In times of fundamental social change, institutions face both mortal threats and unparalleled opportunities. Such is now the case with the unique class of health care organizations known as academic medical centers.

For the purposes of this discussion, we take academic medical centers to consist of the roughly 120 to 380 institutions (depending on one's precise definition)\(^1,2\) that carry out the three missions of teaching, research, and patient care and do so in close affiliation with or as part of a degree-granting university. Imminent reforms in health care promise to accelerate trends that have made the discharge of the traditional missions of the academic medical center increasingly problematic. For these centers to survive, let alone prosper, their leaders, faculty, and staff members need a clear, unromanticized understanding of the changed environment they face and of the comparative advantages and disadvantages that their institutions bring to these new situations. The purpose of this article is to shed some light on these matters.

In this tumultuous time, no one can claim special knowledge of what the future holds for the health care system in general or for academic medical centers in particular. But much can be learned by identifying and reasoning from the fundamental forces -- the tectonic plates, if you will -- whose movement underlies the current changes in our health care system. In this regard, several predictions seem useful.

First, now that security of health care has become a middle-class concern, universal entitlement to basic health services is inevitable.

Second, regardless of the details of any plan that is enacted, the customers of our health care system -- government, business, and the public -- will require that health care institutions and providers be accountable for their actions. The mechanisms through which that accountability is enforced may vary, but all will require that academic medical centers, like other institutions, respond to the wishes of society that they constrain health care spending, improve the efficiency with which they discharge all their functions and the quality of the work they do, and provide evidence that they have done so.

Third, the size of our nation, its geographic and political diversity, and politicians' appropriate uncertainties about how best to organize our health care system ensure that considerable variation will persist in local health care arrangements\(^3\).
Finally, change is occurring so fast in some of our health care markets -- parts of California, Minnesota, and Massachusetts, for example -- that national and local legislators will find their options for reform increasingly limited. One of the reasons that competition among integrated health care systems (so-called accountable health plans) will be permitted, if not encouraged, under any package of health care reform is that such organizations now dominate many markets and enjoy strong local support. …

These developments suggest three possible scenarios for the future of academic medical centers. Given the variability in markets, different scenarios may predominate in different localities. The first is that the valued functions traditionally performed by academic medical centers will be broken up and parceled out to other institutions that demonstrate they can perform the functions as well or better. Leaders of academic medical centers believe that teaching, research, and patient care are interdependent functions that are best performed together, but this contention is difficult to prove.

A second scenario is that academic medical centers will separate into two distinct classes: a small group of “super-tertiary” institutions that concentrate on biomedical research, the training of researchers and subspecialists, and the care of patients with extraordinarily complex conditions; and a much larger group of community-oriented academic institutions that focus on the training of primary care practitioners, research on ambulatory care and health services, and the provision of secondary and tertiary care.

The final possibility is that the great diversified academic medical centers that currently dominate research, training, and specialized care in our country will find the resources and political will to become fully integrated into our transformed health care system. To train the health care work force of the future, they will develop or affiliate with integrated health care systems. To provide intellectual leadership in a revised health care system, they will become as adept in health services and outcomes research as they have been in biomedical investigation, and to attract a sufficient number of patients, they will achieve previously unimaginined efficiency in the delivery of health care.

To achieve this last result, the leading academic medical centers would probably have to change so profoundly that the very term “academic medical center” would become obsolete. A better name might be “academic health system.” These new entities would embody not only the traditional strengths of academic medical centers, but also enough characteristics of our revised health care apparatus that they could carry out the teaching, research, and patient care required for continuous improvement in the public health.

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Excerpt from Remarks at AMERICA’S HEALTH INSURANCE PLANS -- MEDICARE CONFERENCE, WASHINGTON, D.C. - SEPTEMBER 13, 2010

Or, as we say in the world of quality improvement, “Every system is perfectly designed to achieve exactly the results it gets.” If we want new results – and we do – we need a new system. All improvement is change.
And so that brings me back to the question that the Affordable Care Act poses: “Will we change?” “Will we redesign health care in America?”

That question will be answered, if at all, not primarily by government – and certainly not by government, alone.

The job of changing care – for the benefit of our people and our society – belongs properly, first and foremost, to those of us who give care – professionals, health care organizations – encouraged and supported by those who arrange for them to give care – insurers, employers, and communities.

The Triple Aim – The Answer

What should that redesign accomplish? I have written about, and I recommend, a set of goals that I call, “The Triple Aim.”

The Triple Aim refers to three goals at once:

(a) better care for individuals – as described by all six dimensions of quality in the Institute of Medicine report: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity;

(b) better health for populations with respect to the upstream causes of so much of our ill health – like poor nutrition, physical inactivity, substance abuse and unwise behavioral choices, violence, and economic disparities; and

(c) reducing per capita costs by eliminating waste and needless hassles… and, hear me clearly, specifically not by withholding from us or our neighbors any care that helps then – specifically not by harming a hair on any patient’s head.

I invite stakeholders throughout health care to rally around the Triple Aim, and to begin, together, to make the changes that allow for it.

I am trying to focus the attention of my CMS colleagues on three arenas of strategic priority for starters: acute care, integrated care, and community-based prevention… with specific aims for improvement in each.

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*Accountable Care Organizations.*

*Under the health reform law, Medicare will be able to contract with these to provide care to enrollees. What are they and how will they work?*


The ACO has emerged over the last few years as a way of promoting integration while avoiding some of the perceived problems of past efforts. The concept began with the observations that physicians who are tied to a particular hospital
often already function as a sort of informal network, and that their patients tend to stay within the network for most of their care. These facts suggested that groups consisting of one or more hospitals and doctors who use the hospitals, but aren’t necessarily employed there, might be brought together in organized systems. Public and private payers could then hold these systems accountable by assessing whether they provided high-quality care to their usual patient population while reducing the unnecessary use of resources. Organizations that took steps to improve their performance would be financially rewarded; this would encourage further steps to improve care management, leading to further rewards and a steady evolution toward fully coordinated care systems.

**Expanding Models and Structures:** Discussions of ACOs have broadened from a focus on hospital-centered systems to include models based on physician practices—including large, multispecialty groups and independent practice associations (IPAs), which bring together solo practitioners and small physician groups in order to share resources and improve their bargaining power. And different people have advanced different ideas about how an ACO might operate—tightly or loosely structured, formed voluntarily or with the organization imposed on providers by Medicare or other insurers, and so on.

Because the ACO concept is a new one, it can be expected to evolve over time, as payers and providers learn which models work best.

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Patient-centered medical homes are considered by many to be among the most promising approaches to delivering higher-quality, cost effective primary care, especially for people with chronic health conditions. Although there is no single standard definition of a medical home, there is an agreed upon set of principles behind the concept, and most medical homes share common elements. For example, each patient has close contact with a clinician (physician, nurse practitioner, or physician assistant) for continuing care, and that clinician takes the lead when referring the patient to specialists. Medical homes also make extensive use of electronic health records and seek active participation of the patient and his or her family. Health care reform legislation authorizes the Department of Health and Human Services (HHS) to test medical homes among other new care-delivery models. Supporters hope patient-centered medical homes will help refocus the U.S. health care system on the benefits of primary care.