



Women's Health as a Model for Change in Academic Medical Centers: Lessons From the National Centers of Excellence in Women's Health

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Academic health centers serve a unique role in the American health landscape. They teach and train new doctors, conduct cutting-edge research, and provide quality health care services, including charitable care to the poor and very sick. In the current health care marketplace, academic health centers are under increasing pressure to maximize efficiencies, avoid redundancies, and cut costs. Their challenge is to do so without jeopardizing their mission to provide high-quality care, form well-trained doctors, and conduct important research. Within this context, the National Centers of Excellence in Women's Health (CoE), located in leading academic health centers across the United States and Puerto Rico, are exploring whether women's health can be a model for a more coordinated, informed, and accountable system of health care in academic health centers.

PRESSURES ON ACADEMIC HEALTH CENTERS

Academic health centers are under increasing pressure from a health care market driven by cost containments and managed care. Due to the combination of their research, teaching, and clinical care missions, costs in academic hospitals average 20 to 30 percent higher than those in nonteaching, community hospitals, placing them at a disadvantage when negotiating for reimbursements with managed care companies.¹ In addition, academic health centers have faced significant funding cuts associated with the Balanced Budget Act of 1997. This act included reductions in Medicare reimbursements for the delivery of charitable health care and cuts in payments to support the direct and indirect costs associated with providing graduate medical education.² These cuts have deeply affected teaching hospitals,

which provide about 40 percent of the nation's charitable health care and have historically relied on Medicare payments for nearly 30 percent of their revenues.^{1,3}

The goal of the Balanced Budget Act was to trim Medicare spending and reduce the numbers of new physicians being trained in what was seen to be an oversaturated market of health care providers. However, in 1999 the Association of American Medical Colleges estimated that the magnitude of the cuts in Medicare payments would be some \$88 billion greater than those originally estimated by the Congressional Budget Office and that, by 2002, cumulative reductions to teaching hospitals could reach nearly \$15 billion.² Two years into the legislation, academic health centers were declaring a state of crisis and successfully lobbied Congress to ease some of the funding cuts imposed in the Balanced Budget Act.⁴ In the 1999 Congressional budget, an estimated 10% of Medicare funding cuts were restored,⁵ which will result in an average 6% increase to teaching hospitals. Nonetheless, the continued squeeze in revenue, increase in health care costs, and growing consumer demand for quality will continue to force academic health centers to adapt or collapse.

STRATEGIES FOR A CHANGING HEALTH CARE ENVIRONMENT

In 1996, the Association of Academic Health Centers (AHC) undertook a large, national study on the impact of changes in the health care environment on the mission, financing, and governance of academic health centers.⁶ Based on the results

of that study, the organization established the following recommendations for ways academic health centers can re-evaluate and reposition their management and operations in a competitive health care environment:⁷

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- As complexity and competition increase, especially in a cost-conscious environment, strategy and focus become more important.
- Clinical restructuring offers a chance to accomplish restructuring across the entire academic health center.
- Societal forces, both from the government and from the marketplace, are making accountability more important than ever before.
- Patient-centered care will require the use of all health professionals, not just physicians.
- Each academic health center must have a research mission.
- Institutions must find a way to preserve individual initiative and entrepreneurship while recognizing and rewarding institutional success.
- Faculty must work across disciplinary boundaries.

THE NATIONAL CENTERS OF EXCELLENCE IN WOMEN'S HEALTH MODEL

Many of the institutional and philosophical shifts suggested by these recommendations mirror those initiated by the CoEs as they endeavor to create a new, integrated system of women's health in academic health centers. The CoE Program, supported by the Office on Women's Health in the U.S. Department of Health and Human Services, is focused on uniting advances in women's health and changing the way women's health is addressed, organized, and conducted in academic health centers. The Center model involves a total transformation from the traditionally fragmented approach of academic health centers along the strict lines of teaching, clinical service, and research to a more coordinated, comprehensive, and multidisciplinary system united around a common goal: improving women's health. This new system integrates the multiple spheres of activity within the academic health center, including the traditional areas of research, teaching, and clinical care along with new priorities: public education, community outreach, and career advancement for women in the health sciences.

