman John Howser said details on that plan would be made available to employees in the next several days.

Additional Facts

VUMC's employee numbers:

At the end of Vanderbilt University Medical Center's fiscal 2012 year, the medical center had about 16,883 employees. That includes 16,293 full-time employees and 570 part-time staff, said VUMC spokesman John Howser. VUMC also has 2,532 faculty members.

From the The Business Journal

:<http://www.bizjournals.com/triad/news/2013/05/02/wake-forest-baptist-adds-cost-cutting.html>

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Hurting financially, Wake Forest Baptist adds cost-cutting measures



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Revenue declines along with the disruptive and costly implementation of a new electronic medical records system have forced **Wake Forest Baptist Medical Center** to take additional cost-cutting measures this year, according to its CEO, Dr. [John McConnell](#).

In a statement released to the media Thursday, McConnell detailed the additional, short-term steps that he said will help provide "immediate multi-million dollar savings," most of which impact nonclinical staff instead of nurses, physicians and other medical staff that deal directly with patients.

"While Wake Forest Baptist is making significant progress it must take additional measures to narrow a financial gap in the final months of the fiscal year," McConnell said. "These measures will have no impact on the quality of care or service that patients receive."

Among the new steps now being taken: management incentive compensation for this fiscal year, which ends June 30, has been eliminated; nonclinical employees have been asked to volunteer for furloughs; nonclinical administrative staff have the option of reducing their schedules to 30 hours a week, and nonclinical hiring has been suspended for two months. Additionally, Wake Forest Baptist has reduced its contributions to employee retirement accounts to a 2 percent match.

The medical center hasn't disclosed exactly how much it expects to save through these additional steps. Medical center officials declined to comment beyond McConnell's statement to the media.

This move comes on top of [a plan put in place in November](#) to cut 950 positions from the work force of the medical center, which numbers more than 13,000, by the end of the fiscal year on June 30.

Plans called for about half of those positions to be eliminated through retirements, attrition or shedding contract services, while the remainder involved laying off current employees. About a third of those total job eliminations involved positions in corporate services and administration.

In November, and again this week, McConnell emphasized that drops in revenue, both from cuts in reimbursements and research grants from government sources, including Medicare, are behind the need to trim expenses.

What's occurred since November is that [Wake Forest Baptist has seen a substantial loss of revenue due to the disruptions](#), primarily in outpatient settings, to its business from the transition to the Epic records system.

Through the second half of 2012 — the first half of the medical center's fiscal year — the implementation cost the medical center an estimated \$47.9 million, which in turn caused the medical center to post a \$33.7 million operating loss in the second quarter.

It's a drastic change in financial performance for the medical center, which in the past two fiscal years generated operating income of \$45 million to \$50 million on revenues of close to \$2 billion. Prior to taking these additional steps, Wake Forest Baptist officials said they anticipated ending this fiscal year with an operating deficit.

"Even though short-term operations impacts were expected, it was more than initially planned," McConnell said Thursday. "That coupled with reimbursements for clinical services and payer mix declines have resulted in lower payments to Wake Forest Baptist. In addition, further declines in research funding from the federal government added financial pressure on the School of Medicine."

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