PERSPECTIVE

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This issue of *Leadership Perspectives* is a direct outgrowth of AAHC's Annual Meeting held last September, which featured the theme of *Academic Health Centers and the Private Sector*. The three contributors continue the conversation as they focus on the relationships between academic health centers and their particular industry and expertise.

In his commentary, Troyen Brennan, executive vice president and chief medical officer of CVS Health, makes the case for collaboration between academic health centers and the private sector in the context of advancing population health. He suggests that because academic health centers excel at serving the sicker patients, the private sector may be more suited to delivering everyday care utilizing, for example, nurse practitioners. Sunny Ramchandani, deputy chief medical officer of Aetna, Inc., notes that academic health centers are uniquely positioned to study the impact of private sector innovation. He also suggests the basis for a synergistic relationship between the two entities is their complementary qualities. Moshe Vardi, distinguished service professor of computational engineering and director of the Ken Kennedy Institute for Information Technology at Rice University, directly challenges the place of the physician in a technology-augmented healthcare system as the latter will "wrest even more control" from the hands of physicians. As medicine becomes more technology intensive, managing the balance of power between academic health centers and the tech sector will require new kinds of collaborations and partnerships.

It is becoming apparent that the digital "convergence" of many evolving technologies are in a real sense an existential threat to the hegemony of academic health centers in education, research, and particularly patient care. The worlds of the health tech sector and academic health centers in many ways reflect the dualism depicted in C.P. Snow's "Two Cultures," in which difficulties in communication and understanding of different fields can serve to stubbornly prevent them from harmoniously working together and drawing strength from each other.

This is precisely the situation to avoid. The contributors in this issue of *Leadership Perspectives* raise challenges and offer some working solutions. Equally, the new AAHC Thought Leadership Institute was created to envision future possibilities and potential. In particular, the initiative on "medicine and machines" strives to develop solutions to this important challenge.

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LEADERSHIP PERSPECTIVES

Perspectives from Outside the Tent

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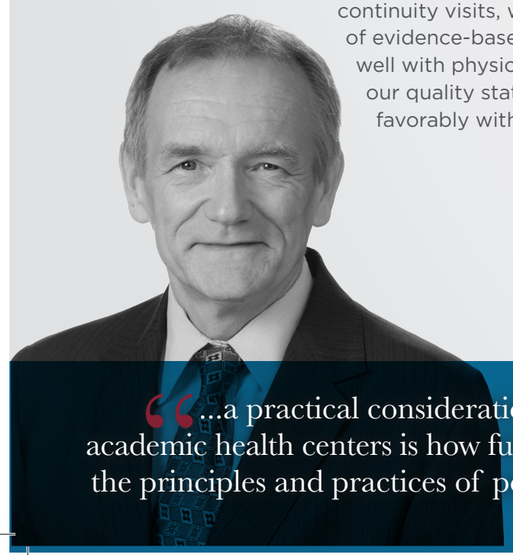
Troyen Brennan, MD, MPH // *Executive Vice President and Chief Medical Officer* CVS Health

Fundamentally, collaboration comes down to advancing population health. From my perspective at CVS, a practical consideration in working with academic health centers is how fully they have embraced the principles and practices of population health. A major consideration in that regard is agreeing on the best place for healthcare delivery based on patient needs, at the lowest cost, such that the patient is getting the best value.

This collaborative population health model would call for a recognition that academic health centers are excellent at serving the sicker patients, but could be more predisposed to routine healthcare delivery being provided more regularly by others, such as the CVS Minute Clinics. However, if academic health centers base their economics on the fee-for-service model, a collaboration may not make a great deal of sense. They might perceive us solely as a direct competitor for patients.

Any opportunity for a collaborative healthcare delivery model would also require electronic connectivity, especially interconnectivity of medical records. Our medical records are connected to about 10 major electronic healthcare record systems, such that patient information and point-of-service lab results feed from all of our nodes directly to the medical record. Building on that connectivity will be important going forward as we continue to serve more primary care patients and work more directly with—and make more referrals to—doctors in settings such as academic health centers.

I also think that it is critically important for everyone to get used to the idea that evidence-based guidelines, built into the electronic medical record and used by a nurse practitioner in a retail health setting, are a reasonable way to deliver good healthcare. Our research shows not only that nurse practitioners can and do deliver high-quality baseline primary care, but that they also make effective use of evidence-based guidelines—such as those for diabetes, hypertension, and hyperlipidemia. Nurse practitioners are also eminently capable of delivering effective, high-quality primary care for acute visits and continuity visits, work well with the framework of evidence-based guidelines, and collaborate well with physicians. When we look at our quality statistics, they compare very favorably with the best physician practices.



> “...a practical consideration in working with academic health centers is how fully they have embraced the principles and practices of population health.”

