

The Evolving Organizational Structure of Academic Health Centers: The Case of the University of Florida

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Abstract

The organizational structures of academic health centers (AHCs) vary widely, but they all exist along a continuum of integration—that is, the degree to which the academic and clinical missions operate under a single administrative and governance structure. This author provides a brief overview of the topic of AHC integration, including the pros and cons of more integrated or less integrated models. He then traces the evolution of the University of Florida (UF) Health Science Center, which was

created in the 1950s as a fully integrated AHC and which now operates under a more distributed management and governance model. Starting as a completely integrated AHC, UF's Health Science Center reached a time of maximal nonintegration (or dys-integration) in the late 1990s and at the beginning of this decade. Circumstances are now pushing the expanding clinical and academic enterprises to be more *together* as they face the challenges of market competition, federal research budget

constraints, and reengineering clinical operations to reduce costs, enhance access, and improve quality and patient safety. Although formal organizational integration may not be possible or appropriate for any number of legal or political reasons, the author suggests that AHCs should strive for “functional integration” to be successful in the current turbulent environment.

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Evolving organizational structure, as the phrase is applied to academic health centers (AHCs), refers to changes over time in the formal and informal interrelationships between a medical school's clinical practice, educational programs, research activities, and associated teaching hospitals. For the purposes of this discussion, AHC integration refers to the degree to which the component organizations, with their clinical (both hospital and physician practices) and academic (educational and research) activities, operate under common management and governance. In Wartman's¹ conception, AHCs generally fall somewhere between two extremes. At one extreme is a model of full organizational integration where the collective components of the AHC are led by a single CEO and a common overarching governing board. At the other extreme is a more loosely affiliated model in which the university academic activities, medical school physician practices, and teaching hospital operations are each managed by different leaders and governed by distinct and independent boards. Under that model, integration

within an AHC can be more functional than structural in nature. Functional integration can be thought of as the degree of shared vision, collaborative strategic planning, and transparency in business functions that exists between the clinical and academic elements of a college of medicine and an affiliated teaching hospital, even though the formal organizations may remain distinct business and legal entities. A graphic representation of these variations in organizational integration, and some representative examples, are shown in Figure 1.

Types of AHC Organizational Integration

Proponents of full organizational integration under unified leadership and governance argue that it makes sense for a number of reasons. First and foremost, full organizational integration facilitates strategic focus. Without such focus and discipline, the individual components of the AHC may pursue diverse interests, invest in parochial programs, and engage in activities that may add economic or academic value to one or another AHC component but don't optimally advance the overarching shared missions of the combined enterprise. Examples abound: the development of a regional primary care network while limiting the expansion of hospital-based academic

tertiary care programs, purchase or construction of general hospitals distant from the AHC campus, and investing heavily in clinical practice development while limiting investment in biomedical and health services research programs. In the absence of the rigorous strategic focus expected under a fully integrated organization, such choices can exacerbate managerial turf wars and squander limited investment resources. By contrast, fully integrated AHCs can be advantaged by the “hedgehog concept” espoused by business author Jim Collins in his “Good to Great” writings: a laserlike focus on the organization's fundamental core business and the discipline to say “no thank you” to opportunities that don't directly and measurably further that end.²

A second reason full organizational integration may make sense is that the academic missions of the AHC can be substantially advanced with the financial support that the clinical enterprise has traditionally been able to provide. It is argued that this is not only true historically but is especially important now when growth in funding for education and research is increasingly constrained.³ Although total annual revenues supporting U.S. medical schools increased from around \$25 billion to \$56 billion in constant dollars during the last 10 years,⁴ serious pressures are slowing the rate of growth of revenues available to