The move from a fragmented to an integrated system for women's health requires the resources, individuals, and institutional setting conducive to *transformative* change—a change that profoundly transforms an existing system.

The CoEs are creating new models that are grounded in a redefinition of women's health as a comprehensive and multidisciplinary field, in new frameworks for thinking about women and their health, and in a gender-based approach to service delivery. Thus there is an emphasis on a cross-disciplinary approach to women's health both as a field and in clinical practice. The focus of clinical services is women-centered, and the outreach and public education activities are geared toward informing women as health care consumers and as health decision makers for their families. Research activities are united across multiple disciplines around a women's health agenda and linked to the teaching and clinical practice activities of the academic health center. Women's health is integrated into the medical curriculum and into training opportunities for residents and junior-level researchers. Leadership plans and activities to promote and retain female faculty, including minority women, are changing the pay equity, hiring, and promotion policies in CoE institutions. Evaluation and accountability are more clearly defined and coordinated through the integrated model.

IMPLEMENTING CHANGE

Change does not come easily to large institutions. The move from a fragmented to an integrated system for women's health

requires the resources, individuals, and institutional setting conducive to *transformative* change—a change that profoundly transforms an existing system. It requires an institutional commitment to women's health, with support from top-level administrators. It also requires an institutional environment that is conducive to change, or the ability to capture opportunities that arise during other institutional transformations (ie, curricular revisions, buying of physician practices, establishment of special service lines). In light of the financial pressures on academic health centers, this type of structural change also needs to bring added value and efficiencies to the institution without consuming valuable resources.

The CoEs have encountered resistance to change in many forms. One example has been the difficulty of engag-

ing elements within the institution that are already strong and independent. Similarly, some Centers have encountered resistance to multidisciplinary collaboration from specialists who do not see themselves as working in women's health. The effort to integrate activities has gone against traditional currents that relegate women's health to a low status, emphasize specialization, and take a disease-based approach to medicine. Some institutions face the challenge of demonstrating how women's health can be valuable to the bottom line, particularly in a model that emphasizes primary care, prevention, and patient education.

The CoEs have faced these challenges by maximizing the potential of their institutional resources in women's health with added efficiencies and coordination. Examples have included the establishment of electronic databases for women's health researchers, organization of interdisciplinary teams, and sponsorship of cross-disciplinary meetings. CoEs have also developed women's health teaching instruments, provided support for women's health grant proposals, and coordinated patient recruitment for clinical studies. They have rationalized electronic and library resources on women's health and education and developed women-focused patient-satisfaction surveys. CoEs have partnered with community businesses, organizations, and schools to promote patient education, outreach, and leadership development.

As suggested by the AHC recommendations, the restructuring of clinical services and other women's health activities through interconnected, interdisciplinary pathways has led to broader institutional restructuring. The links and networks developed and maintained by the CoEs have changed the way their institutions do business. They have brought together individuals and spheres of activity that might not otherwise intersect—for example, uniting basic science researchers with clinicians, creating multidisciplinary teams of providers, linking faculty with community representatives, or developing stronger partnerships with community and other outside organizations. The refocusing of activities around women's health has redefined institutional boundaries and underscored the commonalities

between disciplines and across research, teaching, clinical care, and outreach.

The CoE model has also provided a market draw around women's health for institutions in areas of intense health care competition. It has attracted national and international attention and even engendered its own movement. CoE faculty and staff have come together across centers to exchange information, replicate new models, collaborate on research initiatives, and develop joint articles for publication. Cross-center evaluations are currently in development to more fully capture the effect of the CoEs on their institutions, on women's health, and on other academic health centers.

Transformative change takes time. Future evaluations and time will be the test of the long-range success of CoEs. If successful, women's health as practiced in the CoEs will indeed serve as the vehicle for moving academic health centers in a new direction.

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