Sunny Ramchandani, MD, MPH, FACP // *Deputy Chief Medical Officer* Aetna, Inc.

Over the past decade, healthcare has been shifting from a system based on volume to a new model based on value. In the midst of this evolution, both private industry and academic health centers are uniquely positioned to advance innovation in technology, payment models, and healthcare delivery. As both an Assistant Professor at an academic health center and an executive at a national healthcare company, I truly believe that each sector possesses complementary qualities that can synergistically help us all achieve the Triple Aim of healthcare.

Academic health centers have always been pioneers in advancing quality improvement programs and developing clinical management tools that optimize healthcare delivery. This has allowed the private sector to use its financial capital to optimize and scale these systems to other parts of the healthcare ecosystem. Academic health centers also offer a unique capacity to better study innovations and to build a needed body of evidence for future applications. These capabilities have been critical in assisting private industry to better understand which solutions provide real benefit and value.

Not to be outdone, the private sector has used its structural advantages to invest in new strategies that can help drive individuals' engagement in their own health behavior. For example, Aetna recently announced a program that will partially subsidize the cost of an Apple Watch for select large employers and individual customers. This initiative is designed to develop personalized technology solutions that can improve the overall health experience. As these new solutions emerge, academic health centers can play a critical role in helping private industry understand which innovations have the most impact and how to best deploy them.

And that's just the beginning. Other opportunities for collaborative efforts include having academic health centers and payers work together to develop new payment models, test delivery system reforms, and better understand the important new role of genomic-based medicine. The healthcare world (as a whole) has yet to develop a full grasp of the new genomic-based frontier. This will provide a significant opportunity for the research capacity of academic health centers—one that they are uniquely positioned to fill.

As our healthcare system continues to evolve, the willingness of academic health centers and payers to collaboratively commit to transformational change is more important than ever. Strong leaders who can both envision and merge business and health opportunities will be the ones who forge the new way ahead.

> “...the willingness of academic health centers and payers to collaboratively commit to transformational change is more important than ever.”

Moshe Y. Vardi, PhD // *Karen Ostrum George Distinguished Service Professor of Computational Engineering, Director of Ken Kennedy Institute for Information Technology* Rice University

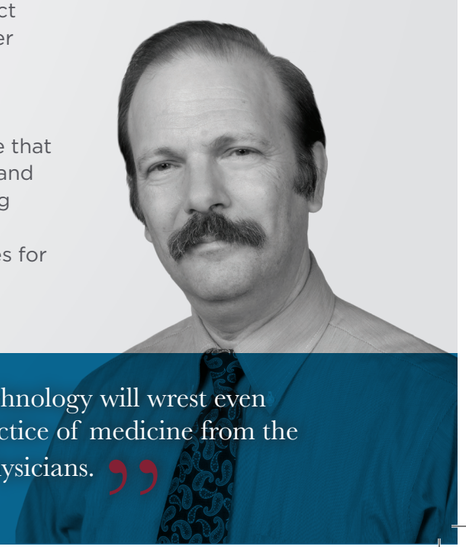
Over the next 25 to 30 years, certain medical areas and medical specialties will cease to be the sole domain of human beings. That change in dynamics is likely to impact relationships between the private sector and academic health centers.

One specific domain that is likely to change is the tradition of the physician being the center of the practice of medicine. For example, over the next several decades, imaging technology will advance to the extent that machines will become better than people at reading images and will be doing much if not most of that work. That evolution is likely to challenge the respective positions in medicine of specialties like radiology and pathology. A similar evolution is reflected in advances in robotic surgery, which are already changing the role of the surgeon. Rapid developments in that realm are also likely to challenge the standing of physicians.

The rise of technology will wrest even more control in the practice of medicine from the hands of physicians. IBM's Watson has the capacity to far eclipse any one doctor's ability to analyze many different medical records, or to digest the whole of the medical literature. As other technologies and tools—such as data analytics—take hold, we are likely to see a further shift in the balance of some power away from those who are using the technology to those who are designing, developing, and selling the technology.

Today, doctors are at the center of transactions with patients, insurance companies, Pharma, and medical instrument suppliers. But if the physician's role evolves such that the doctor is no longer at the center of such transactions, it stands to reason that transformation will, in turn, change the relationship between the private sector and academic health centers. Already, for example, we see doctors losing control over their practice to entities that control the money flow, including insurance companies and the government.

As the field of medicine becomes much more technology-intensive, that evolution alone will likely affect the dynamics and balance of power between the private sector and academic health centers. It will be incumbent on leaders in those respective sectors to both manage that effect to their respective benefits and to learn news ways of collaborating that reflect this changed dynamic, including seizing new opportunities for partnerships.



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