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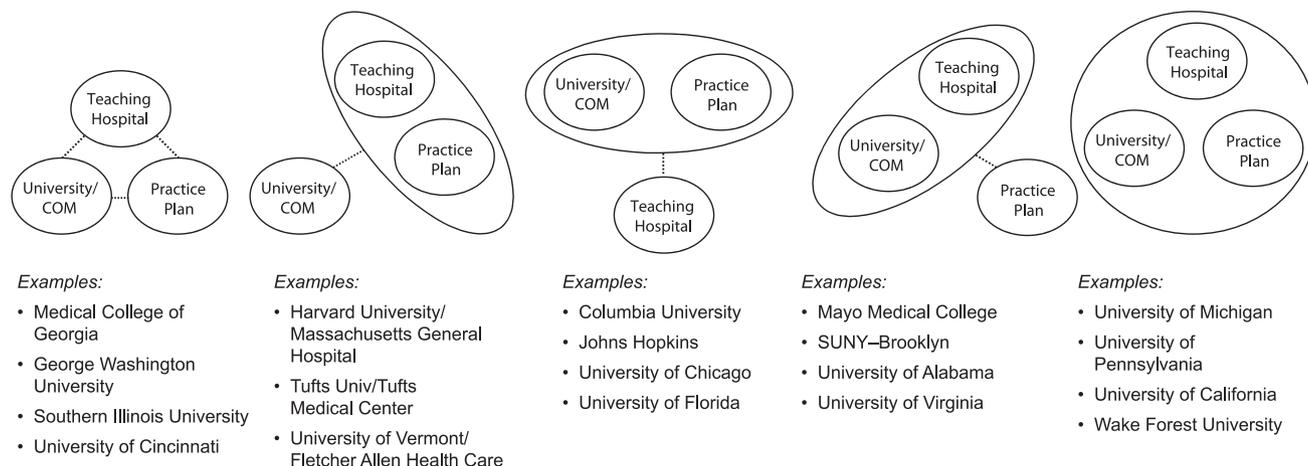


Figure 1 Five organizational models of academic health centers. The models, including the least integrated on the extreme left and the most integrated on the far right, are shown with examples of each.

Source: Presentation by Jay K. Levine and ECG Management Consultants to the Association of American Medical Colleges in August 2001. Updated May 2008. Used with permission.

AHCs. These pressures include decreases in states' general revenues to public medical schools, flattening of the National Institutes of Health budget supporting research at medical schools, and reductions in reimbursement for physicians' clinical services. AHCs that have more integrated organizational structures may find it easier to rationally balance the allocation of revenues and expenses across the three missions, arranging subsidies where necessary while providing appropriate incentives and rewards for superior performance and fostering high levels of accountability. Moreover, unified management can make sure that these incentives are aligned across the academic and clinical enterprises to the greatest extent possible so that members of the leadership team aren't working at cross-purposes.

Parenthetically, the existence of an academic physician practice under independent management and governance that is distinct from other elements of a state-university-based AHC has resulted in the loss of the benefit of governmental sovereign immunity for the physician practice. This can result in multimillion-dollar increases in liability insurance costs for the AHC.⁵ Similarly, a completely independent hospital that operates as an arm's-length affiliate of the medical school may be at risk under Stark and antikickback laws if it provides direct financial support to physicians in a school's practice organization. In contrast, AHCs that operate under a more unified governance structure may

enjoy a degree of protection under "safe harbor" exemptions.⁶

To summarize, proponents of integrated organizational models maintain that, above all, they provide clarity and transparency in determining two fundamentals: what an AHC is going to do (strategic focus), and how the AHC is going to pay for it (financial discipline).

On the other hand, formally integrated organizational models have certain important limitations. Corporate and academic cultures can collide, juxtaposing the expectation of loyal teamwork within a corporate hierarchy against the principles of academic autonomy and the practice of rugged individualism among academic practitioners and investigators.⁷ Even under a common organizational structure, differences in fundamental values and strategic emphasis between physician practice leaders and hospital administrators must be managed carefully to maximize the effectiveness of the overall organization. Furthermore, a certain degree of autonomy can facilitate entrepreneurialism of leaders and managers with specific skills and experience dedicated to running physician practices, administering hospitals, or developing academic programs. In contrast, a monolithic organizational structure might diminish creativity and discourage risk taking. One could even view more distributed organizational models as a kind of hedge against "groupthink," promoting a healthy battle of ideas from which the best decisions emerge.⁸

Clearly, there are examples of successful institutions at both ends of the integration spectrum, and their effectiveness seems to hinge on much more than just their particular organizational model.⁹ It is noteworthy, though, that in the last few years a number of prominent institutions, including, for example, Ohio State University and the University of Iowa on the public side and Wake Forest University among private institutions, have taken significant and sometimes dramatic steps to more fully integrate the components of their AHCs. In this context, we will briefly share the experience of the University of Florida (UF) Health Science Center through 50-plus years of organizational change (see Figure 2).

Organizational Change at the University of Florida's AHC

Integrated at birth

At its founding in 1956, the UF Health Science Center was unusual if not unique. The brainchild of a university president and leading academic thinker of that era, J. Hillis Miller, the UF Health Science Center was designed with organizational integration as a fundamental principle. Miller envisioned a single place to train an array of health professionals for the state of Florida and to pursue research that would safeguard the health of Floridians. Importantly, this "health center" would educate not just doctors and nurses but also pharmacists, allied health professionals, and, later, dentists and veterinarians—all on a single campus that was part and parcel of the greater

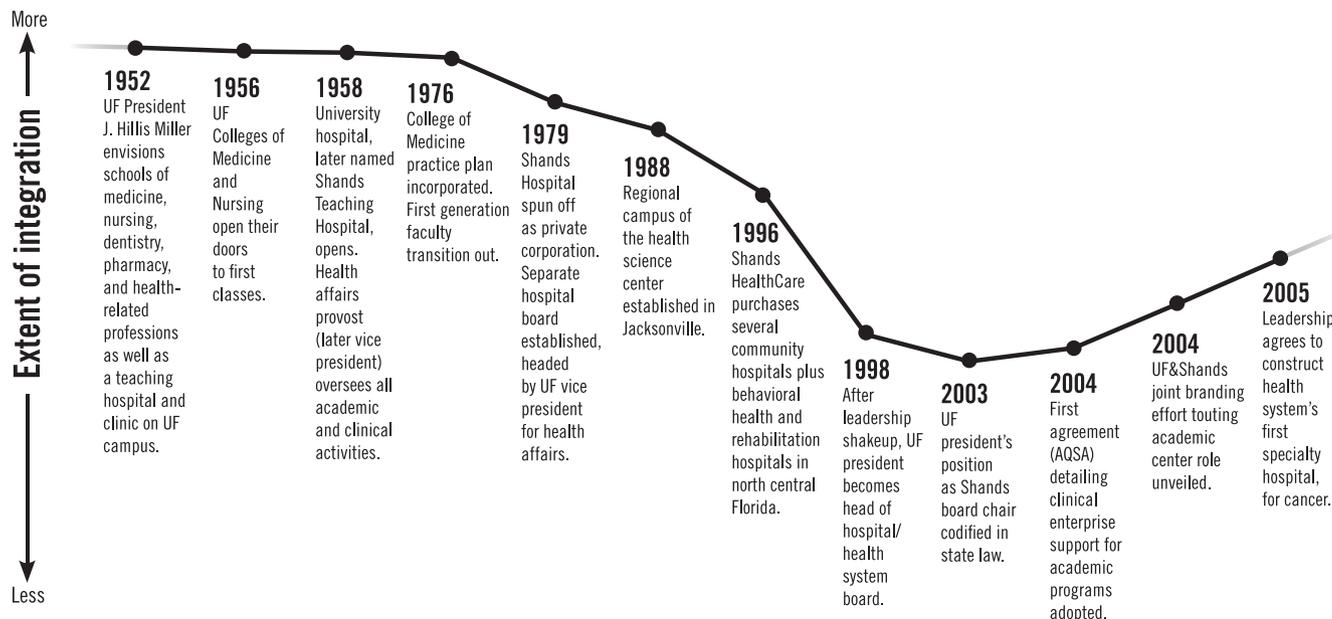


Figure 2 Timeline of formal and informal organizational integration at the University of Florida Health Science Center. From a relatively integrated beginning in the mid-1950s, the health center became less cohesive through the opening years of this century, when a number of steps were taken to enhance functional integration. Chronology not to scale.

university. Two years later, UF constructed a teaching hospital that was named for a prominent state senator, William A. Shands. The entire health center, including the Shands Teaching Hospital, was overseen initially by a health center provost and later by a vice president for health affairs who, in subsequent years, at times, also held the title of dean of the college of medicine.

During the ensuing half century, the UF Health Science Center grew substantially in size and became much more complex. The colleges of medicine, nursing, pharmacy, and allied health professions that constituted the original AHC were joined by those for dentistry in 1972, veterinary medicine in 1977, and public health in 2005.

Perhaps not surprisingly, the ideals of integrated education and interdisciplinary clinical care envisioned by the founders of the UF Health Science Center have been harder to sustain over time. The passion for educating students of various health professions side-by-side faded somewhat after the turnover of the first generation of faculty and after the health center colleges became more interested in advancing their own individual standing among national peer colleges. This phenomenon, familiar to everyone involved in professional health education, is something we who administer AHCs continually try to counterbalance by

developing innovative interdisciplinary educational programs and service-learning projects.

In 1976, a faculty group practice was developed as a distinct business unit within the university, a 501(c)3 corporation acting solely to support the college of medicine. Governed by a board composed of the dean and clinical department chairs, the practice serves as the sole billing and collecting entity for the clinical activity of each of the college departments. Monies generated by faculty billings from each department belong to the college of medicine and become a component of that department's operating funds after the costs of collection, clinic operational expenses, and a 5.45% college assessment ("dean's tax") are applied.

In the late 1980s, the health center formally established a regional campus in Jacksonville, about 70 miles away from the main campus in Gainesville. This urban campus complements the university-based educational programs and has become one of the largest regional medical campuses affiliated with a medical school. The student experience on this regional campus is characterized by exposure to the clinical programs of an urban inner-city population, including issues of disparities in health care access and quality, and a large, urban-based, emergency department with a busy level 1 trauma unit. The

Jacksonville campus is overseen by an individual with the two-part title "dean of the regional campus/associate vice president for health affairs" and reports to the senior vice president for health affairs. From the standpoint of this article, the Jacksonville regional campus could offer its own case study of the challenges of balancing AHC integration with local autonomy in a growing regional campus.¹⁰

These two developments—the establishment of a medical practice plan and the regional campus—represented progress by many measures. But, they also had the natural effect of challenging the cohesiveness of the health science center. They essentially represented new campus entities with unique interests that needed to be accounted for and blended into the common interest, not always without conflict.

On the hospital side, two major trends in national health care had the effect of distancing the hospital enterprise from the university and the faculty practice in the college of medicine. The late 1970s and early 1980s were a turbulent period for teaching hospitals, as they experienced the first significant curbs in reimbursement from the federal Medicare program and rising competition from private hospital chains. Leaders of UF were concerned that the financial and legal risks posed by Shands Teaching Hospital were likely

to become a serious liability for the university. Moreover, they concluded that the hospital would have more operational flexibility, and it could compete more effectively, if it were not a part of the state university system with the attendant encumbrances of state-regulated purchasing and personnel policies. As a consequence, in 1985 Shands was spun off as a separate private nonprofit corporation whose primary mission remained to support the UF Health Science Center. The hospital corporation was to be governed by a new board of directors, all appointed by the university president. At least half of the board members were to be private citizens. The chair of the board was the university vice president for health affairs. Transitioning from a state university institution to a private nonprofit corporation almost immediately improved the ability of the hospital to operate as an efficient business and helped ensure its financial viability. From an integration standpoint, although Shands was separated from the university in a strict legal sense, the new governance structure and board leadership were designed to ensure that the hospital system maintained fidelity to supporting the academic enterprise. Despite those precautions, it was, perhaps, inevitable that the hospital management and staff—now operating a legally separate enterprise with distinct business systems—would gradually develop an organizational identity separate and apart from the rest of the health science center.

In the mid-1990s, the teaching hospital corporation (now known as Shands HealthCare) purchased one acute care hospital and two specialty hospitals (behavioral health and rehabilitation) in Gainesville and three small general hospitals in more rural communities nearby. These acquisitions were, in part, the result of an expansion strategy in vogue at the time to respond to the spread of capitated managed care that (it was thought) threatened to remake the health care landscape, and in part to prevent private-sector competitors from buying the Gainesville-based facilities. As seen in hindsight and through the lens of integration, some of these clinical facilities may seem today to be less essential to the academic mission (e.g., rural community hospitals with nonfaculty members of the medical staff). In that sense, some perceive these acquisitions as diverting the teaching

hospital enterprise from its primary purpose to support the academic mission.

In addition to changes in the size and composition of the teaching hospital system, its governance structure also changed in a critically important way. In 1998, in a leadership shakeup, the position of vice president for health affairs was combined with that of the dean of medicine. At the same time, the university president assumed the position as the chair of the board of directors of Shands Teaching Hospital. Although the latter change was expected to be temporary, it persisted through the selection of the next health affairs vice president, the appointment of an interim UF president, and the recruitment of a new CEO of the teaching hospital system—five years altogether. Then, in 2003, the university successfully pursued legislation to permanently establish the president of the university as chairman of the hospital system board. As of this writing, both the senior vice president for health affairs (now also vice chairman of the hospital system board) and the chief executive of the teaching hospital system report to the university president. Leadership of the hospital system and the university's clinical, educational, and research enterprise is divided between two distinct positions.

Taken together, these major organizational and governance changes have had a significant effect on the relationship between the academic and the clinical components of the AHC. A few of the impacts have been substantial and measurable. For example, the spin-off of the hospital as a private corporation resulted in the loss of sovereign immunity for the hospital system. Incremental medical liability insurance coverage is now estimated to cost the teaching hospital an extra \$12 million each year. On the other hand, at the time of the divestiture, trading sovereign immunity for the operational flexibility required to ensure a solvent hospital was thought to be a prudent risk.

What can be equally detrimental to the organization over the long run is the possibility that the components of the AHC fail to agree on a common strategic vision about how to move forward. This lack of synchrony can manifest itself in a variety of ways—from the profound to the petty—leaving a trail of missed opportunities, anemic performance, and personal animus

that can prevent the combined organizations from achieving their full potential as an AHC. Edward Miller, dean of Johns Hopkins School of Medicine, described this phenomenon in an interview for the Association of Academic Health Centers 2006 annual report: “You cannot have wars between the school of medicine and the hospital. It just doesn't work. You spend too much energy protecting your own turf rather than thinking about the entire enterprise.”¹¹

Reversing the trend

Despite the changes of the 1980s and 1990s that pushed the UF Health Science Center toward a more distributed organizational structure, today there is growing recognition among administrators and board members that success for each component of the AHC increasingly demands that we work together. Circumstances are now requiring the expanding clinical and academic enterprises to be more *together* as they face the challenges of market competition, federal research budget constraints, and reengineering clinical operations to reduce costs, enhance access, and improve quality and patient safety. The faculty increasingly recognize that the partners who run the hospital have exceptional business acumen and management expertise. In turn, there is greater understanding by the hospital system leadership that optimal competitive positioning and financial success are linked to the high-end tertiary care programs of an AHC. This view is reinforced by recent market surveys of how the public perceives AHCs and what they most value about AHCs as providers of health services.

Thus, the current emphasis is on *functional integration* as distinct from formal organizational integration. Functional integration operates at both the strategic and operational levels and is more a choice than a structural condition or constraint. At the strategic level, it involves reaching and then upholding agreements—about who we are, what we will do, and how we will support each other. At the operational level, functional integration is about the hard work of building interdisciplinary teams around agreed-on objectives that define our combined success and then holding the organizations and their leaders accountable for their results.¹²

A number of recent initiatives support the concept of functional integration

between the UF medical school, its physician practices, and the hospital system. Five years ago, the Shands HealthCare system and the UF College of Medicine finalized a formal agreement that provided a major increase in academic development funds from the hospital to the college. Under this arrangement, termed “Academic and Quality Support Agreement,” or AQSA, the hospital provided financial support linked to improvements in clinical quality metrics compared with national benchmarks. The AQSA was renegotiated and improved last year, with another increase in funding for academic program development and additional flexibility for the dean to use the funds to invest in clinical programs, translational research, and biomedical science. In 2007–2008, the hospital system will provide the college of medicine with approximately \$40 million in academic and clinical program development funds. One can view the AQSA as a formal and tangible example of how the college and health system will support each other to be more integrated on a functional level.

We’ve also come into better harmony about who we are. For many years, the teaching hospital system (doing business as Shands HealthCare) branded itself as simply “Shands” in its consumer advertising and promotional efforts. Today, we have adopted a new brand identity for public relations and marketing: UF&Shands—The UF Health System. The message points in the new branding campaign make it clear that our foremost role in the marketplace is as an AHC offering the highest-quality comprehensive care as well as superspecialized and innovative health care.

A crucial next step in this progression toward functional integration will be in formalizing and expanding interdisciplinary clinical teams that integrate diverse groups of providers to deliver a given clinical service, say, for cardiovascular disease, with the construction and management of specialized facilities where that care is delivered. Such teams bring together the relevant medical, surgical, and ancillary providers in dedicated clinical centers

and organize their activities around objectives that are consistent with the most efficient delivery of high-quality, cost-effective health care. Then, through translational research, there’s a natural bridge between these clinical teams and the UF research centers and institutes where, already, team science is being pursued. Comprehensive cancer centers on AHC campuses are excellent examples of this approach. Between the UF College of Medicine, Shands HealthCare, and the Moffitt Cancer Center, the leadership of the AHC has initiated a planning process toward a multicampus, multiinstitutional, integrated cancer care program designed to improve the quality of cancer care regionally. A centerpiece of this effort is a 190-bed cancer hospital slated to open on the UF Health Science Center campus.

This “bottom-up” or “micro” integration will not be constrained by what identification badge members of the team wear or who signs their paycheck. The one overriding concern should be to accomplish those things that result in the best care for the patients their team manages in the context of an AHC. Our part, as AHC administrators, will be to functionally integrate these teams by reconfiguring and aligning the incentives that reward the provider teams and the administrative managers for achieving the desired results regardless of whether they are part of the university, physician practice plan, or Shands HealthCare. This is no small task, because there are likely to be resource winners and losers in this reallocation—a financial fact of life that only adds to the argument for enhancing integration as an AHC.

Looking Toward the Future

In summary, the UF Health Science Center may never again resemble the unambiguous, fully integrated, unified organizational structure it embodied at its creation. The complexities and challenges of the competitive clinical and academic environments preclude a return to “yesterday.” For some of those same reasons, other AHCs may not be able to, and, indeed, may not need to, implement

a fully integrated, completely unified organizational structure. But I believe that, at a minimum, AHCs must achieve improved functional integration at the strategic and tactical operational levels to advance in the new environment. In other words, as a practical matter, if AHCs in this country are to effectively manage the daunting challenges they face, we’d better have our act together, and we’d better “act together.”

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